LEARNING FROM THE VANGUARDS:

IMPROVING THE EXPERIENCES OF PEOPLE WHO USE SERVICES

This briefing looks at what the vanguards have been doing to improve the way people experience and interact with health and care services, and shares the lessons that other organisations and partnerships can take from the vanguards' experiences.

WHAT WERE THE VANGUARDS' AMBITIONS?

The *Five year forward view*[1] (the *Forward view*) set out a bold vision for fundamentally changing the way people interact with health and care services. The vision was for a future in which people are empowered to take more control over their care and treatment, the traditional divide between services is dissolved, and people no longer have to visit multiple professionals for multiple appointments. It was also a vision of a health and care system designed to support people with multiple conditions, with care delivered as locally as possible, unless better results would be obtained in a specialist centre.

To deliver this vision the vanguards have had to make significant changes to the way services are provided. They have re-designed services around the needs of people using them, sought to deliver care closer to people's homes – rather than making people travel to services – and considered how health and care services could help to improve health and wellbeing among whole communities. This final briefing in our *Learning from the new care models* series highlights how the vanguards are improving the experiences of people using services and their families.

1 Care Quality Commission, Health Education England, Monitor, NHS England, Public Health England, Trust Development Authority (2014), *Five year forward view*.

WHAT CAN WE LEARN FROM THE VANGUARDS?

COORDINATING CARE AROUND PEOPLES' NEEDS

- The *Forward view* recognised the central role that health and care services have in supporting people to manage long-term conditions. This requires services to work with people on an ongoing basis, looking holistically at all their health and care needs, rather than providing single, unconnected 'episodes' of care in response to acute physical illness or other crisis. People who use multiple services have reported their frustrations at the fragmentation and lack of coordination of the services they receive as well as at having to repeat their story each time they see a different health or care professional. A common approach to address these issues has been to set up integrated care 'hubs' across a range of long-term conditions where professionals work in partnership to seamlessly address the needs of the person using the service. To facilitate such joined-up care, many vanguards have developed multi-disciplinary teams involving a range of health and care professionals such as specialist doctors, nurses, physiotherapists, occupational therapists, social workers, mental health professionals and pharmacists. In the Encompass vanguard in Whitstable, Faversham and Canterbury, new hubs link together across groups of GP practices to offer mental health, social care, and specialist nursing support, as well as access to voluntary and community services. This means that people no longer have to navigate their way through a range of different services and can access the support they need more easily.
- Some vanguards have introduced new information sharing processes to improve the experience for patients and ensure that accurate information is available when required. The Mental Health Alliance for Excellence, Resilience, Innovation and Training (MERIT) vanguard in the West Midlands includes four mental health trusts covering a population of more than three million people. The partners have established a shared information system to ensure that no matter which of the vanguard hospitals a patient attends, clinicians there will have an up-to-date understanding of the patient's needs.

ENSURING PEOPLE RECEIVE HIGH QUALITY CARE WHEREVER THEY ARE

- Coordinating care around people's needs means services have to collaborate and join up their approaches. This has supported health and care services to share best practice and standardise pathways of care to address unwarranted variations in care. Within the vanguards, services are sharing data and clinical knowledge, improving education and training and making more effective use of the workforce. This means that people can be better assured that they will receive high quality care wherever they are.
- This is particularly important for specialist care as it is increasingly difficult for some hospitals to deliver safe and cost-effective care, particularly in the smaller clinical specialties, which are too small to offer the critical mass of patient numbers or specialist staff and equipment needed to keep going. Some of the vanguards, including the Walton Centre's Neuro Network, have set up 'network' models of care. In networks, specialist consultants and multidisciplinary staff provide local care for people across a number of smaller hospital settings. This means they receive the same quality of care they would in a specialist hospital but closer to home.

SPECIALIST CARE CLOSER TO HOME
The Neuro Network vanguard

Tom Reynolds lives with his wife Marje who is also his full-time carer. Tom was diagnosed with Parkinson's disease in 2011 which was completely life-changing. There have been ebbs and flows in his condition with some quite difficult times, including the need to be admitted to hospital by ambulance for emergency treatment.

Having an integrated neurology nurse specialist assigned to work with them is something both Tom and Marje not only take comfort from but also, at a time when most of their efforts are spent managing Tom's condition, helps make this a lot easier.

Marje said: "Initially Tom lost his sense of smell but eventually, he started walking wrong. He was diagnosed with having Parkinson's disease which was something I'd never contemplated. I thought he had perhaps had a slight stroke.

