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NEW CARE MODELS:

Vanguards - developing a blueprint for the future of NHS and care services

NOVEMBER 2015

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WHAT IS THE NEW CARE MODELS PROGRAMME?

In January 2015, the NHS invited individual organisations and partnerships to apply to become 'vanguard' sites for the new care models programme, one of the first steps towards delivering the *NHS Five Year Forward View* and supporting improvement and integration of services.

In March, the first group of 29 vanguard sites were chosen. There were three vanguard types – integrated primary and acute care systems; enhanced health in care homes; and, multispecialty community providers.

Integrated primary and acute care systems will join up GP, hospital, community and mental health services, whilst multispecialty community providers will move specialist care out of hospitals into the community. Enhanced health in care homes will offer older people better, joined up health, care and rehabilitation services.

In late July, eight additional vanguards were announced. Urgent and emergency care vanguards will develop new approaches to improve the coordination of services and reduce pressure on A&E departments.

A further 13 vanguards were announced in September – known as acute care collaborations, they aim to link local hospitals together to improve their clinical and financial viability, reducing variation in care and efficiency.

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

Each vanguard site will take a 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.

What does it mean for patients?

The vanguards are improving the care received by millions people across England.

Through the new care models programme, complete redesign of whole health and care systems are being considered. This could mean fewer trips to hospitals with cancer and dementia specialists holding clinics in local surgeries, having one point of call for family doctors, community nurses, social and mental health services, or access to blood tests, dialysis or even chemotherapy closer to home.

It will also join up the often confusing array of A&E, GP out of hours, minor injuries clinics, ambulance services and 111 so that patients know where they can get urgent help easily and effectively, seven days a week.

The partners

The new care model vanguards are a key element within the *Five Year Forward View* which is a partnership between NHS England, the Care Quality Commission, Health Education England, Monitor, the NHS Trust Development Authority, Public Health England and the National Institute for Health and Care Excellence.

Supporting the vanguards

In July, the Forward View partners published an initial support package for the first 29 vanguards.

The support package was developed following extensive engagement with the vanguard leaders, including two-day visits to all 29 sites in April and May 2015 and follow-up discussions and seminars. It aims to enable them to make the changes they want to make effectively and at pace.

Building on the best practice already being displayed, the support package is designed to be led by vanguard leaders alongside national experts, and aims to help the vanguards be as successful as possible in making the changes they are planning.

It is also intended to maximise sharing of learning and practice across the vanguards and, importantly, with the wider NHS and care system – a key element of the vanguards' work.

The support package, which covers 2015/16, focuses on eight areas:

1. **Designing new care models** – working with the vanguards to develop their local model of care, maximising the greatest impact and value for patients;
2. **Evaluation and metrics** – supporting the vanguards to understand – on an ongoing basis – the impact their changes are having on patients, staff and the wider population;
3. **Integrated commissioning and provision** – assisting the vanguards to break down the barriers which prevent their local health system from developing integrated commissioning and provision;
4. **Empowering patients and communities** – working with the vanguards to enhance the way in which they work with patients, local people and communities to develop services;
5. **Harnessing technology** – supporting the vanguards to rethink how care is delivered, given the potential of digital technology to deliver care in radically different ways. It will also help organisations to more easily share patient information;
6. **Workforce redesign** – supporting the vanguards to develop a modern, flexible workforce which is organised around patients and their local populations;
7. **Local leadership and delivery** – working with the vanguards to develop leadership capability and learn from international experts, and;
8. **Communications and engagement** – supporting the vanguards to demonstrate best practice in the way they engage with staff, patients and local people.

A number of dedicated workstreams – which are being led by a vanguard leader and national subject matter expert – are working with the vanguards to refine what is being offered so that it is fully tailored to their needs.

In addition to the practical support outlined in the new document, vanguards also have access to a £200m transformation fund.

Support for more recently announced vanguards – acute care collaboration vanguards and urgent and emergency care vanguards – will be published shortly.

New care models - vanguard sites

Integrated primary and acute care systems - joining up GP, hospital, community and mental health services

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Multispecialty community providers - moving specialist care out of hospitals into the community

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22 Lakeside Healthcare (Northamptonshire)
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Enhanced health in care homes - offering older people better, joined up health, care and rehabilitation services

24 Connecting Care - Wakefield District
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Urgent and emergency care - new approaches to improve the coordination of services and reduce pressure on A&E departments

30 Greater Nottingham System Resilience Group
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32 North East Urgent Care Network
33 Barking and Dagenham, Havering and Redbridge System Resilience Group
34 West Yorkshire Urgent Emergency Care Network
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37 South Devon and Torbay System Resilience Group

Acute care collaborations - linking hospitals together to improve their clinical and financial viability

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

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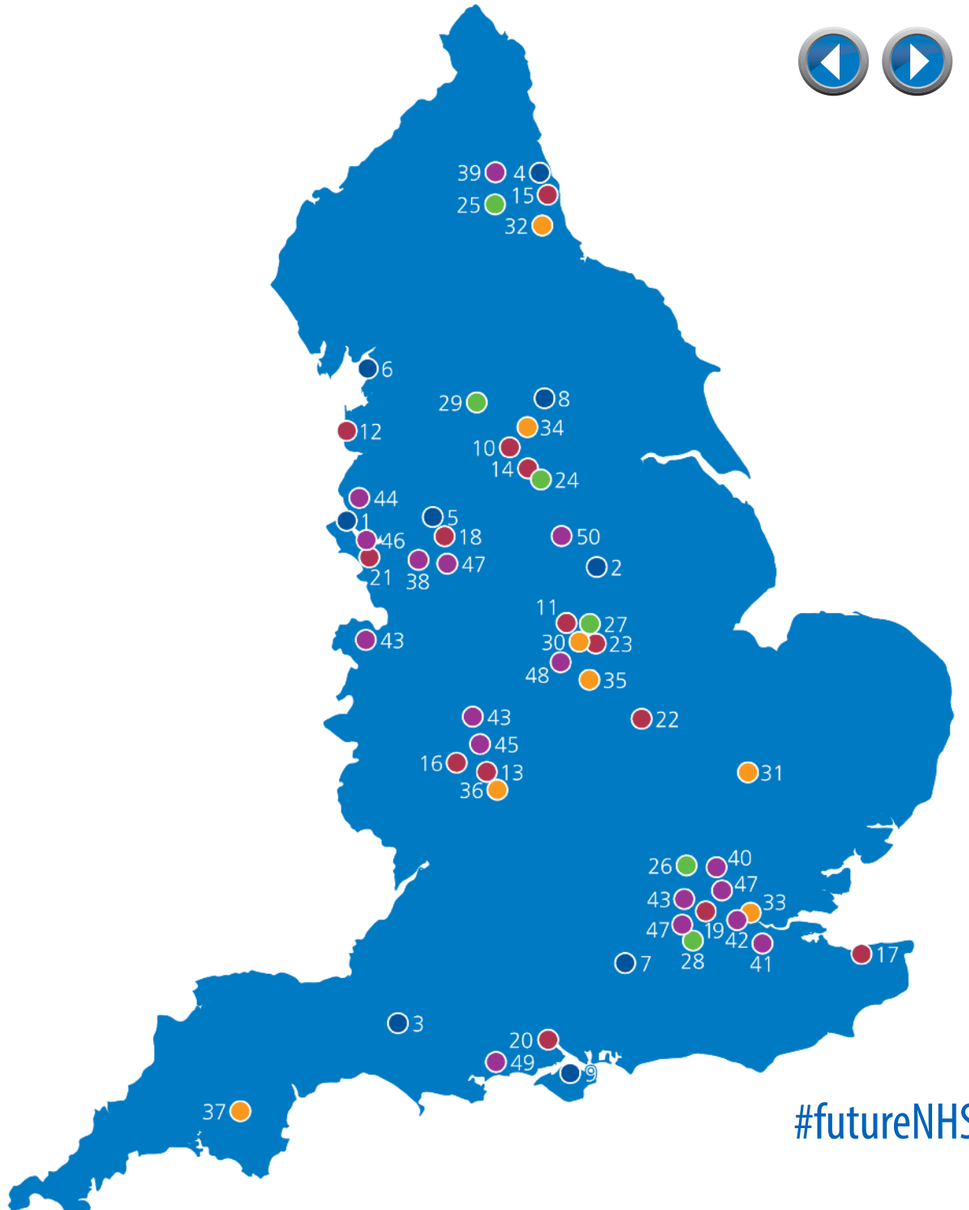

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The vanguards: integrated primary and acute care systems

1. Wirral Partners

PARTNERS
Wirral University Teaching Hospital NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Community NHS Trust, Wirral Clinical Commissioning Group, GPs on the Wirral, Wirral Metropolitan Borough Council, Cerner UK Ltd and Advocate Physician Partners (accountable care organisation) alongside local patient and community groups and Wirral Healthwatch.

The organisations jointly serve a population of more than 400,000.

AIM
The vanguard aims to use a range of approaches to meet the different needs of specific sections of their local population.

