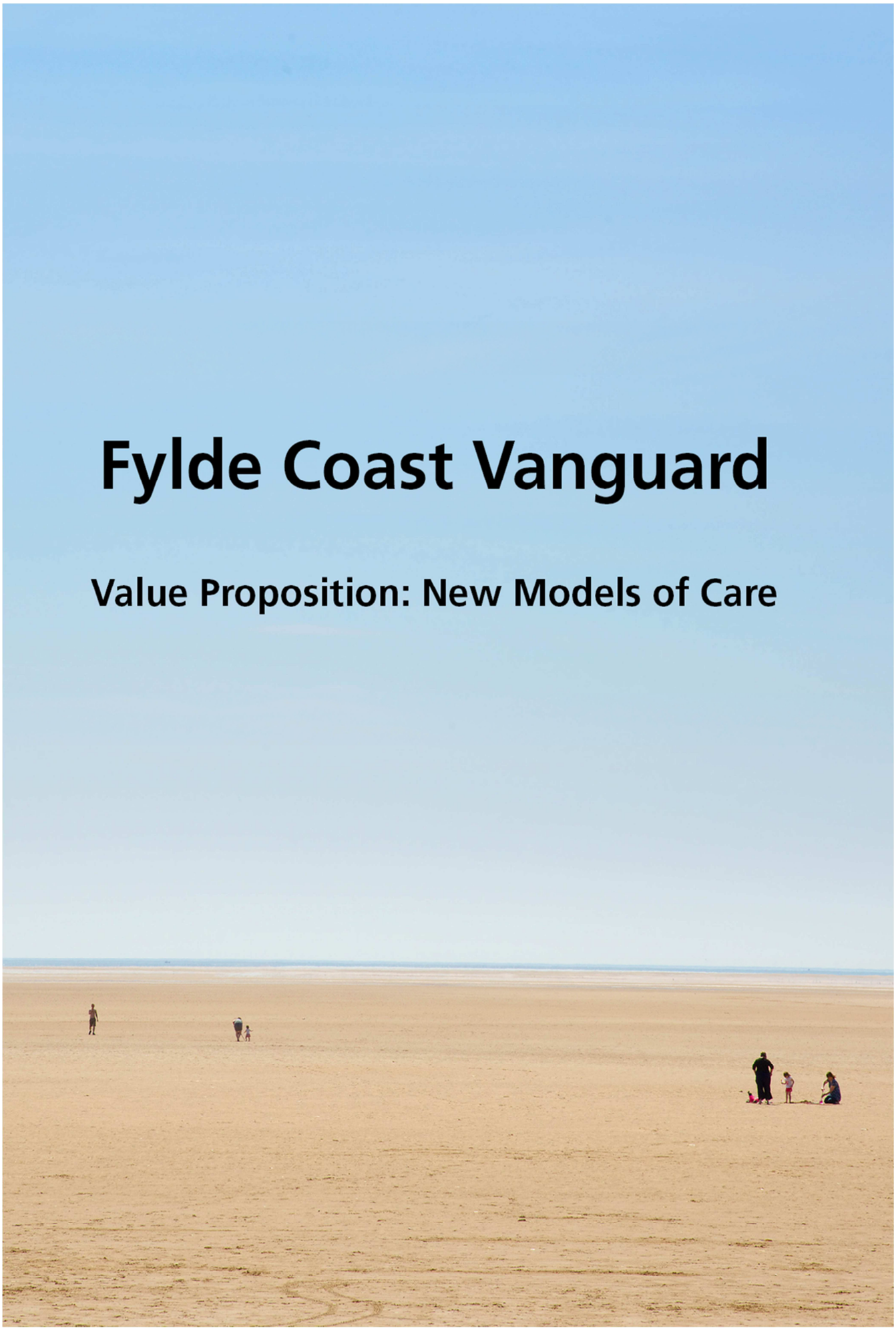
Fylde Coast Vanguard

Value Proposition: New Models of Care



1 Our Value Proposition

Building on successful collaborative work, our Value Proposition details our care models and how we intend to radically transform care for people on the Fylde Coast over the next 3 years.

1.1 Our Challenge

Our population is growing, as is the proportion of older people. On the Fylde Coast those aged over 65 is set to rise to between 31% and 35% by 2028 and there are increasing numbers of people with multiple and complex long-term conditions. These factors are putting a strain on resources, which is not possible to respond to without transformation in the way we provide care.

Health inequalities mean that men in the most deprived areas die over 13 years younger than those in the least deprived, and for women the difference is more than 8 years.

The Fylde Coast has a diverse population with areas of Blackpool experiencing the most deprivation whilst in contrast, areas such as Lytham, are affluent and have a higher proportion of older people. With a population of over 320,000 our communities range from rural areas to those more reflective of inner-cities.

We know more people are cared for in hospital than is necessary and that care can be provided more effectively in the community or at home. Our care is not always as coordinated as well as it might be and this can lead to poor experience for our patients and their families.

Continuing to care for our communities in the same way is not financially sustainable. Forecasts for the next 5 years show that commissioner deficits could reach £15m, the acute provider deficit is expected to grow to £56m. In addition, each of our local authorities are anticipating spending cuts of 10% over at least the next two years.

1.2 Our Response

Partners across the Fylde Coast began work to develop new models of care in early 2014 when we reviewed successful international models. Since then our work has developed approaches to Extensivst and Enhanced Primary Care, to develop models that meet the needs of our population and the health and social care system in the UK.

Our care models integrate health and social care, provide parity of esteem for mental health with physical health, and will build on community assets with the support of voluntary and 3rd sector partners. They are designed to improve effectiveness, safety and experience.

We have already implemented Extensive Care Services in two localities, established our neighbourhoods and developed plans for the implementation of Enhanced Primary Care. Our approach will tailor our Enhanced Primary Care and Extensive Care models to meet the needs of each neighbourhood, addressing the diverse needs of our communities and the health inequalities.

Our services will be based in our Primary Care Centres across the Fylde Coast, providing an excellent environment for integrated, local care and enabling our workforce to work directly in the communities they are caring for.

1.3 Our Offer

As a Vanguard site and with support from the national New Models of Care team, the Fylde Coast offers the following:

- Enhanced Primary Care and Extensive Care models which have been developed by clinicians that will be implemented between June 2015 to April 2017 and, over time, learning about how these models will evolve and their impact on the rest of the health and social care system.

- Clinical blueprints and operating models for new models of care which reflect the needs of diverse neighbourhoods through which the can be replicated elsewhere in the country.

- Learning from our business intelligence and risk stratification approaches which will expedite implementation in other sites.

- Innovative approaches to role development and recruitment which responds to current workforce constraints, taking a whole system approach to ensure current services are not destabilised and plans for the future to ensure sustainability of services.