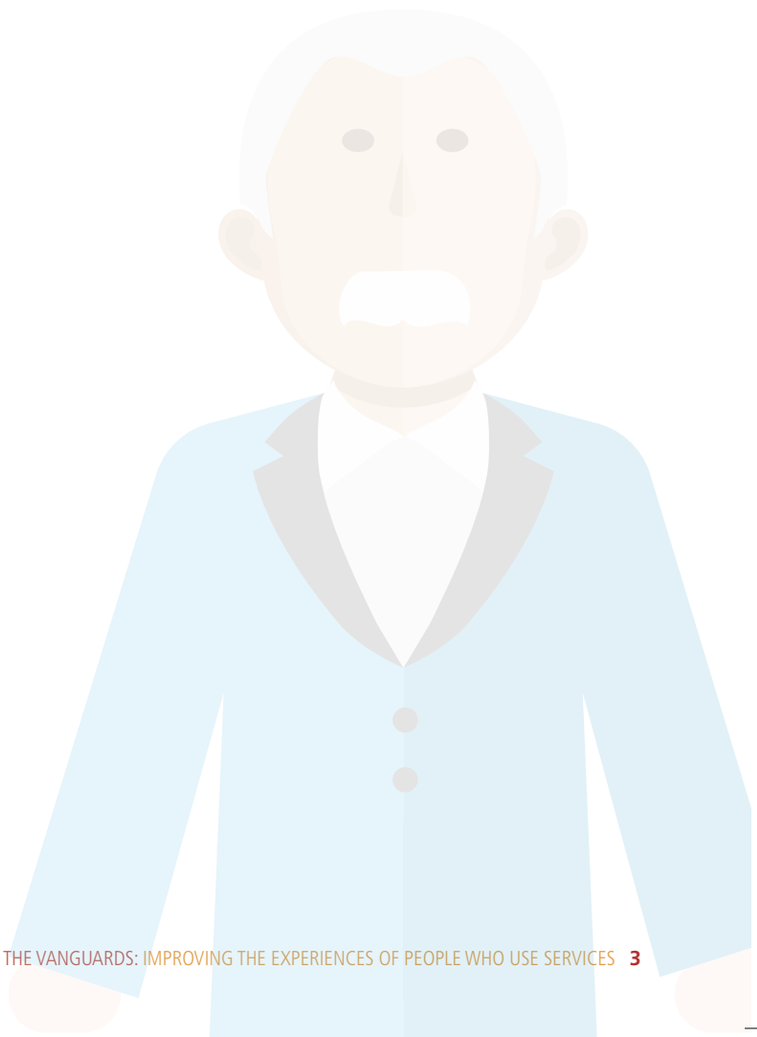
We were lucky that a specialist nurse came out to us at home and got Tom on the right medication and helped him with taking the medication at the right intervals. I just think it's wonderful if people can be seen in the community or at home, away from hospital. And for me that's the best part of the vanguard programme – that they are hoping to provide more of this service so people can be seen at home or in the community.

Lydia (integrated neurology nurse lead) has always been there for us. She has been able to come and see us at home. Tom last year had a bad episode and had to be admitted to hospital. It was the most dreadful month of my life, but Lydia was able to liaise with the hospital and get him home.

It's really important that someone has that one-to-one knowledge of the patient that Lydia has. It means that you are not having to start at the beginning with your medical history because they already know you."

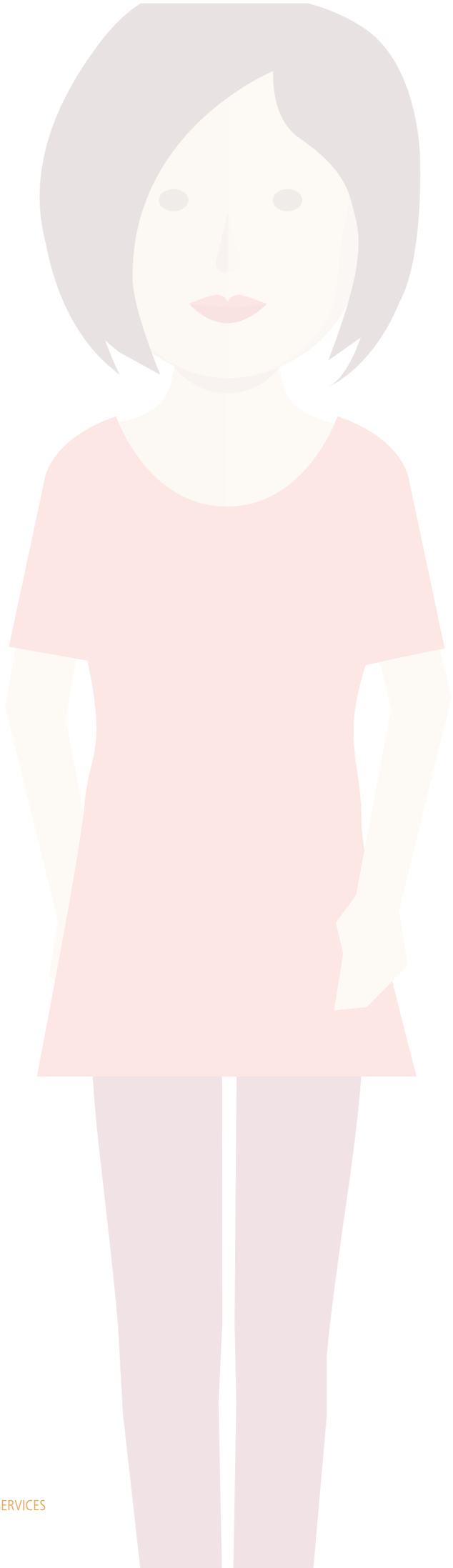
Tom added: "This service makes a huge difference to us. When you are initially diagnosed you spend the first couple of months in a daze. You need some information. Having a nurse that specialises in Parkinson's disease was not something I knew existed. She has kept us informed and made a big difference. It's important to have that point of contact. It might be a specialist you need, or a dietician, but you have that point of contact who can direct you."