OUTLINE
Wirral Partners health and wellbeing model is based on self-care and independence as a foundation to wellbeing. Work is underway to enable more timely access to services with a care-navigation approach which will guide people to the support they require to be healthier for longer.

There are plans for integration between traditional acute and primary care roles and the provision of more care in community settings.

Expected outcomes include a reduction in emergency admissions to hospital, fewer permanent admissions to residential or nursing care and a rebalancing of health inequalities such as life expectancy.

Another important element is the vanguard's plan to create health economy-wide patient records, giving real-time access to the best information to support care. This will also enable better care planning and the delivery of care pathways across organisational boundaries.

Follow us: @wuthnhs

2. Mid Nottinghamshire Better Together

PARTNERS
Central Nottinghamshire Clinical Services, Circle Health Limited, East Midlands Ambulance Service NHS Trust, Nottinghamshire County Council, Nottinghamshire Healthcare NHS Trust (including County Health Partnerships), Nottingham University Hospitals NHS Trust, Sherwood Forest Hospital NHS Foundation Trust and United Lincolnshire Hospitals NHS Trust.

The partners together serve a population of around 310,000.

AIM
Better Together aims to ensure that everyone receives the best possible care with high quality, sustainable services. The vanguard is working towards care becoming much more integrated, with doctors, nurses and social care staff working together more closely to support the needs of patients, their families and carers.

OUTLINE
Better Together sets out a bold vision for the way health and care services will look over the next five years, based on population needs and public, stakeholder and staff feedback about current services.

It focuses on several important areas – urgent and proactive care (including care for people with long term conditions like diabetes or asthma, and frail older people) and early and planned care (such as surgery for hips and knees, or cataracts).

Feedback from local communities is central to planning and the Better Together team has completed a considerable amount of engagement with patients, the public and staff. They have used this feedback to shape the design of future care services and understand what health outcomes are important to the local population.

Follow us: @bettermidnotts

3. South Somerset Symphony Programme

PARTNERS
Yeovil Hospital, the Somerset GP Federation, Somerset Clinical Commissioning Group and Somerset County Council.

The population covered by the South Somerset Symphony Programme is 200,000.

AIM
This vanguard aims to develop an integrated care system in south Somerset which removes organisational boundaries and allows staff to work together to provide the population with swifter and easier access to services and support.

The integrated care organisation will be managed by a joint venture of health and social care professionals.

OUTLINE
The Symphony project will develop new care pathways which provide early intervention and proactive care, closer to where patients live. Patients – particularly those with complex conditions – will be supported to retain their independence, stay healthier for longer, and avoid unnecessary admissions to hospital.

GPs, hospital clinicians, therapists, social workers and patients will develop packages of care together which recognise the totality of an individual's care and lifestyle needs.

The Symphony project is also exploring new models of care which make routine clinical interventions – such as certain day surgery procedures – more accessible and efficient.

Follow us: @symphonyproj

4. Northumberland Accountable Care Organisation

PARTNERS
Northumbria Healthcare NHS Foundation Trust and NHS Northumberland Clinical Commissioning Group in North East England are the lead partners. Other partners include Northumberland County Council, local GPs, mental health services, the ambulance service, as well as local patients, Healthwatch and the Health and Wellbeing Board.

These NHS organisations jointly serve a population of more than 320,000 in Northumberland – one of the largest geographical and most rural areas of England.

AIM
The collective ambition for the NHS in Northumberland is to create a single accountable care organisation (ACO) from 2017. The ACO will: focus on preventing ill health and empower people to live long and healthy lives at home; improve patient outcomes and experience; provide seamless coordination of care; and, maximise resources and reduce duplication.

What will this mean for patients?
- Better access to care seven days a week – both for serious emergencies and primary care.
- Better use of technology to empower people to take control of their own health and wellbeing, live independently and stay healthy.
- Care delivered by an aligned, integrated workforce, operating as one team, in one system with joined-up.
- One unified patient record, reducing the need for patients to repeat 'their story' to different health professionals and different parts of 'the system'.

OUTLINE
In June 2015, this vanguard completed its first phase of work by opening Northumbria Specialist Emergency Care Hospital to provide seven day specialist services in acute care for all serious emergencies. Urgent care is now available 24/7 for walk-in patients at general hospital sites.

The next phases of work involves creating central primary care 'hubs' across Northumberland with GPs working in networks to improve access to primary care services during working hours, in the evenings and at weekends to meet patient need.

Work will also take place to identify alternative, flexible, workforce solutions, to allow more care to be delivered by different types of health care professionals in people's homes and community settings with a strong focus on prevention.

Follow us: @NorthumbriaNHS
@NHSNLandCCG

5. Salford Together

PARTNERS
Salford City Council, NHS Salford Clinical Commissioning Group, Salford Royal NHS Foundation Trust and Greater Manchester West Mental Health NHS Foundation Trust.

Salford has a population of 230,000.

AIM
Salford Together aims to integrate health and social care for older people in Salford, bringing the contributions of GPs, district nurses, social workers, mental health professionals, care homes, voluntary organisations and local hospitals into a more aligned system and provide older people with the support they need to manage their own care.

OUTLINE
This new care model has already been tested and refined in two areas which account for 40 per cent of older people in Salford. By the end of 2015, it is hoped the whole city will experience the benefits of this new, integrated way of working.

The vanguard is developing multidisciplinary groups of clinicians and other staff to provide targeted support to people who are most at risk. There is also a population focus on screening, prevention and signposting to community support.

This includes establishing a contact centre which acts as a central health and social care hub, supporting multidisciplinary groups. The centre will also help people to navigate services, access support and will coordinate the use of telecare. The vanguard also intends using local community support to help enable people to remain independent and develop greater confidence to manage their own care.

Follow us: @SalfordTogether

6. Better Care Together (Morecambe Bay Health Community)

PARTNERS
The Better Care Together vanguard is a partnership of 11 organisations based across Morecambe Bay and includes University Hospitals of Morecambe Bay NHS Foundation Trust, Cumbria Partnership NHS Foundation Trust, North West Ambulance Service, Blackpool Teaching Hospitals NHS Foundation Trust, Lancashire Care NHS Foundation Trust, Lancashire County Council, Cumbria County Council, Lancashire North Clinical Commissioning Group (CCG), Cumbria CCG, North Lancashire Medical Services and South Cumbria Primary Care Collaborative.

It serves a population of 365,000 people in an area that is geographically dispersed, financially challenged and has areas of deprivation and health inequality.

AIM
Better Care Together aims to improve the sustainability of services, enhance the quality, safety and experience for patients, and reduce the health system financial deficit. It aims to do this by working interdependently with a much more integrated out-of-hospital sector and moving to a smaller, more productive group of hospitals.

OUTLINE
Better Care Together will see the development of multidisciplinary core teams based within communities across Morecambe Bay. There will be increased general practice capacity and capability, with an expansion of community based specialist services.

Increasingly, hospital clinicians will work within the community based teams fostering a shared approach to staff development and improving pathways of care.

The vanguard is focusing on ensuring that people who use local services experience care and support that works the way it should and that they are supported to take control of their health and wellbeing. Most of their care and support will be provided within their local community, based around their GP practice, with access to safe and high quality specialist care as and when it is needed.

This vanguard programme was developed by over 200 healthcare professionals together with input from a wide range of local patients, community groups and third sector colleagues.

Follow us: @BCTMorecambeBay

7. North East Hampshire and Farnham

PARTNERS
NHS North East Hampshire and Farnham Clinical Commissioning Group, Frimley Health NHS Foundation Trust, Southern Health NHS Foundation Trust, Surrey and Borders Partnership NHS Foundation Trust, Virgin Care, South East Coast Ambulance NHS Foundation Trust, North Hampshire Urgent Care, and Hampshire and Surrey county councils.

This vanguard serves a population of more than 220,000.

AIM
The vanguard aims to keep people happy, healthy and at home by motivating and supporting local people to improve their own health and ensuring a seamless service when they are ill or need support.

OUTLINE
The focus of the vanguard is on the way services are commissioned and the way organisations are set up. These will be reshaped to best support the new model of care.

The programme will focus on preventing ill health and maximising self-care, helping people to manage their own health conditions, empowering them to make choices about their care and ensuring the right services are available to all.

It will also develop integrated teams of specialist health and social care professionals. These teams will comprise community nurses, occupational therapists, physiotherapists, social workers, a psychiatric nurse, a lead psychiatrist, a pharmacist, a geriatrician, GPs, the voluntary sector, and specialists in palliative care and domiciliary care. They will ensure joined up care for patients, especially those who are vulnerable or have complex needs.

There will also be enhanced community services for people in their own homes, in GP surgeries and local community hospitals. There will also be access into and out of specialist inpatient care – in community hospitals (such as in Farnham and Fleet) as well as Frimley Park Hospital.

The vanguard's work will enable health and social care professionals to speed up plans to develop new ways of providing and paying for support and services for local people. It will also provide better value for money, helping to close the gap between the available resources and the costs of providing services to meet need.

8. Harrogate and Rural District Clinical Commissioning Group

PARTNERS
Harrogate District NHS Foundation Trust, Harrogate and Rural District Clinical Commissioning Group, North Yorkshire County Council, Tees Esk and Wear Valley Foundation Trust, Harrogate Borough Council and Yorkshire Health Network.