- Accelerated introduction of an Information, Communication and Technology Strategy that will support new ways of working, transform the way care is delivered and develop integrated patient records.

- An evidence base created through a comprehensive evaluation approach that will include our logic model, bespoke patient evaluation, a clinical research study, evaluation of implementation and organisational form. Benefit realisation plans for outcomes in safety, effectiveness and patient experience as well as financial and activity measures.

- Learning from a communications and engagement strategy that places the citizen at the heart of the care we provide and how we design services.

- An executive leadership team with membership across 6 health and social care organisations who are passionate about transforming care and who have the drive to deliver our ambitions.

- Robust programme management and governance arrangements that will ensure success of the programme and delivery of our Value Proposition.

Without new models of care, commissioner deficits could reach £15m, social care services will reduce by 10% per annum and our acute provider deficit will reach £56m. By our transforming the way care is delivered, we expect to achieve the following by 2020/21 through our most ambitious plans by:

- Investment of £20.4m into new models of care
- A reduction of 15% on the current baseline for acute activity (£184m) releasing £27.7m
- Current commissioner investment and growth funding from 2017/18 releasing £18.6m
- The remaining savings of £27m can be used to stabilise the financial position for the health and social care economy.
- 'Cost Avoidance' equivalent to forecast growth in acute activity over the period - £10m

2 Vision

2.1 Our Vision

The vision for our vanguard new models of care across the Fylde Coast is for an integrated care system to improve the health and wellbeing of our population; ensuring people are empowered to make informed decisions about their health and care.

We are transforming the way care is delivered through a targeted and highly coordinated integrated model of delivery, bringing health, social and third sector services together based within neighbourhoods with a focus on prevention, early intervention, shared decision making and self-care.

2.2 What this means for people we care for

Our current care system…

Jean is a 71-year-old widow. She moved to Blackpool 10 years ago to enjoy her retirement after happy memories from childhood holidays here. She has lived alone since her husband passed away last year. She gave up smoking 10 years ago but still suffers with emphysema. She also has type-2 diabetes and arthritis. She is lonely and becoming increasingly forgetful and is reluctant to leave the house.

Jean frequently visits her GP but finds it difficult to remember to discuss all her medical needs in a brief 10 minute consultation, often forgetting the important things. When Jean can't get to see her GP she calls 999 which often results in her being taken to hospital and admitted to a ward. She has to speak to lots of different healthcare professionals and gets frustrated having to explain her conditions repeatedly and often diagnostics are duplicated. She often has to wait for social services before she can go home, the result is that she spends longer than is necessary in hospital. When she is discharged there is often a lack of co-ordination between the hospital, her GP, community and social care services, resulting in Jean not getting the support she needs.

Eventually, after several admissions in just six months, Jean is admitted to a care home.

Our future care system where services are integrated, wrapped around the individual who is supported and empowered to make decisions about their needs with professionals who are dedicated to their care…

With a care coordinator identified and responsible for coordinating Jean's care, this person meets with Jean, her social worker and her GP. Jean decides she wants to manage her care at home with the support of 'Enhanced Primary Care'. A care plan is devised to meet Jean's needs; a copy is given to Jean and the professionals can access this plan online at any time.

Jean now gets regular visits from her care co-ordinator, who supports her to manage her chronic conditions. When Jean's condition deteriorates she knows who to contact and rarely requires an ambulance. On the rare occasion she is admitted to hospital, the discharge process is much quicker, involving a review of her existing care plan.

Unfortunately, Jean deteriorates. Her coordinator reviews her plan with her GP and they escalate her case to the 'extensivist' – a clinician skilled in dealing with patients like Jean who are at high risk of hospitalization who is part of the Extensive Care service. After tailoring her care to meet the deterioration in her physical and mental health, the extensivist mobilises some telemedicine support to enable Jean to remain safely at home and de-escalates her care back to her GP and care coordinator.

Jean has chats with her care coordinator and through a designated care navigator is also put in touch with a local charity, which offers a befriending service, and introduces her to community groups to take up her love of knitting; this has made her less lonely and isolated and she is no longer scared to go out.

Jean didn't need to be admitted to a care home and now gets the help and support she needs to remain in her own home.

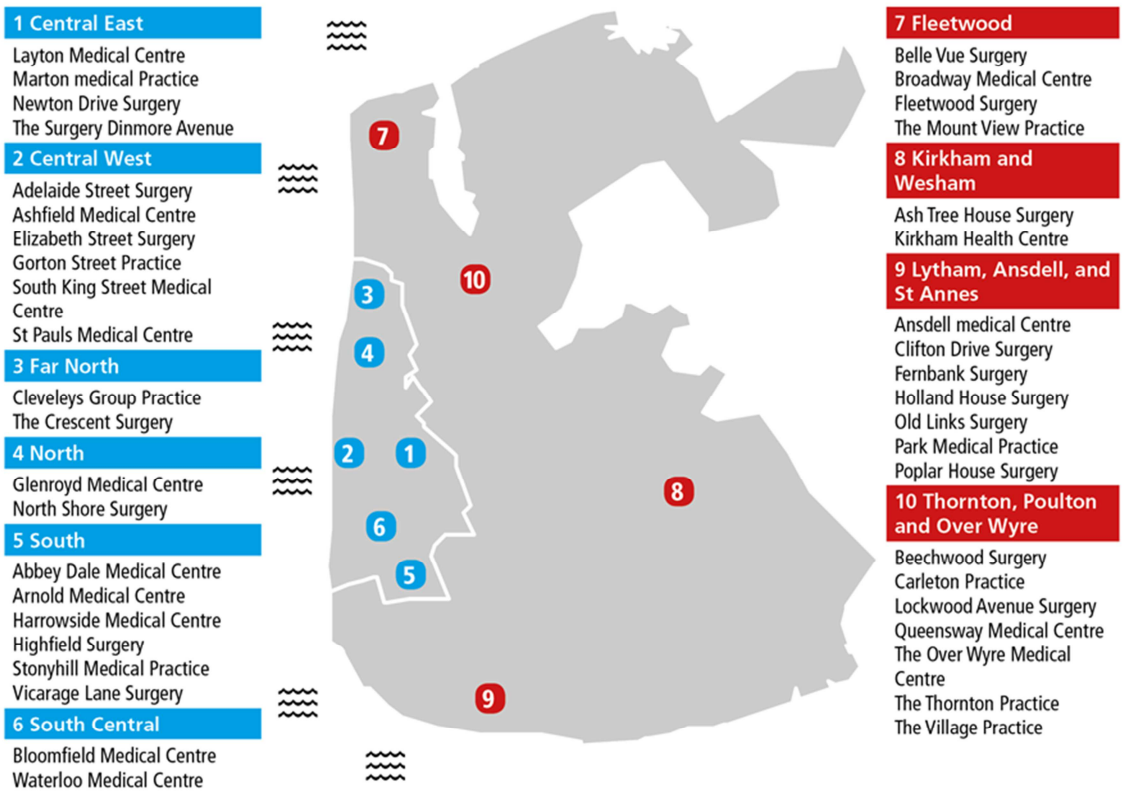
3 Strategic Context

3.1 The Fylde Coast

Blackpool and the boroughs of Wyre and Fylde are collectively referred to as The Fylde Coast. The main statutory commissioning and provider organisations are:

Blackpool CCG	Fylde and Wyre CCG
Blackpool Council	Lancashire County Council
Blackpool Teaching Hospitals NHS FT	Lancashire Care NHS Foundation Trust

Our GP practices are grouped into 10 neighbourhoods, six in Blackpool and four in Fylde and Wyre, representing the two CCG footprints. Whilst the total population sizes are similar geographical size is very different. Blackpool's population is contained within a relatively small area whilst for Fylde and Wyre the population is more dispersed with some more rural areas .