For more information visit
www.thewaltoncentre.nhs.uk



REDUCING THE NEED TO TRAVEL

- By bringing together all the healthcare professionals involved in a person's care, and bringing care closer to peoples' homes, the vanguards are helping people avoid unnecessary travel. The Foundation Group partnership involves Dartford and Gravesham NHS Trust (DGT) in Kent and Guy's and St Thomas' NHS Foundation Trust (GSTT) in London. This collaboration helped to identify a gap between the paediatric neurology care delivered at the Evelina London Children's Hospital (part of GSTT) and the care at DGT, particularly a lack of support for families back in the local community following treatment in London. The Foundation Group highlighted that if patients were supported closer to home they would need to make fewer trips to London. Thanks to the links with GSST through the group model, DGT has been able to appoint an epilepsy specialist nurse who can provide support, information and practical care to children and their families closer to home.
- Technology is also playing a key role. The Better Care Together Morecambe Bay vanguard has introduced telemedicine video links between GP surgeries and the emergency department at the local hospital. If a patient is not in an immediately life-threatening condition, clinicians at the emergency department will carry out a triage assessment remotely via video link. This initiative is helping some local people avoid the two-hour round trip to hospital whilst still being able to access necessary clinical support and advice.



DIRECTING PEOPLE TO THE RIGHT CARE, FASTER

- The vanguards have also worked to re-organise care to ensure that people are seen as quickly as possible by the most appropriate health or care professional. For people using services, this can remove the frustration of having to be assessed by multiple professionals before receiving the appropriate care.
- For most people with health or support needs, GPs are the first port of call, but sometimes the GP isn't the best person to see. On the Isle of Wight, as part of the My Life a Full Life vanguard, GPs can now refer people to care navigators who have been employed to help people develop independence, self-confidence, health and wellbeing. Care navigators are supporting people to access a wide range of services including domestic support, falls prevention and benefits and housing services.
- In the Wakefield Connecting Care vanguard, care navigators are receptionists and administrative staff who have received additional specialist training and will signpost people directly to nurse practitioners, pharmacists, opticians and dentists where appropriate. They are also being signposted to the new PhysioFirst service, where they can see a physiotherapist for an initial assessment rather than wait to see a GP. This is also helping free up time for GPs to spend with those people who have the most complex needs. During the course of the first 2,200 assessments 82% of patients were given advice on self-care, 29% were referred onto community physiotherapy and just 7% needed to be referred on to see their GP.

SUPPORTING PEOPLE TO MANAGE LONG-TERM CONDITIONS

- The increase in the number of people living with multiple long-term conditions means that the demand on health and care services is growing. Consequently, the vanguards have been supporting people to develop the knowledge, skills and confidence they need to be able to manage their conditions at home. This approach recognises that people are the experts in their conditions, and spend the vast majority of their time caring for themselves. It also means services can tailor the way they support people based on an individual's specific needs. Some vanguards, including Fylde Coast and South Somerset vanguard's *Symphony* programme have employed health and wellbeing workers and health coaches who are helping people to better manage their conditions, set personal health and wellbeing goals, and provide practical advice on lifestyle and diet. They also support people with wider issues that impact on health and wellbeing, such as support with managing their finances.
- The Better Together Mid Nottinghamshire vanguard has identified the role that technology can play in supporting people to manage their own health and care. The vanguard rolled out the Florence (or Flo) automated health tool that uses SMS text messages to help people manage their own conditions at home. Flo sends text messages to patients' own phones to prompt them to carry out tasks such as sending in vital sign readings. Flo also sends timely and appropriate reminders such as medication prompts. Among people with heart failure using Flo, there have been significant reductions in the number of GP consultations and hospital admissions thanks to clinicians being able to detect signs of deterioration earlier.

SUPPORTING PEOPLE TO DEVELOP SELF-CONFIDENCE

Fylde Coast vanguard

In mid-2016, 67-year-old Blackpool resident Stephen Power had a serious fall at home. This started a downward spiral that led to him being referred to Fylde Coast vanguard's Enhanced Primary Care service by his GP.