The vanguard covers a population of approximately 160,000.

AIM
This vanguard aims to transform the way care is provided locally with GPs, community services, hospitals, mental health and social care staff working together to support people to remain independent, safe and well at home. The vanguard wants to see care provided by a team that a person knows and feels they can trust. This will be set out in a care plan.

OUTLINE
The vanguard focuses on prevention. Targeted services will be increased including their Stronger Communities Programme (focused on building communities and self-care), prevention officers (working with people who may need care in the future) and falls, bereavement and mental health preventative support services.

This work is built on what local people told the vanguard partners is important to them. Services will be provided by an integrated care team including GPs, community nurses, adult social care, occupational therapy, physiotherapy, mental health and the voluntary sector.

Boundaries between primary, community, acute, mental health and social care will be removed and hospital beds will be used only when they are truly needed.

9. My Life a Full Life (Isle of Wight)

PARTNERS
Isle of Wight Clinical Commissioning Group, Isle of Wight NHS Trust (a unique provider of ambulance, community, hospital, learning disability and mental health services), Isle of Wight Council, One Wight Health (a GP collaborative) and the voluntary and independent sectors.

Jointly the partners serve a population of 140,000.

AIM
The vanguard's new care model is aimed at improving health and wellbeing. It also works to enhance care and improve quality outcomes, delivering more care in people's own homes and in the community, and making health and wellbeing more financially sustainable. Care on the island has historically been reliant on statutory services and is no longer financially sustainable. Vanguard support is helping accelerate the move to the new care model.

OUTLINE
The integrated 'My Life a Full Life' model is prevention-based, promotes health and wellbeing and is built on experience-based co-design. It is also founded on the principles of self-care and empowered communities.

At the centre of our model is the person, whose care across the community and system is coordinated and supported by care navigators. This single point of contact will triage, reduce perceived system complexity, increase awareness of services, and maximise efficiency.

Another key element of the model is integrated locality teams which deliver person-centred care and support in the community, with GP clinical leadership and multi-specialist teams.

Follow us: @MyLifeAFullLife

The vanguards: multispecialty community providers

10. Calderdale Health and Social Care Economy

PARTNERS
Calderdale Pennine GP Alliance, Calderdale and Huddersfield Foundation Trust, Calderdale Clinical Commissioning Group , Calderdale Metropolitan Borough Council, South West Yorkshire Partnership Foundation Trust, Locala Community Partnerships and Voluntary Action Calderdale.

This vanguard will service a patient population of around 100,000.

AIM
This vanguard will build on ongoing work to integrate health and social care – the 'care closer to home' programme – enabling the team to deliver benefit at a greater pace and scale. It aims to offer a measurable shift in the balance of service delivery from avoidable unplanned admissions to hospital, to planned, integrated care, delivered in primary care and community settings.

OUTLINE
Calderdale has a shared commitment towards a common goal – a sustainable people-centred, future proof system for delivering health and social care locally.

One of the challenges that the vanguard faces is its valley geography, which has an impact on access and flow. The team is already trialling pilot schemes to provide truly integrated services closer to where people live.

The focus of the programme is on three patient cohorts – people with long-term conditions, people at risk through frailty, and children with complex health and care needs.

The vanguard will pilot innovative schemes to help these groups, firstly in the more remote west side, the 'upper valley,' but quickly roll-out learning across Calderdale.

The team has also already installed telecare technology in care homes and is confident about the positive effect that it is having upon the experience of care for residents, reducing their dependency upon hospital care. Patients with chronic obstructive pulmonary disease (COPD) now have access to telehealth.

Progress is also being made on a 'staying well' programme for older people, helping to tackle social isolation and loneliness.

At the other end of the age spectrum, a child health pilot has been launched in north east Halifax, bringing together the local hospital trust, GPs and children's community nurses to run paediatric clinics at a children's centre in the community.

11. Erewash Multispecialty Community Provider

PARTNERS
Derbyshire Community Health Services NHS Foundation Trust, Derbyshire Healthcare NHS Foundation Trust, Erewash GP Provider Company, Derbyshire Health United and NHS Erewash Clinical Commissioning Group.

This vanguard covers a population of 97,000 people.

AIM
This vanguard aims to bring together major community and mental health services alongside GPs to develop a prevention and support team. The team is made up of health and care staff, including GPs, advanced nurse practitioners, mental health nurses, extended care support and therapy support.

OUTLINE
The vanguard focusses on the delivery of services to people with long-term conditions including diabetes, chronic vascular disease and chronic lung conditions.

There are also plans to extend GP access and improve records so that the treatment plans of the most vulnerable people are available for all community and primary care staff. This will reduce duplication and assist in times of need for out of hours or emergency treatment.

Health professionals will talk frail and vulnerable people through their concerns and support them to remain in their homes. Healthcare 'hubs' will bring medical, nursing and mental health professionals together to share information and knowledge about patients with long-term conditions and acute medical needs so they get the best care possible to stay well for longer.

The vanguard will also further develop telehealth technology to help people with long-term conditions to manage their health better – particularly for those with cardiovascular disease, respiratory diseases and diabetes.

Follow us: @DCHStrust
@NHS_Erewash_CCG @derbyshcft

12. Fylde Coast Local Health Economy

PARTNERS
NHS Blackpool Clinical Commissioning Group, NHS Fylde and Wyre Clinical Commissioning Group, Blackpool Teaching Hospitals NHS Foundation Trust, Lancashire Care NHS Foundation Trust, Lancashire County Council and Blackpool Council.

NHS Blackpool and NHS Fylde and Wyre Clinical Commissioning Groups have a joint registered population of 320,000 people living across a mix of coastal town and rural villages.

AIM
The vision for the Fylde Coast is to 'wrap' healthcare around the patient, delivering more support in the heart of the community and less in hospital.

OUTLINE
This vanguard is already delivering new extensive care services where clinical and non-clinical staff work together, providing proactive care for elderly and frail patients with long-term conditions. This dramatically reduces the need for unplanned hospital visits. Two extensive care services went live in June 2015 and another five will become operational during the next 18 months.

Complementing extensive care, plans for enhanced primary care will enable even more support to be delivered closer to patients' homes. Integrating community services will see GPs working in neighbourhoods alongside community care and social workers. Supported by shared electronic care records and a single point of contact for all out-of-hospital services this will ensure seamless care for all.

Follow us: @blackpoolccg
@fyldeandwyreccg @BlackpoolHosp
@Bpoolcouncil @lancashirecc
@lancashirecare

13. Vitality (Birmingham and Sandwell)

PARTNERS
Birmingham Children's Hospital, Birmingham City Council, Birmingham Community Health Care Trust, Birmingham and Solihull Mental Health Trust, Sandwell and West Birmingham Hospital Trust, Sandwell and Birmingham Clinical Commissioning Group, and Vitality Partnership (15 GP practices).

The vanguard covers 200,000 patients within Birmingham and Sandwell.

AIM
This vanguard aims for a future where patients will tell their story once. It wants care to be better joined up and for patients to be at the very heart of care planning and health management.

OUTLINE
By working together and centralising some processes for streamlined, efficient and effective care, health and social care staff will release more time for patients. A new clinical model has already released capacity with positive feedback from patients and clinicians.

The vanguard will also be looking at improvements in technology to help make it easier for people to access healthcare. In the new model of care, all health and care organisations will encourage patients to take responsibility for their health – making sure they get checks, attend appointments and live a healthy lifestyle.

The model will be delivered by the full range of health and care partners who are committed to the long-term vision of transformation for healthcare through the 'Right Care Right Here Partnership'. This includes the build of a new hospital (Midland Met) by 2018, moving more services into local settings and a drive for improving people's health by focusing on prevention, access and choice.

14. West Wakefield Health & Wellbeing Ltd

PARTNERS
West Wakefield Health & Wellbeing Ltd is a federated network of GP practices in west Yorkshire. Other partners include: NHS Wakefield Clinical Commissioning Group, Wakefield Council, Wakefield District Housing, South West Yorkshire Partnership NHS Foundation Trust, Healthwatch Wakefield, Mid Yorkshire Hospitals NHS Foundation Trust, NOVA (voluntary community sector representative body), Yorkshire Ambulance Service and Local Care Direct.

It is currently responsible for around 65,000 patients. Under vanguard there are plans to merge with two other GP practice networks in the area, which will see the number rise to 152,000.

AIM
As a multispecialty community provider, West Wakefield Health & Wellbeing Ltd will be working to provide a larger, more diverse primary care team locally. There are currently 73 care navigators working in practices. The majority of these care navigators are administrative staff who generally have first contact with patients, trained to direct them to the most appropriate care.

OUTLINE
A key element of this vanguard's programme is improved physical access to care. It is working to improve its care navigation system, directing patients to the help they need faster. The extended operating hours service has been running since October 2014, and the plans to work with two other GP networks under vanguard will expand both the number of clinicians and patients. Meanwhile the HealthPod, West Wakefield's mobile clinic, is improving engagement with 'hard to reach' groups such as members of the gypsy/traveller community.