The development of new models of care on the Fylde Coast is an ambitious transformation programme. It is designed to ensure that health and social care services for the people of the Fylde Coast are integrated to provide better care outside of hospital and that parity of esteem is achieved between physical and mental health needs. The programme has a number of sponsors and primary stakeholders from all six health and social care organisations with executive representation at our Programme Board.

A programme team has been established under the leadership of the Director of Integration and Transformation, Blackpool CCG, to provide a programme management support function, maximise the overall success of the programme and provide appropriate governance and assurance to the Fylde Coast Vanguard Programme Board. Our governance arrangements are described more fully in *Appendix 2*.

3.2 Our case for change - the Fylde Coast Story

The challenge we face across the Fylde Coast is significant, as our aging population grows, many have complex care needs and increasing numbers of long-term conditions. Consequently, the Fylde Coast is reflective of most health systems in that relatively few patients account for a substantial proportion of the healthcare budget. The proportion of these populations is increasing expenditure, putting pressure on budgets and requiring health and social care professionals to consider radically different approaches to delivering effective care.

While the health of people across the Fylde Coast is generally improving, it is still worse than England's average. In addition to the resident population, Blackpool sees an estimated 11 million visitors each year and has considerable amount of transience, including movement in and out of the town, as well as movement within it. This, coupled with high unemployment, rising prevalence of long term conditions, has led to significant levels of deprivation and health inequalities that rank amongst the worst in the country - Blackpool being the worst for life expectancy in the country for men and the third worst for women. Within the most disadvantaged areas of Blackpool men can expect to live 13.3 years and women 8.3 years less than people in the least disadvantaged areas. Not only do people in Blackpool live shorter lives, they also spend a smaller proportion of their lifespan in good health and without disability and in the most deprived areas of the town disability-free life expectancy is around 50 years.

In contrast, in Fylde and Wyre, 57% of the population live within the two most affluent quintiles and there are over 16,800 people living in neighbourhoods that are classified as being amongst the fifth most disadvantaged areas in England, with men dying on average, 10 years younger than those in more affluent areas and for women, the difference is 6 years.

Projections of the population of Blackpool indicate that the number of residents over 65 will show a considerable increase within the next 20 years, from under 27% to over 35%. Fylde and Wyre also have a high proportion of older people; 24% of residents are over 65 years of age and by 2028 it is expected that this will have risen to 31%. These demographic changes will inevitably increase pressure on health and social care services. People aged 65 + many of whom have more than one long term condition and account for at least half of all GP appointments. With increasing numbers of elderly people living alone isolation can significantly affect a person's mental and physical health, confidence and wellbeing.

We know that services across the Fylde Coast are generally good; however, feedback from some service users and carers tells us that their experiences are not always as positive. Too many people go to A&E unnecessarily and often people are admitted to hospital when this could have been avoided. When people are in hospital, they often stay longer than is clinically necessary because the care and support they need in the community is not available at the right time. Feedback also tells us that some people find the system complex and confusing and it is key to delivering our new models of care that people are better informed about local provision, the choices available to them and encouraged to only use emergency care at the right time and for the appropriate types of needs.

Ultimately, our aim is to develop a model of integrated and coordinated health and social care so that organisations work together seamlessly, sharing data and communicating better between themselves and with service users, their carers and families.

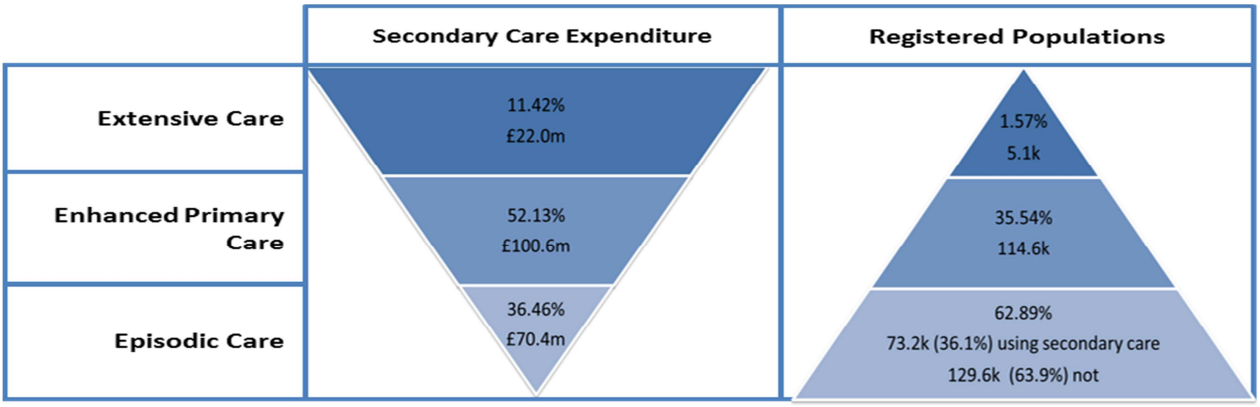
3.3 Evidence Base

A key part of our Vanguard application is that we have already developed an evidence base for new models of care. During the early part of 2014 we worked with an external consultancy to look at what works from healthcare systems across the world to assess which new models of care could be successfully implemented locally to improve quality and patient experience and address the challenges we face. This work suggested that a reduction of up to £29m could be possible for the local health economy, an overview of this and our subsequent work is included in *Appendix 1.*

Our subsequent work has successfully refined the Extensive Care cohort to a much more targeted approach. The cohort has reduced from the 3-5% suggested by Oliver Wyman down to 1.6% and with further analysis, we have been able to remove areas of expenditure which are deemed not to be affected by new ways of working whilst still developing a model which we estimate will deliver the same savings from acute expenditure.

Conversely, the Enhanced Primary Care cohort has grown to 36% of the population. Although saving assessments remain broadly the same as the initial work, this indicates there are a larger proportion of people for whom we can change the way care is delivered.