A physiotherapist helping Stephen to recover from his fall noticed he had become withdrawn and called in the help of David, a health and wellbeing support worker. Stephen said: "It was very quick to get on the service. I was recommended by my doctor and within a couple of weeks someone was here checking me out to see if I was suitable for the programme. I saw Anne first who is a physiotherapist, David got involved later and that's when things really started to change."

David said: "When I first met him, he hardly ever went out. He was very introverted. He spent most of the time watching TV or playing scrabble online with other people, which of course put a strain on his relationship as him and his partner hardly ever spoke. When people came to the house he regularly retreated into his room to avoid speaking with visitors. He had no self-confidence, was very anxious and was very self-conscious."

Stephen had put on a lot of weight, reaching nearly 22 stone. In turn, this was putting extra strain on his hip, making his condition worse.

"I wouldn't go out, I had no friends. This [my home] was my sanctuary." Stephen says. "David has instructed me and put ideas in my head of what to do. I learnt from him and I've done it. He's built me up from nothing. He helped me dismantle a wall that was in front of me, a mental wall, once you get rid of that things do become easier."

David is trained to get to the bottom of the issues that are contributing to a patient's conditions. He has access to a wealth of expertise and other healthcare professionals from GPs to nurses and physiotherapists. He can direct people to all kinds of support to help them deal with all aspects of life from finance to grief counselling. In Stephen's case, David helped to improve his self-confidence.

David said: "It was about building Stephen's confidence and breaking down the barriers for him. Some of that was about losing weight too so I was able to help him with his diet, going through his shopping list to see what could be replaced with healthier alternatives. Since then he's really taken things in to his own hands. He eats better than I do now."

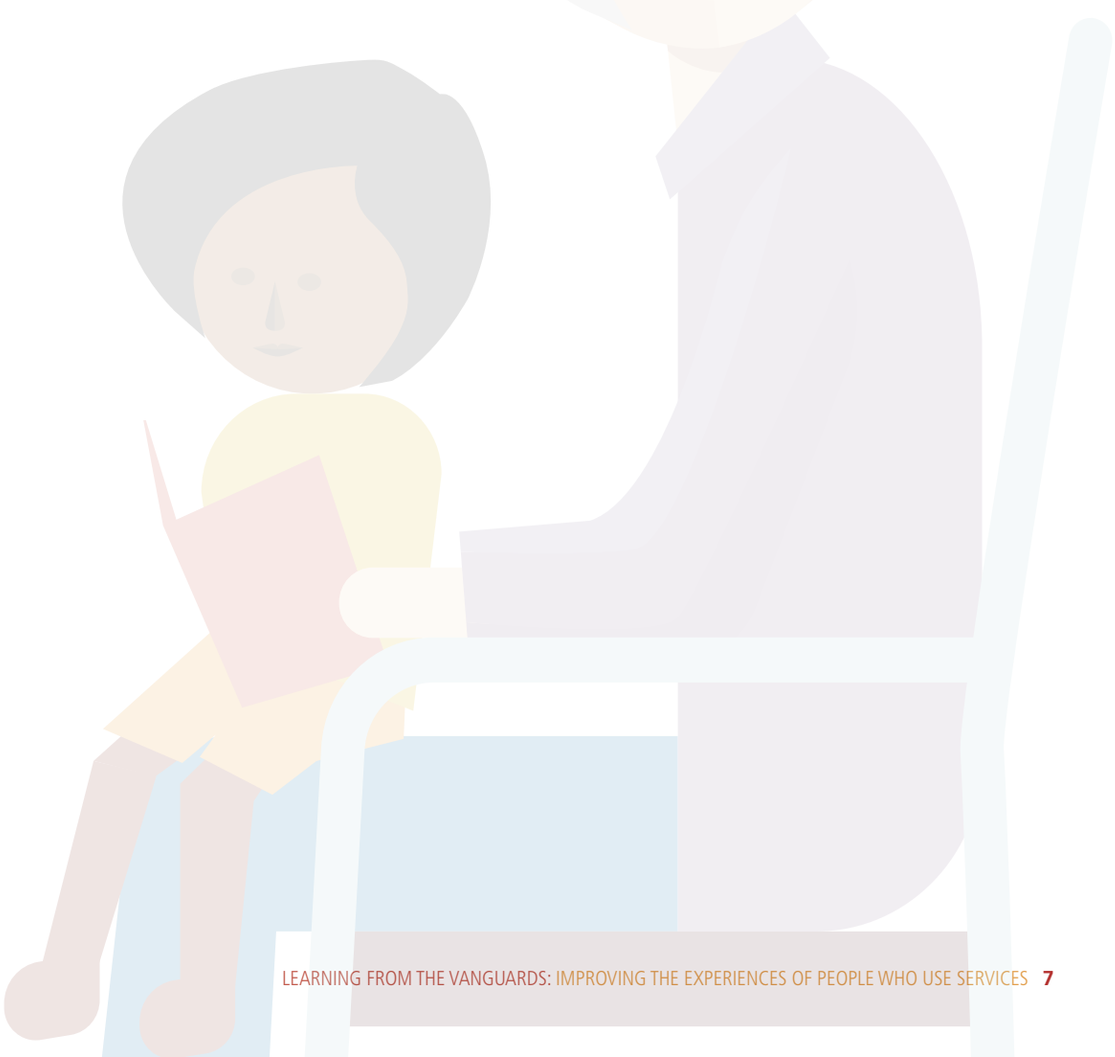
Having lost nearly three stone in weight Stephen aims to lose another two stone this year and ultimately would like to be down to 15 stone. He goes out two or three times a day and goes away on holiday on his own if his partner can't join him. He has made friends and his relationship with his partner is stronger as she has helped him with his weight loss goals, even losing weight herself as a result.