The vanguard is also creating more ways for patients to digitally access healthcare. This includes an online directory of local services, which pulls information from a variety of sources online including social media and a library of helpful health apps on its website. The vanguard is also engaging primary school pupils in health using a competition to design health apps. An app is now being built based on the idea of last year's winning team.

Self-service kiosks in practices will help patients to access these and other helpful resources, pointing to appropriate care before a patient enters a clinic room. The vanguard is also looking at the potential for use of email/instant messaging and video consultations.

Follow us: @westwakefield

15. Better Health and Care for Sunderland

PARTNERS
This vanguard is led by NHS Sunderland Clinical Commissioning Group (CCG) and Sunderland City Council, in collaboration with local providers including Sunderland Care and Support Service, South Tyneside NHS Foundation Trust (providing community services in Sunderland), Sunderland City Hospitals NHS Foundation Trust. It also includes the city's two GP Federations (Sunderland GP Alliance and Washington Community Healthcare), Sunderland Carers Centre, Sunderland Age UK, and Northumberland and Tyne and Wear NHS Foundation Trust.

This vanguard covers a population of 284,000 people.

AIM
The vanguard has an ambitious vision to transform care out of hospital through increased integration of community services to provide person-centred coordinated care.

OUTLINE
The vanguard is working to provide an enhanced citywide recovery at home service to offer rapid response at home or in community beds to prevent emergency admissions to hospital and support patients after they are discharged from hospital.

Another key area is integration of community nursing, social workers, GPs and voluntary staff in five locality teams, wrapped around GP practices providing planned and proactive care.

The integrated locality teams will ensure care is better coordinated, planned and more proactive, particularly for patients most at risk of avoidable emergency admissions. Based in one location in each locality but working closely with clusters of practices, the teams will be supported by the recovery at home service.

GP practices will be supported to work more collaboratively through the two federations, with the aim of providing enhanced care to patients with long-term conditions.

Follow us: @BhforSunderland

16. Dudley Multispecialty Community Provider

PARTNERS
NHS Dudley Clinical Commissioning Group, Dudley Metropolitan Borough Council, Dudley Group NHS Foundation Trust, Black Country Partnership Foundation Trust, local GPs, Dudley and Walsall NHS Partnership Trust and Dudley Council for Voluntary Service.

Dudley has a population of around 318,000 people.

AIM
This vanguard aims to integrate services in order to wrap health and social care around patients – putting them at the centre of their care and in control.

OUTLINE
The vision is for teams to work together, and with patients, their families and carers to ensure they have the help and support to live life as independently as possible.

GPs are at the centre of the model as they have the responsibility for the patients that choose to register with them. The vanguard seeks to empower local communities to take control and responsibility for their health and happiness, and use their skills and expertise to build community connections and cohesion.

The model already includes voluntary sector link workers as part of the teams which are contributing to building relationships and networks and reducing social isolation. There are also plans for a single GP record operating across the whole system and to develop new technologies to improve access, continuity and coordination of care.

The vanguard aims to streamline and simplify patient pathways, removing complexity and bureaucracy from the system and looking holistically at the whole person and not just their illness or issue.

17. Whitstable Medical Practice

PARTNERS
GP practices across Whitstable, Canterbury and Faversham, NHS Canterbury and Coastal Clinical Commissioning Group, Kent County Council, Pilgrims Hospices, local NHS trusts, mental health services, public health and voluntary and community services.

The organisations jointly serve a population of approximately 170,000 people.

AIM
The new model of care being developed by Whitstable, Northgate and Saddleton Road Medical Practices is a multispecialty community provider. This is expanding to include an additional 13 practices across the Canterbury and Coastal area.

This new model will ensure health and social care is integrated and based around local needs and patients can receive more of their treatment in their local communities, rather than having to travel to hospital.

OUTLINE
This vanguard is focussed on developing a seven day a week expanded primary care team approach. This will reduce hospital admissions and length of stay through expansion of community health and social care teams.

We want to create a more cost and clinically effective service by treating patients closer to home using specialist GPs, allied health professionals and community based consultants. There will also be a greater use of information technology, using telecare and telemedicine to enable people to maintain their independence through self-care and self-management, and a shared single electronic patient record.

Three health and social care hubs will also be created and will include community hospital beds, nursing home beds and extra care facilities.

Additionally, focusing on prevention will ensure that the whole health and social care system is working seamlessly to support people to stay well and supports them where necessary.

Patients are involved in helping to decide which services the vanguard should include through groups known as community networks.

18. Stockport Together

PARTNERS
Stockport NHS Foundation Trust, NHS Stockport Clinical Commissioning Group, Pennine Care NHS Foundation Trust and Stockport Metropolitan Borough Council along with Stockport's GP federation, frontline staff, the public and third party voluntary organisations.

Stockport Together will be serving a GP registered population of more than 305,000.

AIM
Stockport Together aims to develop a single strategic plan to improve health and social care services across the borough. It wants to fundamentally reform the way health and social care is delivered in Stockport to ensure the best possible outcomes for local people. This is against a backdrop of growing demand and restricted funding

OUTLINE
The model in Stockport is a GP-led neighbourhood-based out-of-hospital service, which includes community health services, mental health, social care and the third sector.

Initially, the vanguard will be commissioned to deliver care to the over 65 population of Stockport on a weighted capitation basis. The model covers a range of measures including screening for early detection of diseases and supporting people to manage their own care where appropriate through education.

Where people have complex conditions crisis response will be put in place through an anticipatory plan to help support them in the management of exacerbations themselves and reduce the stress that this can cause.

A facility will also be developed to allow GPs to call consultants directly for advice initially across up to eight specialties using a cascade system. The vanguard will also utilise the skills of social care and third sector partners to build community capacity in each neighbourhood.

Follow us: @Stockport2gther

19. Tower Hamlets Integrated Provider Partnership

PARTNERS
Tower Hamlets GP Care Group Community Interest Company, Barts Health NHS Trust, East London NHS Foundation Trust and London Borough of Tower Hamlets.

The vanguard serves around 280,000 people.

AIM
This vanguard aims to establish a new model of community care which will enable social care, primary, community and acute health services to truly coordinate their services around the patient.

OUTLINE
The vanguard is working to ensure that more patients have their care coordinated around their needs and are not left to navigate themselves through numerous different services. It will also help more vulnerable patients receive care in their own homes, limiting time spent in hospital away from their family and friends.

A key part of the vanguard is a greater focus on a positive patient experience. Patients can expect improved experience of care across all health and social care services in the local community.

Follow us: @THIPPVanguard

20. Better Local Care (Southern Hampshire)

PARTNERS
Better Local Care is a growing partnership of around 30 GP practices, Southern Health NHS Foundation Trust and local commissioners based in Hampshire.

The teams currently support around 220,000 people with more teams following in the coming months.

AIM
This vanguard aims to provide better access, experience and outcomes for patients closer to their homes. This means fewer people will need to go to hospital, and more will be supported to take control over their own health and wellbeing.

OUTLINE
Better Local Care is joining services up to form one extended team of health, social care, third sector and GP colleagues who support the same local population. This will improve access to the right professional at the right time, including specialists – with fewer unnecessary appointments in between.

By working in this way, health and care professionals will have more time to support people who are most at risk of worsening health and wellbeing.

This vanguard understands that people who use services are experts too. A big part of Better Local Care is finding new ways to collaborate with users and carers so new care models really work for them and their families.

Follow us: @betterlocalcare

21. West Cheshire Way

PARTNERS
Primary Care Cheshire (GP Federation involving all 36 GP practices based in west Cheshire) and the local community services provider supported by West Cheshire Clinical Commissioning Group, Cheshire and Wirral NHS Partnership Foundation Trust, the Countess of Chester NHS Foundation Trust, Cheshire West and Chester Local Authority and partners from the third sector. Local patient voluntary and community groups are involved too, including Healthwatch Cheshire West.

These organisations serve a population of around 250,000.

AIM
With an emphasis on transforming care from cradle to grave, West Cheshire Way focusses on starting well, living well and ageing well as the drivers for change.

OUTLINE
A key theme running throughout the West Cheshire Way vanguard is that the individual and their family and carers will be given the tools and confidence to manage their condition for themselves, so far as is possible. This will involve clinicians and local people working together to build an understanding of what self-care means and to co-design it together. Where self-care is not the solution, West Cheshire Way is committed to involving local patients, families and carers in co-designing care models that meet their needs.

Babies, children and young people will look to their local GP and cluster team as their gateway to coordinated support. Adults will be helped to make healthier choices via innovative self-care programmes, and people with long-term conditions will be identified and supported to minimise the impact on their daily lives.

Vulnerable older people will be cared for by GPs and integrated community teams who will proactively identify and target those most at risk, develop shared care plans with a single care coordinator and ensure care is provided by specialist, multidisciplinary teams.

Follow us: @WestCheshireCCG

22. Lakeside Healthcare (Northamptonshire)

PARTNERS
Kettering General Hospital, University Hospital Leicester, Northampton County Council, Corby Borough Council, Celesio, Lloyds Pharmacy, Leonard Cheshire Homes and Olympus Social Care Services.