Our current financial modelling suggests that Fylde Coast should expect a reduction of up to £27.7m in secondary care expenditure, approximately 17% of our baseline contract for acute services . Further analysis and details about the assumptions and associated risks are provided in the finance section. Overall our conclusion is that through clinically led, locally developed new models of care a similar level of savings can be delivered in the UK as experienced internationally, albeit that these assumptions still require testing through implementation, evaluation and clinical research.



3.4 Risk Stratification

The cohorts for Extensive Care and Enhanced Primary Care services have been derived using a risk stratification tool. The Combined Predictive Model (CPM) algorithm was developed by the King's Fund as successor to the PARR (Patients at Risk of Readmission) and PARR+ tools. The algorithm builds on its predecessors by combining secondary care data and GP practice data to give a higher level of predictive accuracy, particularly for patients with no recent history of secondary care treatment.

In essence, the model uses secondary care activity data and GP system data relating to long-term conditions and disease registers to predict the likelihood of emergency hospital admission within the next 12 months. Patients are ranked and grouped into categories that are based on anticipated intervention level (case management, disease management, supported self-care, prevention & wellness promotion). In practice GP judgement is applied to the patients identified through the CPM when making decisions about access to Extensive Care services and the same will apply as Enhanced Primary Care services are rolled out.

The risk score determined from the Combined Predictive Model underpins our activity and financial assumptions and has been used in the development of our care models. Costs for cancer related treatments have been excluded as they are deemed not to be affected by new ways of working. An example of how this approach is used in the analysis of cohorts is included in *Appendix 3*

3.5 Future Clinical Model

During the development of the CCGs five year strategies, our vision was developed and tested by extensive engagement with a wide range of partners, patients, the public and their representatives and revealed that they wanted to see services that were coordinated and integrated, that there should be more recognition and support for self-care and the promotion of personal responsibility. Local people want information about

services and their conditions to be readily available and want to feel involved and listened to when planning their care so they can influence decisions about their health and wellbeing.

Our new models of care seek to radically transform the outcomes and experience of people supported by our health and care system, by building a system of integration and delivering care closer to home. To achieve our ambitions across the Fylde Coast, one of our main aims is to change the way we manage the treatment and care we provide.

The health economy has created the foundations for new models of care. Delegated responsibility for commissioning of primary medical care is an enabler for delivery and specifically our vision for enhanced primary care. We cannot meet current and future demand for primary care if we continue to do 'more of the same'. This is reflected in reports from our GP membership of difficulties with GP recruitment and retention, increasing demand, and a shift in workload to support more long-term conditions. Extending the role of primary care increases the local primary care offer to our resident population enabling the shift of resources to ensure we are able to design, implement and integrate out of hospital care.

We acknowledge the different health and social care challenges we face across the Fylde Coast and the impact this has on choosing a care model that works for very different populations and therefore will develop and deliver our New Models of Care initially across 10 neighbourhoods, integrating a range of primary, community, acute, social, third sector and other services around the registered populations of practices.

Neighbourhoods are based on groups of GP practices that have come together in natural geographic and demographic groups covering populations of 19,000 to 51,000 patients. They build on their local health, social care, voluntary service and estate assets available to enable the delivery of integrated care and will be the local delivery units at an operational level having clear pathways to services provided on a wider basis and input and influence on the strategic planning of services.

Taking a geographic approach to the provision of services based on GP lists will enable place-based synergies to be maximised, especially with respect to related social and third sector services. There will be a richer service response to patients that will enable their wider needs to be met. This will achieve parity of esteem in mental health provision and enable steps to reduce social isolation therefore improving overall well-being and the wider determinants of health.

3.6 Programme Aims

Aim	Deliverable	Outcome
To increase health and care services outside of hospital	Safe and effective community based services	Less hospital-based treatment with material reductions in admissions, length of stay, A&E and outpatient appointments
To integrate the public service offer across the Fylde Coast	Care focussed on those who are most at risk of hospital admission	Better management of complex conditions
To provide care which anticipates escalations and necessary interventions	Carefully constructed proactive care plans	Move from acute medical system responses
To provide care which increases patient confidence, knowledge and independence	Care orientated to the needs of the individual	Increased health and wellbeing
To provide care through teams with accountability on behalf of the whole system	Care which is truly integrated and unrestricted by organisational boundaries	Seamless care without gaps for patients to fall through
To increase patient adherence with best practice, improve long term condition management and diagnose conditions earlier	Create capacity in general practice to care for more complex patients	Improved outcomes amendable to health interventions
To reduce social isolation	Networks of public and third sector services in neighbourhoods	Increased wellbeing
To move away from medically-led models of care	Staff development to develop skills in promoting self-care and proactive care planning	Culture of patient activation embedded

4 Our New Models of Care – Meeting Variation of Need

The key principles underpinning our new models of care however is to provide both targeted support to those who require services, to ensure a focus on prevention and early identification in the wider population and access to appropriate support where necessary, across the continuum of need.

The model is founded on identifying distinct cohorts of patients, who are then supported and enabled by fully integrated health and social care teams. For many people, contact with health and care services will be occasional with little or infrequent need for medical or social care intervention.

If the population is considered in 'tiers of need' then the next cohort might be made up of people with long term conditions which are not well managed or who have mental health, anxiety, drug/alcohol dependence or other social care issues which impact on their daily living. This results in demand on a range of services which in turn increases pressure on the system, both in terms of capacity and increased cost. This is the cohort of the population described as requiring 'Enhanced Primary Care'.

Initial identification of need will be based on extending the risk stratification approach (see section 3.2) we have used to define the Extensive Care cohort together with professional judgment and local knowledge. Those that are likely to benefit from an Enhanced Primary Care approach are those individuals whose needs cannot be met by one discipline, who will benefit from a multi-disciplinary approach to the assessment and delivery of care, as well as a proactive approach to the management of predictable risk of escalation. The numbers of patients within the Enhanced Primary Care cohort are considerably larger than those within Extensive Care and so we are proposing a phased approach to the implementation. This is described in more detail in section five.

The top tier of the population has more complex needs, unmanaged conditions perhaps exacerbated by known or unknown emotional health issues which results in them accessing services more frequently, including unplanned admissions, A&E, calling ambulances and frequent visits to the GP in hours and use of out of hours services. This is not unique to the elderly or frail elderly, within this cohort of the population there will be adults of all ages, some of whose mental health impacts upon their physical health or manifests in unexplained symptoms, anxiety and presentation to GP, A&E, resulting in frequent admissions and investigation.