He says: "This is only the beginning. I want to throw my walking stick away. My ultimate goal is to throw it away and not need it anymore. The weight loss and getting out more means I'm going to get there. I started by walking down the driveway which was a struggle but now I can walk a mile. It doesn't seem a lot to you but to me it's a marathon."

For more information visit
www.fyldeandwyreccg.nhs.uk/about-us/fylde-coast-vanguard

TAILORING CARE FOR PEOPLE WITH THE GREATEST NEEDS

- Many vanguards have sought to develop a better understanding of peoples' specific health and care needs in order to offer them more tailored and personalised care. For example, the enhanced health in care homes vanguards are using risk stratification tools to identify care homes residents at high risk of unplanned hospital admissions.
- The Fylde Coast vanguard has set up a new 'extensivist care service' for around 500 patients with the highest needs and who are most at risk of unplanned hospital admission. The service is specifically for people aged over 60 with two or more long-term conditions. Rather than have to see a number of different health teams, the extensivist service means these patients have one comprehensive service for all their needs. After a full assessment, the care team develops a care plan with each patient, which is tailored to their individual goals relating to their healthcare as well as other aspects of their life. The service allocates a wellbeing support worker to each patient who keeps in regular touch, helps the patient to meet their goals and can respond quickly to any issues with their care.



MAKING ACCESS TO URGENT CARE AS SIMPLE AS POSSIBLE

- Another focus for many vanguards has been to simplify the confusing mix of places that people can go when they have urgent health care problems. As part of the Morecambe Bay Better Care Together vanguard, people who call NHS 111 on Saturday mornings and require clinical attention are being offered the option of a consultation with a GP via video link. The out of hours GP virtually assesses the patient and they agree the best course of action, which may include a prescription being sent electronically to a local pharmacy. This initiative is allowing people to access urgent care without needing to visit hospital.
- The Barking and Dagenham, Havering and Redbridge System Resilience Group vanguard found that local residents' confusion about the urgent and emergency care options available to them meant that around 40% of the people in A&E in the area didn't have emergency needs and therefore didn't need to be there. As a result, the vanguard has worked with local people to streamline services. This has included boosting the number of GPs, nurses and specialist clinicians in the clinical hubs supporting NHS 111 services, so that people who call NHS 111 get even better advice and reassurance.

PROMOTING HEALTH AND WELLBEING AMONG PEOPLE AND COMMUNITIES

- The *Forward view* called for a 'radical upgrade in prevention and public health' and emphasised the need to promote and strengthen the factors that support good health and wellbeing beyond just traditional services. Morecambe Bay vanguard has brought together the NHS and council public health services and staff to consider how it can promote health and wellbeing across the whole population. The vanguard's 'Let's get moving' project aims to improve the health of young people in the area. Working with local primary schools, the vanguard has promoted a 'run a mile' campaign across the region, including working with schools in some of the most deprived wards. Every day in Morecambe Bay, 2,000 children aged 4-11 now run a mile a day, and the project was recently extended to a further 3,000 children in Lancaster. Early data shows that there has been a dramatic improvement in the children's physical and mental health, and educational performance.
- In the Isle of Wight My Life a Full Life vanguard, nine local area coordinators have been employed by the council to work with people of all ages who have a disability or mental health needs, and older people. The coordinators support people to think about what a 'good life' might look like for them by spending time talking about their life and what might make it better. They help people identify their strengths, skills and passions and how they might use them in their community, for example through getting involved in local groups or volunteering. Among the 500 people that coordinators worked with, 92% said they had improved their family/social situation and 57% had broadened their social connections.