Lakeside Healthcare is the largest single GP 'super-practice' partnership in the NHS with a patient list of over 60,000. It is headquartered in Corby, Northamptonshire with several branch surgeries in nearby towns.

Through Lakeside Healthcare this vanguard looks after over 100,000 patients.

AIM
By April 2016, Lakeside Healthcare aims to be one of the first accountable care organisations in the NHS.

OUTLINE
The model is to further develop their home and community based service that puts the patient at the very centre of everything they do.

The vanguard will offer patients four new models of care which complement each other: Lakeside Extensivist Services; Lakeside Enhanced Primary Care; Lakeside Ambulatory Surgery Centres; and, CorbyCare Urgent Care Model.

Lakeside Extensivist Services is a holistic care system which will provide coordinated, comprehensive care to the most needy and frail patients. It aims to ensure patients receive highly personal care with better access and are engaged in the management of their conditions.

Lakeside Enhanced Primary Care is team-based care that provides comprehensive and convenient medical care to a specific patient segment. This will also allow patients to receive whole-person focussed care delivered by their current GP.

Lakeside Ambulatory Surgery Centres are outpatient centres delivering high efficiency care in a convenient setting with improved patient scheduling which supports increased patient choice.

CorbyCare Urgent Care operates either as a standalone service or on a hospital site and has satellite primary-pharmacy spokes.

23. Principia Partners in Health (Southern Nottinghamshire)

PARTNERS

12 GP practices in Rushcliffe are coming together as a 'partnership of partners' to form the cornerstone of a new multispecialty community provider organisation. It will combine with general practice, GP out-of-hours services, community and local mental health services, social care, third sector, hospital and ambulance trusts.

This vanguard will serve a population of 126,000.

AIM

Serving Rushcliffe's whole population, the vanguard aims to accept contractual responsibility for the quality and costs of healthcare within a single capitated budget. The vanguard will be defined by integrated working and a culture of mutual accountability for patient experience and outcomes.

OUTLINE

A new model of integrated care will focus on promoting health and wellbeing through prevention and providing care at the right time in the right place. This will enable people to live independently at home for as long as possible and avoid unnecessary hospital admissions by moving traditional hospital-based services into community settings, such as specialist long-term conditions management, nursing, diagnostics and some consultant-led care.

This vanguard will see the local health and social care system working as one to focus on proactive healthcare, with commitment and pride in bringing benefits to patients and the professionals who serve them. The result will be a significant culture change, with the health and social care workforce coming together to agree ambitions that are patient-centred and empower people to personalise the care they receive, replacing the one-size-fits-all model currently delivered by individual organisations.

The vanguards: enhanced health in care homes

24. Connecting Care - Wakefield District

PARTNERS
NHS Wakefield Clinical Commissioning Group, Wakefield Council, seven GP networks and the Provider Alliance which includes Nova-Wakefield, Age UK, Wakefield District Housing, South West Yorkshire Partnerships NHS Foundation Trust, Mid Yorkshire Hospitals NHS Trust and Yorkshire Ambulance Service.

Wakefield district has a population of around 361,000.

AIM
This vanguard focuses on the wider determinant of wellbeing – 'somewhere to live, someone to love, something to do'.

OUTLINE
The vanguard is working to ensure people in care homes are offered proactive, holistic assessment and care planning. Care needs will be reviewed on admission to a care setting, at scheduled intervals (according to need) and after an unplanned episode e.g. an urgent GP call out.

There will be a joined up support package for people in independent living schemes, i.e. sheltered housing, to keep them socially connected within the scheme and in the wider community.

Evidence from existing pilots indicates this will reduce fragmentation in care and give equal access to high quality health care whether in a care home or their own home. It will also help keep residents and their families in control of their care and reduce accidents and health deterioration, resulting in urgent GP calls and hospital attendance or admission.

This will also reduce the number of people choosing to go from independent living into care settings to escape loneliness and enable couples to be supported to stay together in independent living schemes.

The vanguard is also working to ensure every resident has an end of life plan – allowing people to die in their place of choice.

25. Gateshead Care Home Project

PARTNERS
NHS Newcastle Gateshead Clinical Commissioning Group and Gateshead Council.

Gateshead has a population of around 206,000.

AIM
This vanguard is a pioneering project to improve the health of care home residents in Gateshead.

OUTLINE
Gateshead Care Home Project sees individual GP practices each allocated to a specific care home, making it possible to offer greater continuity of care and more effective prevention of illness through regular home visits.

There will also be changes to the way services are commissioned and contracts managed with a wide range of providers for this group of patients. It will bring together a network of organisations working together for a more coherent health and social care offer to patients.

The vanguard is also reviewing the care pathway and a new model for contracts and payments as well as the development of co-commissioning for all community bed and home based care. Co-commissioning is the clinical commissioning group and Gateshead Council working together to bring a simplified and joint approach to enhanced healthcare, making it easier for patients and professionals to navigate, with the potential to take out some transactional costs.

Personalised care delivery and multidisciplinary working has already brought a 14% reduction in avoidable hospital admissions, together with an improvement in the quality of care delivered.

Follow us: @NHSngccg @GMBCouncil

26. East and North Hertfordshire Clinical Commissioning Group

PARTNERS
East and North Hertfordshire Clinical Commissioning Group, Hertfordshire County Council and the Care Home Providers Association.

East and North Hertfordshire Clinical Commissioning Group covers a population of 580,000.

AIM
This vanguard aims to facilitate all parts of the health and social care system to work together to do more to look after vulnerable patients in care homes and prevent them having to make unnecessary trips to hospital.

OUTLINE
Patients living in care homes are often some of the area's most vulnerable patients. Most have more than one long term medical condition, such as diabetes, breathing problems or heart disease and often need to take several medications. These patients can also become very unwell very quickly and can sometimes need to be rushed to hospital because their condition has deteriorated.

This vanguard will focus on improving services for these patients in a number of ways.

It will enhance the skills of care home staff through a package of education and training, so that patients with complex care needs can be looked after with confidence. It will also create teams of GPs, district and practice nurses, mental health nurses, older people's specialists and pharmacists, who will work closely with care home staff to support residents.

The vanguard aims to bring together 'rapid response' teams of community nurses, matrons, therapists and home-carers who can get to care homes within 60 minutes, as an alternative to sending elderly patients to A&E, when that is in their best interests.

There will also be an investment in technology to give all GPs access to comprehensive information about each care home resident when they visit them.

27. Nottingham City Clinical Commissioning Group

PARTNERS
Nottingham City Clinical Commissioning Group in partnership with the Care Home Steering Group which includes Nottingham CityCare Partnership, Nottingham University Hospitals, Nottinghamshire Healthcare Trust, Age UK Nottingham and Nottinghamshire, Care Home Managers Forum, Nottingham City Council and Nottingham University.

The organisations jointly serve a population of more than 314,000 people.

AIM
Nottingham City's vision is for care home residents to be healthier, have a better quality of life and to be treated with dignity and respect. This vanguard will focus on the capabilities of those living in care home settings rather than their dependencies with the aim that all residents, and their families, are able to enjoy a positive experience of care.

OUTLINE
Care home residents, commissioners and providers are committed to working together to transform the model of support provided to care homes by developing a value-based approach. To support the transformation of services, providers will be given greater freedom to innovate in the way they deliver health and care services whilst being held to account for the outcomes and costs of care.

The vanguard wants to remove organisational barriers, implement new technology and ensure that care home staff have support from specialist health services to identify, understand, manage and respond to the everyday impact of providing essential care. Residents will receive coordinated care from GPs and specialist health professionals in partnership with social care and their care home staff. These partnerships are essential and will be built on reliable communication and trust between teams and individuals through a shared ambition to transform services for care home residents and their families.

Follow us: @NHSNottingham

28. Sutton Homes of Care

PARTNERS
NHS Sutton Clinical Commissioning Group, the London Borough of Sutton, Epsom and St Helier Hospitals NHS Trust, St Raphael's Hospice, Sutton and Merton Community Services (the community division of The Royal Marsden), Age UK Sutton, South West London and St George's Mental Health Trust, The Alzheimer's Society, London Ambulance Service and Sutton Centre for the Voluntary Sector.

Sutton Clinical Commissioning Group serves a population of over 190,000.

AIM
The aim of this vanguard is to work together with local care home providers and communities to provide high quality care that enhances the health and wellbeing of care home residents, as well as proving to be financially beneficial to the tax payer.

OUTLINE
The vanguard has introduced a number of interventions including the development of a community team to help prevent unnecessary admissions to hospital and the establishment of end of life care nursing teams. They have also set up a joint intelligence group and established forums for care home managers and senior nursing staff to share best practice, education and training.

These interventions have already demonstrated not only an increase in the quality of care provided to residents, but have also shown a reduction in pressures on the health system.

Whilst much has already been achieved, the vanguard believes that further work could bring even greater benefits not only the population of Sutton, but also care home residents nationally through replication of successful strategies.

