NEW MODELS OF CARE IN PRACTICE

MULTISPECIALTY COMMUNITY PROVIDER VANGUARD

WELLBEING EREWASH

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

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

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

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

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

KEY FACTS IN NUMBERS

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

Local Government Association
NHS Clinical Commissioners
NHS CONFEDERATION
NHS Providers

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

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

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

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

JOHN'S STORY

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

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

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