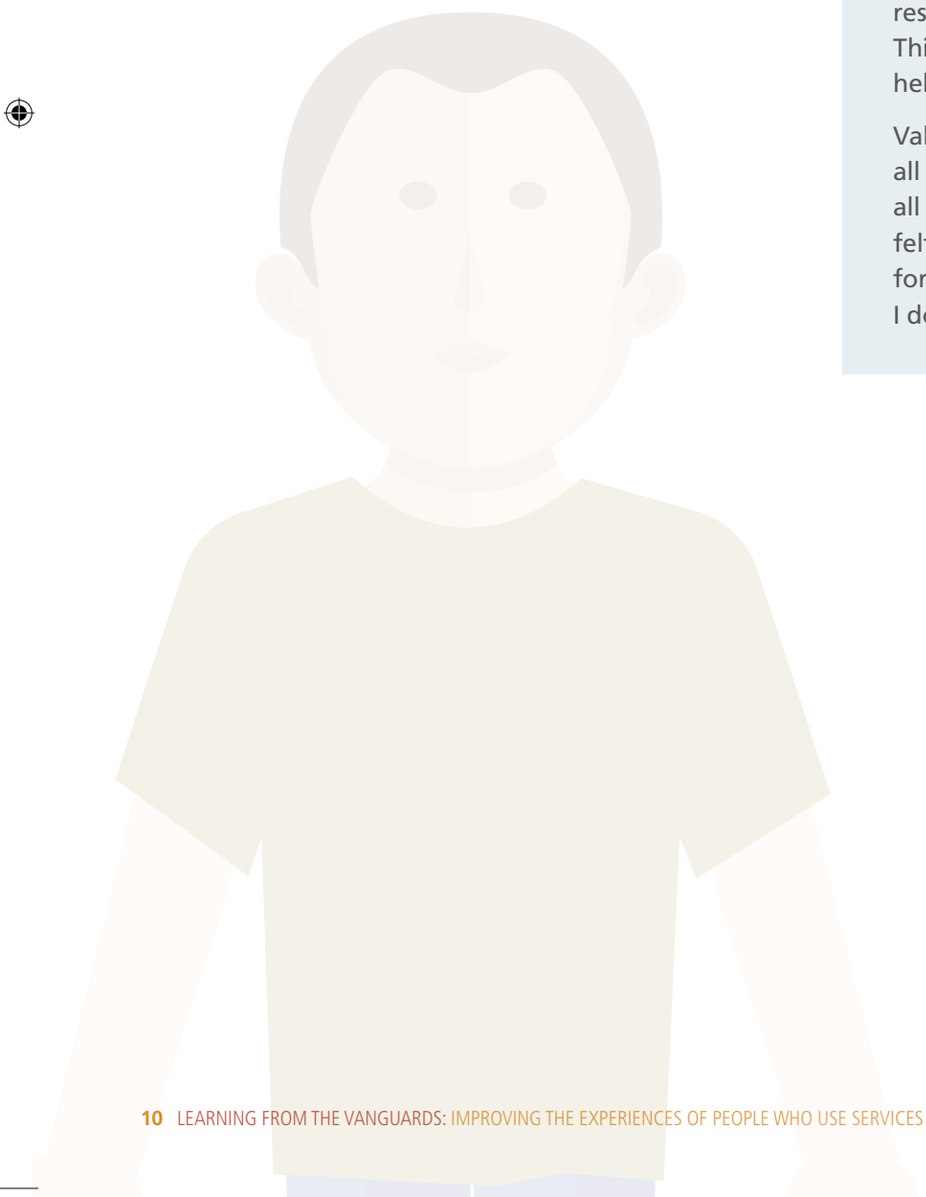
HELPING PEOPLE CONNECT
Isle of Wight vanguard

Dave was new to the area and his mental health was suffering. He had no community connections and his only activity was walking his dog. The local areas coordinator discovered Dave wanted to help other people and had an interest in cooking. The coordinator introduced him to an Age Concern café who funded him to get a food hygiene certificate. Dave then volunteered to set up a lunch group for isolated people. His confidence growing, he has volunteered for other local charities, and led a 72-mile walk around the island, raising money for four local charities. Dave is much happier, contributing to his community, and using mental health services less.

For more information visit
www.lacnetwork.org

SUPPORTING CARERS

- The *Forward view* committed to better support for the 1.4 million full time unpaid carers in England. It recognised that carers and families play a huge role in supporting people with health conditions manage at home, and that like people using services, carers are also 'experts by experience'. Over 100,000 carers in England are over the age of 85 they often have their own health and care needs to manage, as well as those of family members. The support provided from the vanguards like Encompass in Whitstable, Faversham and Canterbury is enabling carers to stay well at home and continue caring for others.