Follow us: @SuttonHoC

29. Airedale & Partners

PARTNERS
Airedale & Partners vanguard is a partnership of over 15 organisations in Yorkshire and Lancashire and includes three hospitals, GPs, three councils, community healthcare, IT partners and a range of independent care home providers.

The organisations jointly serve a population of more than 750,000 people.

AIM
The vanguard is being led by doctors, nurses, and other health and social care professionals, and its main aim is to improve the quality of life and end of life care of thousands of nursing and care home residents.

OUTLINE
This vanguard is using technology to improve care locally. Improvements include supporting residents who are sick by providing a secure video link to senior nurses so they can remain in the care home, where safe to do so.

This means patients have, at the touch of a button, 24/7 access to local care and support.

This helps residents remain active and independent, and reduces hospital admissions and A&E and GP visits, including people with breathing problems, heart conditions and dementia.

The vanguard also aims to help residents improve their health and wellbeing, including older, vulnerable people who are most at risk of getting sick. Using remote technology, such as telemedicine, doctors and nurses can monitor people on screen to stop them from becoming ill or provide care earlier.

Technology partners are also helping to support a shared patient record, including real time information, which is safer, quicker and avoids duplication.

Follow us: @AiredaleNHSFT

The vanguards: urgent and emergency care

30. Greater Nottingham System Resilience Group

PARTNERS
Nottingham University Hospitals NHS Trust, The South Nottingham and Erewash clinical commissioning groups, Nottingham City and County Councils, East Midlands Ambulance Service, Nottingham CityCare Partnerships, County Health Partnership, Nottinghamshire Healthcare NHS Foundation Trust, Derbyshire Health United Ltd (111 provider), Nottingham Emergency Medical Services (GP out of hours), Healthwatch Nottingham and Healthwatch Nottinghamshire.

This vanguard has a population of 685,000.

AIM
The partners which form this vanguard are supporting ambitious improvements to urgent and emergency care services across South Nottinghamshire.

OUTLINE
They are looking at what more they can do, using innovative workforce solutions, to ensure that people receive care in a timely way and closer to home - in many cases avoiding the need for assessment or admission to hospital.

In particular they will focus on enhancing mental health services in the community to ensure that patients get the care they need, in the right setting and in a timely manner. This will include rolling out and extending the National Mental Health 111 pilot to provide faster and better care when it is needed.

The vanguard will also be working to improve access to primary care clinicians at the 'front door' of the emergency department as well as clinical assessments and treatment to allow patients to be assessed and then followed up closer to home. The team is also enabling more direct clinician to clinician conversations so that a greater number of patients are directed to the right service, first time, every time.

The system will involve patients, carers and wider partners to lead the way in developing more timely and safe emergency care.

Follow us: @NHSNottingham

31. Cambridgeshire and Peterborough Clinical Commissioning Group

PARTNERS
Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) has three System Resilience Groups (SRG) and is part of the East of England Urgent and Emergency Care Network.

This vanguard covers a population of 950,000.

AIM
The clinical commissioning group's vision is to create an overarching super system resilience group with strong clinical leaders, as part of the existing network.

As an urgent and emergency care vanguard the CCG will accelerate improvements and develop a best practice model for urgent care services. In particular it aims to address variations in access to services and health inequalities in the region.

OUTLINE
This vanguard's new super SRG will focus on providing highly responsive urgent care services outside of hospital and promoting self-care and management. It will work to help people with urgent care needs get the right advice first time, and to access the right service seven days a week.

In order to meet these needs the vanguard's plans include developing the right workforce including GP Fellows; Advanced Nurse Practitioner and advanced AHP roles; developed community pharmacist roles; physician's assistants, and staff equipped to meet mental and physical health needs.

There will also be a reassessment of service standards based on outcomes and a redefinition of payment methods to incentivise system redesign.

Follow us: @fitforfuturenhs

32. North East Urgent Care Network

PARTNERS
Academic Health Science Network, Clinical Health Information Network, Health Education North East, Nine Strategic Resilience Groups and associated members, North East Ambulance Service NHS Foundation Trust, North East Local Authorities, North of England Commissioning Support, Regional Out of Hours Providers, Royal College of Psychiatry, Voluntary Organisations' Network North East.

This Network covers areas around Northumberland, Tees, Esk and Wear Valley, Newcastle, Northumbria, Gateshead, Tyneside, Sunderland, County Durham, Darlington and Hartlepool – a region with a population of 2.71 million.

AIM
The North East Urgent Care Network– which consists of all the key physical, mental health and care stakeholders and providers – already has a strong history of working collaboratively to deliver successful innovative projects. These support the recommendations made in the Urgent and Emergency Care Review as well as, importantly, improving patient outcomes and experience, benefiting the whole of the North East region.

OUTLINE
This programme will enable the Network to transform the regional urgent and emergency care system and its services to further improve consistency and clinical standards, reduce fragmentation and deliver high quality and responsive health and social care to patients.

It will also enable them to move at pace in terms of creating and implementing one urgent and emergency care model as well as giving strategic oversight to urgent and emergency care services across the region. This will provide consistent and seamless care, wherever patients present, whatever the day or hour with no difference in their clinical outcomes.

33. Barking and Dagenham, Havering and Redbridge System Resilience Group

PARTNERS
Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups, Barking, Havering and Redbridge University Hospitals NHS Trust, North East London NHS Foundation Trust, London Borough of Barking and Dagenham, London Borough of Havering, London Borough of Redbridge, Together First (Barking and Dagenham GP Federation), Havering Health (Havering GP Federation), Healthbridge Direct (Redbridge GP Federation), Partnership of East London Cooperatives, London Ambulance Service, NHS England Area Team, Healthwatch, Local Pharmaceutical Committee.

This vanguard has a population of 750,000.

AIM
Barking and Dagenham, Havering and Redbridge System Resilience Group (SRG) aims to create a simplified, streamlined urgent care system delivering intelligent, responsive urgent care for its residents which live in one of the most challenged health economies in the country.

OUTLINE
The SRG believes there is a need to do things differently and that patients are confused by the various urgent and emergency care services available to them – A&E, walk-in centre, urgent care centre, GPs, pharmacists, out of hours services.

Becoming an urgent and emergency care vanguard supports the SRG in its ambition to streamline these points of access to just three – supported by a smart digital platform that will recognise patients and personalise the help they get as soon as they get in contact. This involves:

1. 'Click' – online support and information – will help people to self-care and book urgent appointments when needed.
2. 'Call' – telephone for those who need more advice, reassurance or to book-in.
3. 'Come in' – where patients really need emergency care – the front door of the hospital will become new ambulatory care centres.

This ambitious plan is being developed with patients and staff, and will be implemented by building on existing successful partnership working between NHS and social care organisations locally.

Follow us: @BHRpartnership

34. West Yorkshire Urgent Emergency Care Network

PARTNERS
10 West Yorkshire Clinical Commissioning Groups; Harrogate and Rural Districts CCG; Five West Yorkshire plus Harrogate system resilience groups including primary care and local authority partners; Seven NHS acute and community providers; Three NHS mental health service providers; Three providers of district-wide services; Yorkshire and Humber Academic Health Science Network; West Yorkshire HealthWatch organisations; NHS England Yorkshire and Humber; Yorkshire Ambulance Service.

This vanguard reaches a population of 3 million people.

AIM
This vanguard's collective local vision is that all children, young people and adults with urgent and emergency needs in West Yorkshire will get the right care in the right place, first time, every time.

OUTLINE
To achieve this the vanguard will transform services provided by local community and primary care and provide urgent acute and mental health services out-of-hospital where appropriate. There will also be a focus on self-care with individuals and communities provided with the support they need to self-care.

The vanguard will also work to ensure that emergency medical centres have the facilities and expertise needed to provide the highest levels of care and there will be improved integration of information and services to streamline the system.

This vanguard is building on the firm foundation of existing network activity, shared learning and system-wide leadership to deliver the five principles set out in the national Keogh Urgent Care Review.

35. Leicester, Leicestershire & Rutland System Resilience Group

PARTNERS
Leicester City, East Leicestershire and Rutland and West Leicestershire Clinical Commissioning Groups; the three upper tier local authorities (Leicester City, Leicestershire County, and Rutland County); Arriva (patient transport service); University Hospitals of Leicester NHS Trust; East Midlands Ambulance Service; Leicestershire Partnership NHS Trust; George Elliott (Leicester Royal Infirmary Urgent Care Centre); CNCS (GP out of hours /Loughborough Urgent Care Centre); Derbyshire Health United (NHS 111); Soldiers, Sailors Airmen and Families Association (acute visiting services).

This vanguard has a population of 1.1 million.

AIM
This vanguard's vision is for a new urgent and emergency care model that blurs organisational boundaries, and clearly defined outcomes enabling it to be responsive to the needs of its diverse city/county population. It also aims to develop a model which will be replicable nationally.

This vision forms part of a five-year whole-system reconfiguration plan signed up to by all local commissioners and providers.

OUTLINE
The vanguard will create a new alliance-based urgent and emergency care system where all providers work as one network. This will bring together ambulance, NHS 111, out-of-hours and single point of access services to ensure that patients get the right care, first time.
The network will include a same-day response team with GPs, acute home-visiting and crisis response services, community nursing, older peoples' assessment unit and urgent care centres.