As a general principle it is expected that people with 2 or more co-morbidities such as dementia, COPD or diabetes, may fall within this tier, particularly those who are in social care crisis and as a result are not coping at home. It may be that their current package of care is not meeting their needs and so they present as 'frequent flyers' in general practice, at A&E, in admission and readmission. This is when most gain in terms of quality and improved outcomes for the individual, in addition to system efficiencies, may be realised. This group is identified as part of our Extensive Care cohort.

For the purposes of testing our new models in our early implementer sites, initial focus will be on patients who;

- Are aged 60 or over
- Have two or more co-morbidities from the following:
    - Chronic Heart Failure
    - Diabetes
    - Atrial Fibrillation
    - Coronary Artery Disease
    - COPD
    - Dementia
- Have a risk stratification score of 20 or more

Discussions are ongoing as to how this might differ in neighbourhoods, such as Central Blackpool or Fleetwood, where care may need to focus on adults of all ages whose needs include substance misuse and mental health.

4.1 Core Features of our New Models of Care

One of the key components of the care model is patient activation which is a behavioural concept and can be defined as; 'an individual's knowledge, skill, and confidence for managing their health and health care' (Hibbard et al 2005). The care teams understanding of an individual's ability to manage or contribute to the management of their own health and well-being is key to ensuring the success of this approach.

The model is new and different and includes the development of a new and unique role 'health and wellbeing support worker'. These individuals will be a consistent feature in a model which enables a fuller understanding of an individual's 'activation' ability so that engagement and support can be tailored appropriately. The wrap around support and lead practitioner may change as the tailored care is adjusted to reflect changing needs but the 'health and wellbeing support worker' will stay with the individual throughout their journey of care until they are stabilised or no longer benefit from the new model of care.

Contact with the 'health and wellbeing support worker' will re-establish should needs change or condition deteriorate and the individual is recommended for inclusion in the new model of care system in future. The 'health and wellbeing support worker' will develop an in-depth understanding of the individual through their regular contact, and tailor their one to one support accordingly. This which will be wide ranging and may include; reminders to attend appointments, take medication, act as advocate, accompany to activities such as wellbeing exercise sessions, encourage new interests and hobbies, confidence building, etc.

4.1.1 Seamless Care

In this newly designed system of care, people will not experience hand-offs or referrals and discharges from one team to another, services will wrap around individuals and manage the system on their behalf.

Increased effectiveness will result from the personalisation of treatment and care, improved assessment processes and development of bespoke care plans held on common systems accessible within and outside of normal working hours. Enabling care teams to be able to intervene at the right time will improve effectiveness of treatment regimes, increase patient adherence with best practice, take account of all co-morbidities which supports earlier diagnosis of additional conditions and potential complications.

As with all 'tiers' within the care model it is important to remember that individuals will only remain in the enhanced or extensive tier if their needs warrant it. The intention is for individuals to be supported to manage their own care. Their own care plans will set out what to do if their symptoms exacerbate and with the right care their needs will reduce, as they do they will seamlessly move down the pyramid of care.

4.1.2 Enhanced Primary Care

Enhanced Primary Care is an enhanced level of clinical support provided in a community setting delivering the health component of the Integrated Neighbourhood Care Team. This provision will combine GP's, practice staff, community and specialist health staff working together to enable individuals to receive a high level of clinical support whilst remaining in a community setting. Enhanced Primary Care will be centered around the patient and will consider health, social and emotional needs in order to deliver the most appropriate support to patients. Patients will be empowered to self-care and self-manage by learning more about their condition and how they can stay well for longer (patient activation). The service will be delivered in a number of community settings and will reduce the need to attend hospital and other care providers. Central to the model will be a responsible clinician, supported by a wider team, who is responsible for supporting the patient to improve their health condition as part of a broader health and care model.

Integrated neighbourhood teams will comprise of a range of services and provision some of which is already delivered (but not integrated) across the Fylde Coast such as:

- Primary Care
- Community and District Nursing

- Community Mental Health Services
- Community Therapies
- Care Navigation
- Social Care
- Third sector and Voluntary services

These existing resources are currently in the process of being attributed to our neighbourhoods. In addition, new roles such as the 'health and well-being support worker' seen in Extensive Care, will be introduced to the Neighbourhood Care teams to ensure that patient activation remains a key focus. This will enable a 'golden thread' of care to run between these two elements of our new approach supporting patients to move seamlessly between the two levels of provision depending on their level of need.

Each individual supported by the team will have an identified Lead Professional who will take practice and workflow decisions for the combined primary/community resources within our integrated neighbourhood teams.

During the first year, fully integrated Neighbourhood Care Teams will be established combining health and social care provision, which will focus on health and well-being and support those with physical and mental ill health needs to ensure that parity of esteem is reflected in provision. The introduction of Extensive Care will enable GP capacity will be freed up so that they are available to better manage and support more complex patients, assuring adherence with best practice to improve health outcomes.
A Directory of Services of statutory and third sector services is being developed to enable a richer response to patients' needs. Our care teams will make best use of the Directory of Service and assist patients in the management of their care. The neighbourhood focus allows for strong relationships to be built between statutory and voluntary services within that footprint building community responsiveness and resilience.

4.1.3 Extensive Care

Extensive Care is a fundamentally different way of delivering care that is reoriented around the needs of the patient, cutting across all aspects of need: medical, social, psychological, functional and pharmaceutical. The model includes health and wellbeing support that will draw together the different health and social aspects of care and access a range of community assets. The holistic care system is designed to ensure early intervention and over time proactive prevention, breaking the current cycle of slow reactive care provision.

With patient consent, clinical responsibility will pass from the GP to the Extensivist, supported by a team of clinicians and non-clinicians skilled in caring for patients with complex needs and having clear responsibility on behalf of the system for providing and coordinating care.

The clinical efficacy of this model is supported by:

- More effective condition management that will keep patients well for longer
- Patients who are more activated are significantly more likely to attend screenings, check-ups and immunisations, to adopt positive behaviours (e.g. diet and exercise) and have clinical indicators in the normal range (*Judith Hibbard et al -Kings Fund, Supporting people to manage their health*)
- 'Extensivist' model satisfies the requirements of NICE and NSF guidelines
- Integrating services around the needs of the individual with LTC's using an established tool of case management which, implemented effectively, will improve patients and carers experience and achieve better care outcomes. *(Shilpa Ross et al- The Kings Fund- Case management)*
- Clinical leadership and accountability that is clear

Each patient's care is led by an Extensivist with a team who are responsible for managing a specific group of approximately 500 patients. The Extensivist coordinates and delivers aspects of disease specific care programmes and general intervention programmes (e.g. end of life care) which are supplemented by specific specialist services, either long term condition related or episodic.

Care takes place at convenient locations for the patient and in settings designed with this cohort's needs in mind, with significant home care and support for transportation. In this way higher levels of adherence with treatment programmes are typically delivered which in turn supports better outcomes and patient experience.