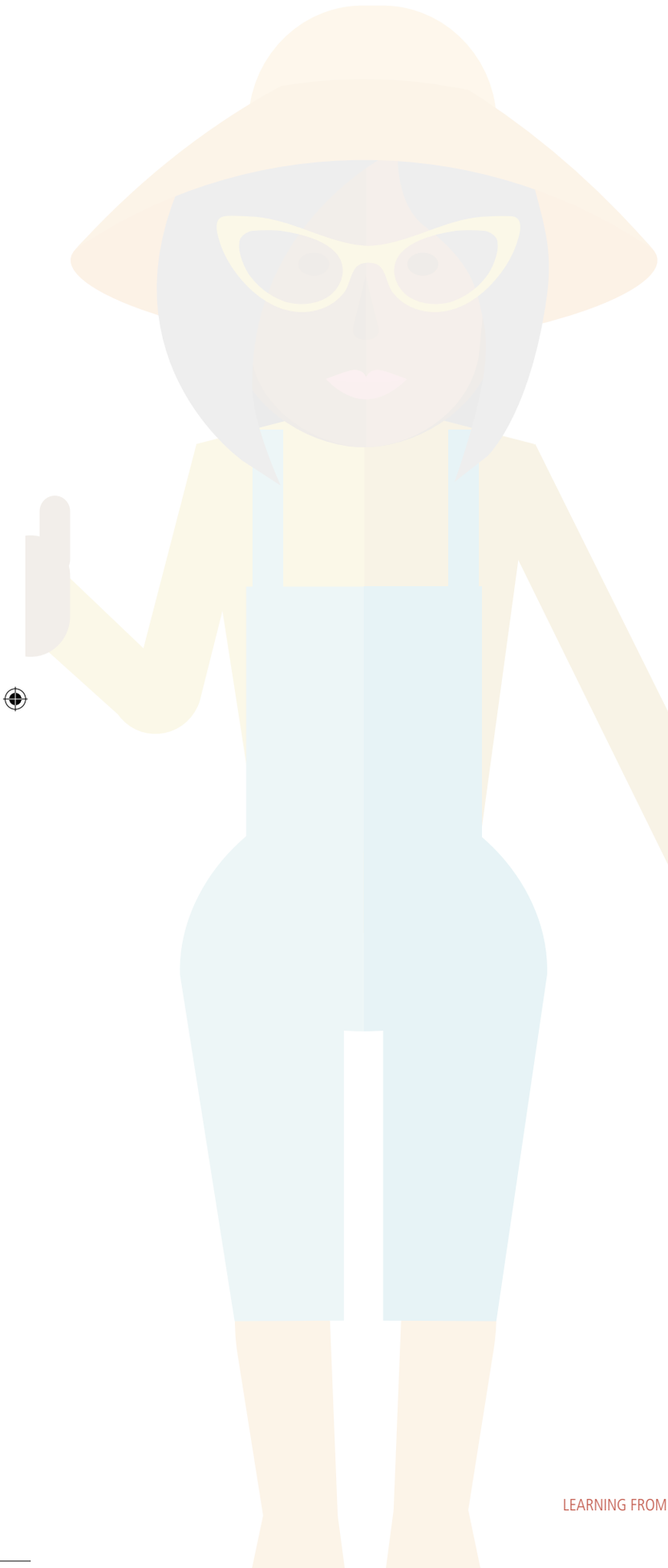
SUPPORTING CARERS TO STAY WELL
Encompass vanguard

Valerie Lowes is 92 years old and cares for her husband who has dementia. She had stopped leaving the house and doing daily tasks through fear of falling. But the integrated care team brought together under the Encompass vanguard meant that after a hospital stay as a result of a fall, Valerie now has daily visits from a carer, Tamsin.

Valerie has also been given a frame to help her move around her house and a falls wrist band which raises alerts if she falls. A named contact in the voluntary sector has responsibility for Valerie's care if she is to fall. This has given Valerie peace of mind and is helping her to stay in her own home.

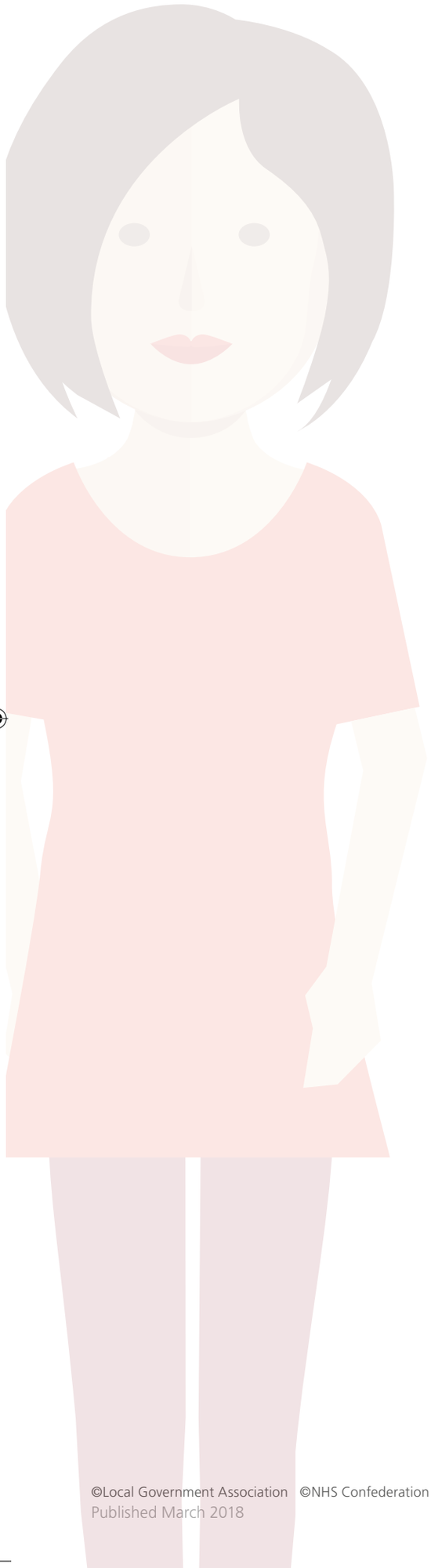
Valerie says, "I got very muddled at first when all the various carers and voluntary workers all turned up. I came out of the hospital and felt very, very low indeed. If it hadn't been for Tamsin I wouldn't have picked up like this, I don't think."