University of Leicester Hospitals NHS Trust runs the largest single site A&E department outside of London. In 2016, the hospital's urgent and emergency care front door will be re-launched to include an assessment team with the ability to refer patients to ambulatory clinics, assessment beds, on-the-spot urgent care centres or primary or community care.

The vanguard also has plans to work with the national team, IBM and Loughborough University to develop a demand and activity model, using realtime data to inform providers' and patients' choices.

Follow us: @UrgentCareLLR

36. Solihull Together for Better Lives

PARTNERS
Heart of England NHS Foundation Trust (includes acute and community services); Birmingham and Solihull Mental Health NHS Foundation Trust; Solihull Metropolitan Borough Council; NHS Solihull Clinical Commissioning Group; Voluntary and Community Sector providers; Primary Care (including confederation of GP practices in Solihull); West Midlands Ambulance Service; West Midlands Police; West Midlands Academic Health Sciences Network; Lay members representative of service users, carers and the wider Solihull community.

The population in this area is 210,000.

AIM
The local Solihull vision is to create an integrated health and care system that optimises wellbeing through preventative and out-of-hospital care, with rapid access to specialist services. The vanguard has the ambition to extend healthy active life and independence with equal focus on physical and mental health. This will be achieved by encouraging healthy lifestyle choices, care co-ordination and empowerment to self-manage long-term conditions which will reduce pressure on secondary care services and alter the balance of care provided in hospital and the community.

OUTLINE
This vanguard's programme is delivering an integrated approach to urgent and emergency care, which incorporates a number of elements.

Patients and carers will be supported in their homes and at the 'Health and Wellbeing Campus' (on the hospital site) through open and accessible information and services using various portals, building on the local authority 'Solihull Connect' service.

There will also be integrated community teams which include improved access to diagnostics and secondary care specialists supported by innovative information technologies.

Mental health services will be enhanced - building on rapid assessment interface and discharge, street triage, dementia and delirium team and outreach.

Finally the vanguard plans to build an urgent care centre that includes GP out-of-hours, walk-in and minor injuries services within the hospital site as part of the 'Health and Wellbeing Campus'.

Follow us: @SolihullCouncil @SolihullCCG @heartofengland @bsmhft

37. South Devon and Torbay System Resilience Group

PARTNERS

South Devon and Torbay Clinical Commissioning Group; South Devon Healthcare Foundation Trust; Torbay and Southern Devon Health and Care Trust; Torbay Council; South Western Ambulance Services Foundation Trust; Devon Doctors Ltd; Community pharmacy (via Local Pharmaceutical Committee).

This vanguard has a population of 287, 594.

AIM

As a vanguard this System Resilience Group will be able to move quickly on the implementation of its urgent care strategy, transforming the local urgent care system, for a sustainable future. This strategy aims to make the best use of the resources spent locally on urgent and emergency care - deriving greater quality and value for money by avoiding duplication of effort, first time.

OUTLINE

The model enables the vanguard to implement two sets of priorities, for 2016 and 2017.

For next year, the priorities will include the rapid development of urgent care centre (UCC) facilities in at least two centres, prioritising areas of higher deprivation to reduce inequalities. The vanguard will also share primary care records with the out-of- hours provider, and co-locate primary care facilities with A&E/UCC facilities in at least two locations.

The following year's priorities will include making a full complement of urgent care centres available. There will also be the co-location of primary care in all A&E/UCC facilities, as well as the decrease in 999 conveyance to A&E of at least 5%.

The vanguards: acute care collaborations

38. Salford and Wigan Foundation Chain

PARTNERS
Salford Royal NHS Foundation Trust and Wrightington, Wigan & Leigh NHS Foundation Trust.

This vanguard serves around 2 million patients.

AIM
The aim of the two organisations is to create a healthcare group that will deliver faster improvements in patient outcomes and greater productivity.

OUTLINE
Salford Royal NHS Foundation Trust and Wrightington, Wigan and Leigh NHS Foundation Trust are working together with Devo Manc partners to create a new healthcare group. This will help them to increase the pace at which they are able to make improvements which will result in better outcomes for their patients and increases in productivity.

They are working in partnership with commissioners and provider organisations across the region to create an Integrated or Accountable Care type organisation and a single service model for elective and specialist services.

Follow us: @SalfordRoyalNHS @WWLNHS

39. Northumbria Foundation Group

PARTNERS
Northumbria Healthcare NHS Foundation Trust supports a number of organisations in the North East and across England.

The population served by the Foundation Group will depend on which partners are identified.

AIM
The Trust aims to create a Foundation Group that drives efficiency and clinical effectiveness within the NHS and delivers high quality patient care for the long term.

OUTLINE
Northumbria Healthcare NHS Foundation Trust's plans to create a Foundation Group will widen the support and services it can provide to other organisations.

The Trust is already supporting a number of organisations within the North East and across England (including North Cumbria University Hospitals NHS Trust for which it is the appointed acquisition partner and buddy), and will use the development of the Foundation Group as a vehicle to better coordinate and further develop this support.

Through the Foundation Group, the Trust and its partners could support others more effectively in a range of ways, these include: acquiring and/or merging other hospital trusts; providing corporate services to other NHS organisations; and creating a standard operating model built on providing excellent clinical outcomes.

This will benefit patients by helping partner organisations to be more efficient and to make sure that patients are receiving the best possible care and that high quality services are more sustainable for the future.

Follow us: @northumbrianhs

40. Royal Free London

PARTNERS
Potential partners will be identified as the proposal is developed but the trust plans to work with Salford Royal NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust to develop proposals on a group model.

The population served by this vanguard is dependent on which partners are identified.

AIM
The trust is interested in exploring horizontal growth to find ways to improve the quality of patient care while also reducing the cost to the healthcare economy as a whole.

OUTLINE
The Royal Free London NHS Foundation Trust plans to become the heart of a group that other organisations will want to collaborate with.

The trust is considering options including buddying, merging specific office functions and other innovative models such as joint clinical and corporate ventures.

The key benefits of this approach are that it would reduce the variation patients can experience in care, increase efficiency and identify ways that high quality services can be delivered at reduced cost.

41. Foundation Healthcare Group (Dartford and Gravesham)

PARTNERS
Dartford and Gravesham NHS Trust (DGT); Guy's and St Thomas' NHS Foundation Trust (GSTT).

AIM
Dartford and Gravesham NHS Trust is exploring and moving into one of the first Foundation Group models with Guy's and St Thomas' NHS Foundation Trust on a management contract basis.

OUTLINE
The Trusts are working together to assess the benefits for patients and staff of becoming one of the first Foundation Groups. These groups will involve different hospitals working closer together, offering clinical services into another site, and sharing corporate services via a management contract.

At present DGT is unsustainable in its current form. The partnership's vision is to create a sustainable care system for Dartford and Gravesham, with DGT patients benefiting from greater integration locally with primary, community, and mental health partners; secondary care partners and a more seamless transition to specialist and tertiary care at GSTT when required. The proposal will also respond to expected population growth in the area (at Ebbsfleet).

Follow us: @darentvalleyhsp

42. Moorfields

PARTNERS
Moorfields Eye Hospital NHS Foundation Trust.

The potential patient population of this vanguard depends on which partners are identified..

AIM
The Trust aims to learn from its experience of existing satellite models to develop future networks and share good practice across the wider NHS.

OUTLINE
Moorfields Eye Hospital NHS Foundation Trust already runs services in 22 locations in and around London in a variety of healthcare settings, but recognises that this model has grown in response to ad hoc requests. Therefore it aims to identify the best approach to establishing and sustaining a chain of services and to produce a toolkit which can be used to roll out service level chains regardless of the specialty to benefit patients in other parts of the NHS.

In addition to analysing the best approach for a successful chain of services, the Trust will also explore the opportunities and risks associated with running an extended network of eye services, based on increasing the number of Moorfields satellite sites and widening the Trust's geographic reach.

43. National Orthopaedic Alliance

PARTNERS
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust in Oswestry; Royal National Orthopaedic Hospital NHS Trust in Stanmore and Royal Orthopaedic Hospital NHS Foundation Trust in Birmingham.

This vanguard has national reach.

AIM
The National Orthopaedic Alliance vanguard aims to create a UK-wide franchise or chain of orthopaedic providers to deliver outstanding and consistent care in more areas.

OUTLINE
The vanguard partners will explore formal ways of collaborating more closely to explore how they could extend their model more widely across the country. This work builds on their already established base of collaboration and will formalise the way organisations work together on a clinical basis as well as through back office functions.

The vanguard will also explore the possibility of enabling exemplar orthopaedic services to be offered on a franchise model across England. Their work will include developing a single common model for NHS franchising that can be picked up by any speciality; to implement best practice; to identify ways of expanding across a wider geography; and to ensure that scale brings with it stronger local patient and community involvement.

For patients this could help deliver higher quality care more consistently across the country and also provide a new model for smaller hospitals and specialist providers.