4.2 Patient Pathway

4.2.1 Enhanced Primary Care

Enhanced Primary Care builds on our existing primary, community, social care, voluntary services and other services. Therefore, practices and their neighbourhood teams will seamlessly manage the process for patients moving between episodic care requirements to more enhanced primary care. As patients' needs increase, they will access more of the co-ordinated services available within their neighbourhoods and have an appropriate care plan developed to meet their needs based on standardised care pathways. If their condition improves and their needs are more episodic in nature the service input would be reduced appropriately by their GP and neighbourhood team.

4.2.2 Referrals to Extensive Care

The Extensive Care service's main source of referrals will be from primary care. During the initial launch of the service, GPs will be provided with detailed information on the patients who meet the service's criteria. A clinical discussion with the Extensive Care Service will determine those patients who will benefit most from the service.

Once the service has been established, secondary care and other community services will be able to refer patients to Extensive Care with the consent of the patient's GP. Agreements and referral protocols will be set-up with GPs wherever possible to facilitate a smooth process.

4.2.3 Pathway from Extensive Care back to Enhanced Primary Care

The aim of the Extensive Care service is to help each patient reach a point where they no longer need the intensive support provided by them. As a patient's health stabilises and improves, the team will monitor the patient and determine whether they still require the Extensive Care Service.

This is not as simple as when the patient has achieved all their objectives as the patient may still benefit from on-going higher level care. If it is decided the patient can be transferred out, the Extensivist will meet with the patient to develop a phased transfer plan. The aim of this process is to ensure the patient has a 'soft landing' when they leave the service.

4.3 Key enablers to our New Models of Care

5 Implementation

The two components of our new model will be implemented across the Fylde Coast during 2015/16 and 2016/17. Extensive Care is a discrete service model which allows specific, targeted rollout. Enhanced Primary Care is a more organic development of existing services which will evolve over a period of time.
The implementation of our model is supported by analysis of patient populations, details of our neighbourhoods and current cohort numbers are included in the table below:

	Extensive Care Cohort		Enhanced Primary Care LTC Cohort		Neighbourhood Population
Neighbourhood	No.	%	No.	%	No.
Fleetwood	433	1.52%	9,889	34.81%	28,407
Far North Blackpool	438	2.26%	7,821	40.36%	19,378
North Blackpool	450	1.70%	9,315	35.14%	26,506
Thornton, Poulton and Over Wyre	903	1.77%	17,875	34.94%	51,152
Kirkham	216	1.12%	6,685	34.63%	19,303
Central East Blackpool	309	1.20%	8,683	33.71%	25,757
Central West Blackpool	546	1.38%	14,379	36.36%	39,547
South Blackpool	593	1.57%	13,580	36.06%	37,660
South Central Blackpool	301	1.32%	8,062	35.27%	22,858
Lytham, Ansdell and St Annes	866	1.67%	18,259	35.27%	51,773
Total	**5,055**	**1.57%**	**114,548**	**35.54%**	**322,341**

5.1 Extensive Care Services

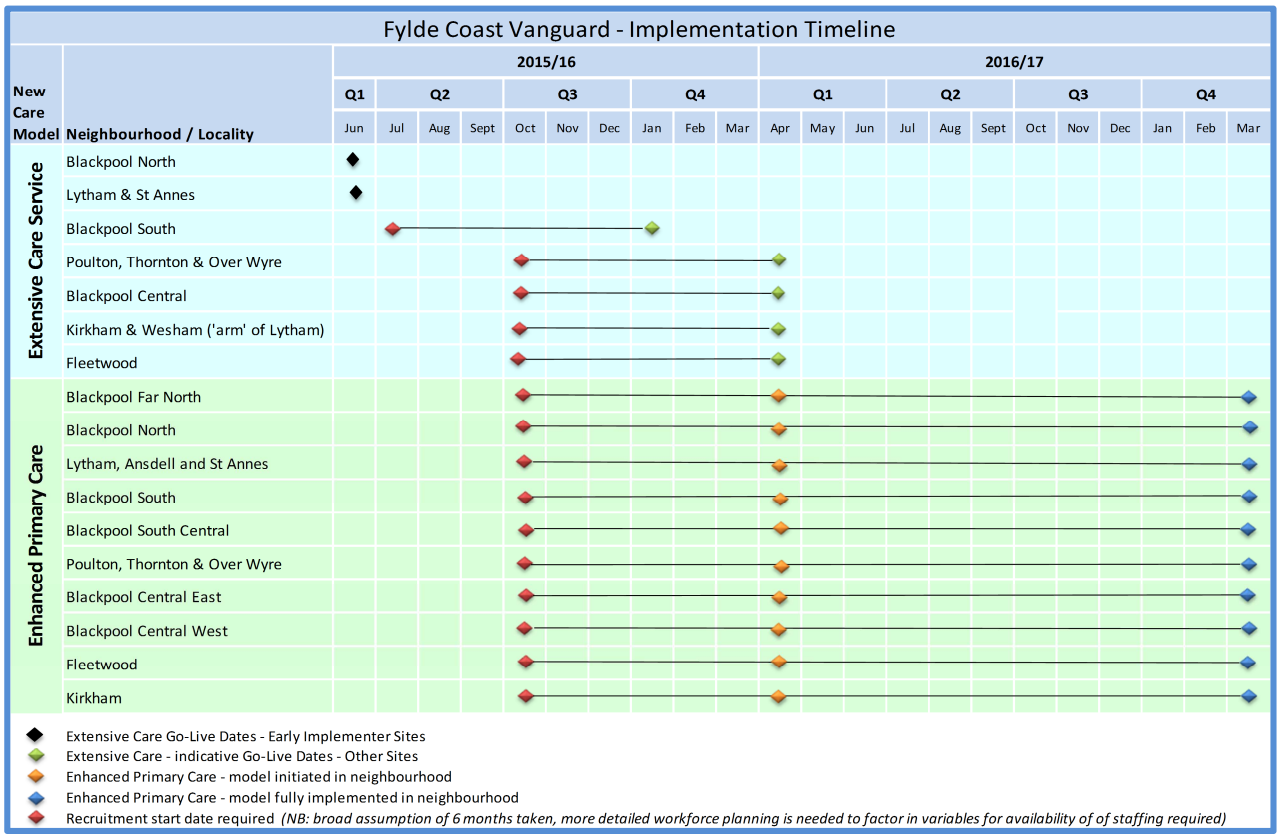
Two Extensive Care Services, Blackpool North (including Far North) and Lytham & St Annes (including Ansdell) went live in June 2015. A further four sites are planned to be established, one in January 2015 and three in April 2016, to complete the roll out of the service across the Fylde Coast. The cohort for Kirkham and Wesham is relatively small and so it is anticipated that this will be achieved through a hub and spoke solution by increasing the capacity of the Lytham & St Annes service.