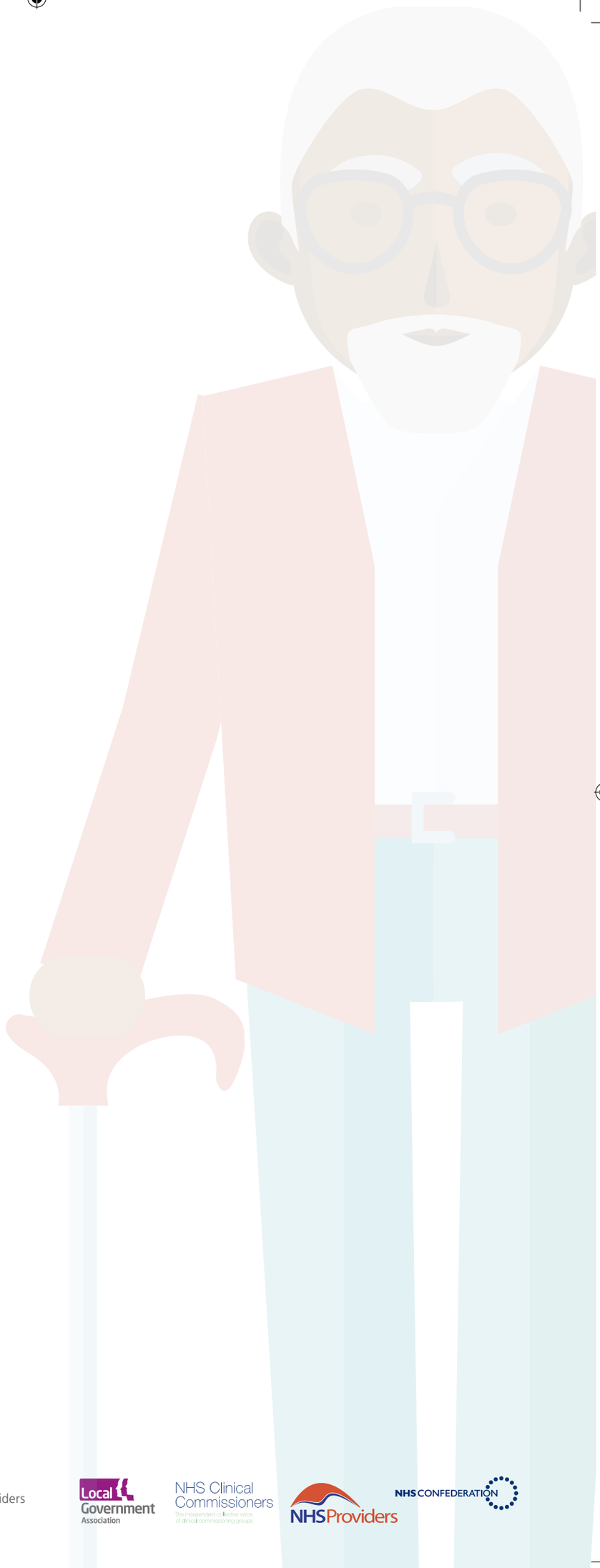
For more information visit
www.encompass-mcp.co.uk



WORKING WITH PEOPLE TO DESIGN SERVICES THAT WORK FOR THEM

- Involving people who use services is essential to making sure that services really meet the needs of people who use them and that the improvements are sustainable in the long term. This co-production means working with people and their carers throughout the whole life cycle of a service – from the initial design phase to implementation, and then seeking feedback from people using the service on an ongoing basis.
- The vanguards have adopted a range of techniques to understand the views of the public and involve them in the work. In Barking and Dagenham, Havering and Redbridge, the vanguard commissioned a telephone survey of 3,000 residents and local Healthwatch organisations delivered community research involving interviews and focus groups. The views and experiences gathered through this process led the vanguard to focus on aspects of care it hadn't previously considered, such as improving the triage processes at the front door of local A&E departments. The Happy, Healthy, at Home vanguard in north east Hampshire and Farnham has engaged members of the public living in local communities through their community ambassador programme. Community ambassadors act as 'eyes and ears' for the vanguard and have met with the vanguard programme team regularly to help shape its thinking and input the views of local people and organisations in to its plans.





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