Follow us: @rjah_NHS @ROHNHSFT @RNOHnhs

44. The Neuro Network (The Walton Centre, Liverpool)

PARTNERS
The Walton Centre NHS Foundation Trust; Warrington and Halton Hospitals NHS Foundation Trust; Liverpool Clinical Commissioning Group; Warrington Clinical Commissioning Group; NHS England Specialised Services Commissioning Team (North).

This vanguard reaches 3 million patients.

AIM
The Neuro Network aims to work with its partners to develop a high quality and cost effective neuroscience service chain.

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

Follow us: @waltoncentre

45. MERIT (Mental Health Alliance for Excellence, Resilience, Innovation and Training) (West Midlands)

PARTNERS
Birmingham and Solihull Mental Health NHS Foundation Trust, Black Country Partnership NHS Foundation Trust, Dudley and Walsall Mental Health Partnership NHS Trust and Coventry and Warwickshire Partnership NHS Trust.

This vanguard has a patient population of 3.4 million.

AIM
This vanguard aims to share best practice and create replicable models for long-term clinically and financially sustainable specialist mental health services. They will work together to solve efficiency, workforce, equality and policy implementation challenges.

OUTLINE
MERIT will focus on three priority areas where the greatest challenges for urban mental health services exist. These are seven day working in acute services; crisis care and reduction of risk; and recovery and rehabilitation. In these areas better integration across organisations will aim to improve quality and increase efficiency rapidly while reducing variations and spreading best practice.

Service users will benefit from faster decision making, such as discharges seven days a week and a co-ordinated emergency response. They will also have a shared care plan, meaning just one assessment and only having to tell their story once.

The vanguards will also be providing more support for recovery in the community to reduce the chance of a relapse or return to secondary care services; and less unnecessary time spent in A&E or police cells.

Follow us: @MERITvanguardwm

46. Cheshire and Merseyside Women and Children's Services

PARTNERS
Alder Hey Children's NHS Foundation Trust; Countess of Chester Hospital NHS Foundation Trust; Liverpool Women's NHS Foundation Trust; Mid Cheshire Hospitals NHS Foundation Trust; Southport and Ormskirk Hospital NHS Trust; St Helens and Knowsley Teaching Hospitals NHS Trust; Warrington and Halton Hospitals NHS Foundation Trust; Wirral University Teaching Hospital NHS Foundation Trust; NHS Halton Clinical Commissioning Group (CCG), NHS Knowsley CCG, NHS Liverpool CCG, NHS St Helens CCG, NHS South Sefton CCG, NHS Southport and Formby CCG, NHS Warrington CCG, NHS West Lancashire CCG, NHS Wirral CCG, NHS West Cheshire CCG; Cheshire and Merseyside Maternity, Children and Young Strategic Clinical Network; North West Neonatal Operational Delivery Network; Adult Critical Care Operational Delivery Network.

2.4 million people could benefit from the work of this vanguard.

AIM
This vanguard aims to develop a clinically managed network for women's and children's services (including maternity, gynaecology, neonatal and paediatric services) across Cheshire and Merseyside in order to further improve quality and ensure services are clinically and financially sustainable.

It has the backing of all provider trusts, clinical commissioning groups and networks across Cheshire and Merseyside.

OUTLINE
The vanguard will address the challenges facing services for women and children locally by creating a new approach between commissioners, clinicians and providers that goes beyond organisational boundaries.

These challenges include a greater demand for services and an increase in patients with more complex needs as well a variation in quality of services. No single organisation, commissioner or provider can alone resolve these issues and this vanguard will also allow organisations to work together to tackle challenges around workforce like recruitment, retention, retirement and skills mix, as well as overall financial sustainability.

Working more closely together will also allow the vanguard to better engage with the people who use their services and create a more personalised offer for them.

Follow us: @LiverpoolWomens

47. Accountable Clinical Network for Cancer (ACNC)

PARTNERS
The Royal Marsden NHS Foundation Trust, The Christie NHS Foundation Trust and UCLH (University College London Hospitals NHS Foundation Trust).

The partners in this vanguard jointly support a population of 10.7 million

AIM
Individual networks led by The Royal Marsden NHS Foundation Trust, The Christie NHS Foundation Trust and UCLH (University College London Hospitals NHS Foundation Trust) will work together to develop plans for implementing Accountable Clinical Networks for Cancer, capable of being reproduced nationally.

OUTLINE
Working with a range of partners, including Devo Manc partners in Manchester, this vanguard will support integration across the entire cancer patient pathway (including public health, primary care and diagnostics), in order to secure improvements in delivering patient centred, quality and more financially sustainable cancer care.

Working together the networks will focus on a number of areas. These include improving early diagnosis and detection of cancer by taking advantage of the scale and pace working together will allow. The aim of this will be on driving improvements in clinical outcomes, particularly around patient survival rates through an alignment of objectives and focussed leadership across cancer services at a local level and less variation in access and outcomes.

Patients should also see an improvement in their experience across the whole pathway from diagnosis to living with and beyond cancer.

Follow us: @royalmarsden @uclh @TheChristieNHS

48. EMRAD - East Midlands Radiology Consortium

PARTNERS
Chesterfield Royal Hospitals NHS Foundation Trust, Kettering General Hospital NHS Foundation Trust, Northampton General Hospital NHS Trust, Nottingham University Hospitals NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust, United Lincolnshire Hospitals NHS Trust, University Hospitals of Leicester NHS Trust.

The population covered by this vanguard is approximately 6 million patients in the East Midlands.

AIM
EMRAD - East Midlands Radiology Consortium is a consortium of seven NHS trusts within the East Midlands working together, hosted by Nottingham University Hospitals NHS Trust. Together they aim to create a clinical network, providing timely and expert radiology care for patients across the East Midlands regardless of their location. Once developed, this Network will be seen as a national benchmark for new models of clinical collaboration within NHS radiology services.

OUTLINE
In order to achieve this vision they will deliver a number of improvements. They have already started work on purchasing a shared, technical system to allow access to patient radiology images at the point of clinical need. In order to maximise the benefits of this technical investment they will develop and implement new regional systems of governance, patient consent, commissioner support and education.

The vanguard also has plans to develop a collaborative network of services, aided by the shared technical systems, which support network-wide clinical care for patients. They hope to develop a mechanism for working regionally, bringing work back into the NHS which is currently being delivered in other sectors, providing expert trusted opinions within the NHS, and supporting both large and small trusts by creating cross-trust expert radiology networks.

Follow us: @emradNHS

49. Developing One NHS in Dorset

PARTNERS
Dorset County Hospital NHS Foundation Trust; Poole Hospital NHS Foundation Trust; The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

Patient population: 850,000.

AIM
The recent Dorset Clinical Services Review, had a vision of sustainable models of care for in- and out-of-hospital care, to meet the needs of local people 24 hours a day, seven days a week. The three district hospital providers in Dorset aim to use a multi-service joint venture to deliver this vision and ensure the future sustainability of health services in Dorset.

OUTLINE
Patients will benefit from a reduction in avoidable variations in care, the implementation of standardised best practice and the spread of service innovation. There will be a more equitable delivery of services to patients across the whole of Dorset, with the clinical network(s) organised to ensure that all patients have faster access to a consistent, high standard of care irrespective of where they live.

It is envisaged that there will be movement to a single shared rota for some agreed clinical services across Dorset which will ensure the best use of senior clinicians. The creation of job plans that allow for the recruitment and retention of high calibre clinicians will facilitate the development of sustainable clinical models.

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50. Working Together Partnership (South Yorkshire, Mid Yorkshire, North Derbyshire)

PARTNERS
Sheffield Teaching NHS Foundation Trust, Sheffield Children's NHS Foundation Trust, Barnsley Hospital NHS Foundation Trust, Doncaster and Bassetlaw NHS Foundation Trust, Rotherham NHS Foundation Trust, Mid Yorkshire Hospitals NHS Trust, Chesterfield Royal NHS Foundation Trust.

The population covered by this vanguard is 2.3 million.

AIM
The programme aims to develop a clinical strategy involving different models highlighted in the Dalton Review.

OUTLINE
The Provider Working Together Partnership is an existing partnership established in March 2013 between seven acute trusts in South Yorkshire, Mid Yorkshire and North Derbyshire. The partners are focussing on key areas like delivering a seven day service and improving patient care. The partners also plan to develop solutions and models for joint ventures on shared services and to work across organisational boundaries.

Models will include greater use of networking, sharing of clinicians across sites and delivery of specialist and diagnostic services across a number of different providers. The focus will be on making sure that local services are both clinically and financially viable in the future.

Follow us: @MidYorkshireNHS @DBH_NHSFT @SheffChildrens @royalhospital @RotherhamNHS_FT @SheffieldHosp @barnshospital @MidYorkshireNHS

"The new care model vanguards are about delivering real change for patients and staff. Working with clinicians and the people who use their services, they are developing a blueprint for the future of NHS and care services across England. They're being led locally, but with national support to help them move forward at pace and to unlock barriers that get in their way."

Samantha Jones
Director - New Care Models Programme
@SamanthaJNHS

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