5.2 Enhanced Primary Care

For Enhanced Primary Care the main vehicle for implementation will be the development of locality-based teams in neighbourhoods. Some of this work has commenced with additional community nursing allocated across neighbourhoods which has laid the foundations for a new model of Enhanced Primary Care.

Implementation will happen between April 2016 and April 2017. An initial tranche of additional community health staffing will allow the new model to be adopted in April 2016, initially focusing on the patients identified by the phased expansion of risk stratification.

By April 2017 we expect that a further tranche of staff with key clinical skills will allow the full model to operate. At this point Enhanced Primary Care will be a universal service available to all patients who require an enhanced level of clinical care, irrespective of condition. The use of the risk stratification approach will support an understanding of local need and ensure the development of Enhanced Primary Care is tailored to the needs of each neighbourhood.



5.3 Further Development of our Implementation Plan

Given the size of the Enhanced Primary Care cohort and the spectrum of needs that our model will need to respond to, activity modelling has been undertaken using additional criteria that breaks down the cohort, see *Appendix 3*. Smaller tranches, based on risk score and long term condition, will ensure we are able to target those patients who have greatest need and allocate our resources appropriately as we implement.

Partners have agreed to a framework from which further detailed mapping work will be undertaken to develop a phased approach to implementation. This work will be completed during September and October through a series of structured workshops designed around our framework which is outlined below:

Model selection	• Which model provides the greatest impact/benefit • Does the available staff skill mix support one model more than another • Dependent on the model, does one 'release' more existing 'acute' focused staff than another?
Cohort selection	• Which cohort provides the greatest impact/benefit? • Does the available staff skill mix support some cohorts more than others? • Dependent on the model, does one 'release' more existing 'acute' focused staff than another? • Are there synergies between the cohorts – e.g. do they require a similar staff skill mix or are there interdependent pathways?
Neighbourhood selection	• Are some neighbourhoods more prepared than others are – e.g. are there estates constraints? • Do some neighbourhoods provide a greater impact/benefit than others do? • What are the synergies between the models e.g. does it make sense to implement both models within the same neighbourhoods?

This approach will enable the selection of the model which best meets the needs of the communities each neighbourhood cares for and allow us to plan our workforce design and recruitment to help mitigate the potential constraints. We also expect this framework will support local teams in the neighbourhoods in a way that they can safely experiment and innovate.

6 Workforce

The total workforce requirements to deliver the implementation timeline are estimated to be an additional 420 – 430 WTE across both Extensive Care Services and Enhanced Primary Care. For Enhanced Primary Care this will build on existing resources to achieve the required capacity and meet the needs of registered populations in neighbourhoods whereas Extensive Care Services will be a discrete service implemented in the form of new teams.

6.1 Enhanced Primary Care Workforce

CCGs have already invested additional funding into community nursing to ensure that each neighbourhood to 'level up' existing provision in an equitable way reflective of neighbourhood need. At the same time, work has already begun with partner organisations to begin to realign key resources such as social work and social care capacity, mental health provision etc. on a neighbourhood footprint in order to develop the wider integrated care teams. This alignment will begin to address some of the duplication within current ways of working and further contribute to the required cultural change and the development of a common shared skill set.

This investment and initial development of neighbourhood resources forms a foundation to the development of Enhanced Primary Care as a model and is the first step to enhance both skills and capacity within primary care. However, in order to accelerate the pace and scale of change an additional 10% capacity is estimated to be required for Enhanced Primary Care. This amounts to about an extra 300 staff across 10 neighbourhoods.

There will be a 'double running' requirement whilst this transition is taking place as the clinicians currently working in other settings are likely to have existing responsibilities and this will complicate and lengthen the process of releasing skills and professionals to work within Enhanced Primary Care.

We anticipate that these 'double running' costs will be incurred over years 1 – 3 of the our programme. As described above, and acknowledging that the availability of staffing will be a constraint, our planning assumption is that an initial tranche of 150 staff will be recruited by April 2016 and a second tranche of 150 will be achieved by April 2017.

Our initial approach is to build on the excellent practices where significant amounts of workload, traditionally undertaken by nurses, GPs and other medical staff, have been undertaken by other health and social care staff such as Pharmacists, Assistant Practitioners, Navigators and Wellbeing Support Workers. We will tailor staffing models and ratios to the needs of each neighbourhood and we see significant opportunities to expand the traditional primary care and community workforce through the use of other health and social care professionals as outlined below:

- Clinical Pharmacists in the management of long term conditions and supporting people in care homes
- Pharmacy support staff with a role in managing minor illnesses and advising people about optimising medicines
- Paramedics – this is a role that has the potential to substitute the requirement for an urgent GP home visit and would require further evaluation as part of the model
- Other support roles – Navigators, Assistant Practitioners, Wellbeing Support Workers,
- Therapists – there is potential for direct access for some conditions which may make better use of health and social care resources
- Administrative Assistant to reduce the administrative burden on healthcare professionals
- Data Managers - because of the numbers of different disciplines and the wide range of activities and functions needed in the model, there will need to be a reliable, systematic data collection methodology to enable improved planning and evaluation of the effectiveness of the service and new ways of working.
- We envisage that there would be a role for Physician Associates however this will need to be evaluated as part of the future model.

Depending upon the need of the neighbourhood, we may need individuals whose first discipline is social work or mental health. For others, it may only require individuals working in that neighbourhood to have that as part of their skill set. In order to maintain an effective single point of access to community services and social services for urgent assessments, we would enhance the current Rapid Response model on the Fylde Coast.

6.2 Extensive Care Service

Extensive Care is a discrete service with a specific clinical model which enables traditional recruitment processes to be undertaken to obtain the right staff with the required skills. Based on the implementation timeline outlined in section 5, the following staffing is required to establish the service fully.

ECS Staffing Model Role	Fylde Coast EST	ECS Blackpool North EST	ECS Blackpool South EST	ECS Blackpool Central EST	ECS Lytham/ Kirkham EST	ECS Poulton EST	ECS Fleetwood EST	Total EST
Extensivist		1.50	1.50	1.50	1.50	1.50	1.50	**9.00**
Advanced Nurse Practitioner		1.70	1.70	1.70	1.70	1.70	1.70	**10.20**
Care Co-ordinator		4.00	4.00	4.00	4.00	4.00	4.00	**24.00**
Wellbeing Support Worker		10.00	10.00	10.00	10.00	10.00	10.00	**60.00**
Pharmacist		0.50	0.50	0.50	0.50	0.50	0.50	**3.00**
Service Manager	1.00							**1.00**
Analyst / Admin Coordinator	1.00							**1.00**
Administrator / Receptionist		2.00	2.00	2.00	2.00	2.00	2.00	**12.00**
	2.00	**19.70**	**19.70**	**19.70**	**19.70**	**19.70**	**19.70**	**120.20**

The Extensive Care Service focuses on the individual needs of the patient and cutting across all aspects of health and social need: medical, social, psychological, functional and pharmaceutical. This holistic care system is designed to ensure early intervention and, over time, proactive prevention which breaks the current cycle of slow, fragmented and reactive care provision.

In order to achieve this, staff will be recruited for their:

- Emotional intelligence and empathy
- Leadership, resilience and the ability to influence
- Drive to act as patient advocates
- Ability to work in a team and balance input from a range of sources
- Comfort with uncertainty and motivation to innovate

The intention is to provide a predominantly non-medical approach to care provision with a key role in the team being the Wellbeing Support Worker. This will be a non-clinical role which will assist the patient in navigating the health and social care economy, working with them to assist in the achievement of mutually agreed goals, and motivating the patient to better manage their condition in normal circumstances and in times of crisis.

6.3 Recruitment Plan

Comprehensive recruitment plans and trajectories across the whole system will be developed over the next two months based on the following principles, outcomes and recruitment approaches

Principles	Approaches	Outcomes
Attract new staff via local, national and international recruitment Retain existing staff by offering enhanced development opportunities and new roles Protect existing services from de-stabilisation during period of transition Support in a structured way, planned re-skilling current workforce Ensure we have the right staff with the right skills in the right place at the right time Ensure a Values based recruitment process	Careers fairs Promotion at conferences local, national and international advertising International recruitment Open days Social media Campaign videos Work with job centres, employment agencies, schools and colleges Alternative roles - Physician associates, advanced practitioners, assistant practitioners Tangible branding to include web page and description of unique selling point Virtual recruitment hub Support mechanisms for revalidation, care certificate etc.	High calibre workforce and a shared recruitment vision/plan Flexible and diverse workforce over 7 days Staff engagement — staff understand how they fit into the "New Models of Care", Cultivating the right attitudes behaviours and values Talent management and career and leadership development Collective workforce planning and profiling - understanding movement across the Fylde coast organisations

6.4 Training & Development Requirements

The workforce presents the biggest opportunity in developing new care models. The change in culture for staff working across the Fylde Coast can be summarised thus:

- Predicting patients' on-going health and social care needs (mental and physical) taking active steps to help them to manage escalations or exacerbations in conditions and intervening when required (no delays).
- The mental health needs of patients to be met on a parity of esteem basis with their physical health and social care needs.
- Efficient operation of integrated care teams, with no organisational or bureaucratic barriers to timely, planned interventions.
- Regular contact with patients (clients) and their carers to be undertaken by health and social care coordinators.
- Taking full advantage of the full range of local statutory and third sector services within a neighbourhood and contributing to a substantial (exponential) increase in social networks to support local people.

- GP responsibility for clinical aspects of care for people when not under the care of a Consultant matched with control over out of hospital resources.

We anticipate that new roles will be described and recruited to, alongside the required transition work that will look to shape and shift roles and responsibilities in line with the developing model. We are mindful that a specialist skill element will remain and that this will need to be factored into our workforce development, allowing for appropriate registration and maintenance of clinical/professional skills.

The new care model will be able to offer a wider range of opportunities for staff development and training. Support and training will be provided for those staff taking on leadership and management roles within these new neighbourhoods. Specific training to support different ways of working, for example, telephone consultation, video conferencing and email consultations.

There will also be a need to provide structured training opportunities for all staff wishing to develop extended clinical roles, specifically the assessment of the acutely ill patient. Specific provision is needed for foundation programmes with minimum training standards for registered professionals who transition from secondary care to primary/community care.

All of the above could be delivered in a community education provider network model that promotes inter-professional learning based around the needs of a local population. This model forms part of the concept of a Training Hub across the Fylde Coast to meet the educational needs of a multi-disciplinary workforce.

In order to make the cultural shift required, capacity will need to be built into the model to support staff to evaluate and share evidence of their effectiveness. It is essential that the evaluation is used to shape future training programmes to ensure that the service remains dynamic.

Over time, we expect to be able to define the core skill set required within this neighbourhood care team approach and ensure that all staff develop this core set of skills. This focus on skills, rather than roles, will ensure the care model approach is as effective and efficient as possible in meeting and supporting patient's needs and will be part of the wider cultural change that will be required.

Requirements for our cultural and leadership development have been discussed in detail with the North West Coast AHSN and we have asked for the support in the following areas to be developed with them:

- **Accelerating System Leadership**
    - Discussion and agreement of a jointly developed, system-wide memorandum of understanding, which clearly articulates the overall purpose, outcomes and desired behaviours of the local health system in respect of Vanguard.
    - Identification of necessary new rules of engagement to support new models of care and to unblock traditional barriers to innovative thinking.
    - Provision of individual executive coaching to support delivery of the programme as required and agreed.

- **Creating Capable Teams**
    - Provision of Team Level support in the form of a Change Leadership Development Programme.
    - Facilitation of team culture, creating new approaches and capability to embrace change, and support for new innovators within teams at a local level.

In respect of workforce strategy and planning we have identified the following support needs which the AHSN is looking to provide support to:

- **Creating a Sustainable Workforce**
    - Develop a Fylde Coast Workforce Strategy for the local system including health, social care and 3rd/voluntary sector, which addresses the changes required to support new models of care.
    - Develop an interface with individual organisational plans and other programmes of work to ensure system wide impacts are recognised and quantified.

7 Outcomes and Evaluation

7.1 Outcomes

The Fylde Coast expects to deliver the following outcomes, through a broad spectrum of improvements delivered with a structured and co-ordinated approach to condition management that will demonstrate a material improvement to patient outcomes. The cumulative effect of this is to achieve the following outcomes:

Effectiveness	Outcome	Measure
Disease progression is slowed or reversed through proactive case finding and management Individuals experience improved mental health and wellbeing through early support and diagnosis and the promotion of social prescribing Advice and signposting to local services and community support are made available to all people in contact with community services to support healthy lifestyles and independence	Number of years of life lived with disability shortened and/or mitigated Reductions in hospital utilization The health and independence of frail older people and those with LTC is maintained or improved through proactive identification, assessment and care	Reduction in years of potential life lost Reduced A&E Attendance Reduced Avoidable NEA Reduced readmission NEA Percentage of patients whose mental wellbeing improves following interventions (using validated scoring tools)
Patient Experience	**Outcome**	**Measure**
Patient and Carer experience is maximised through personalisation of treatment and care delivered in a way that increases well-being Health related quality of life for people with long term conditions improves through care which is holistic and joined up Uncoordinated interventions is stopped and number of hand-offs is reduced Patients are empowered to manage their own condition more effectively through self-care/self-management and shared decision making supported through Care Navigators and the development of Directory of Services for Voluntary and third sector services	Patients and their Carers, have an overall excellent and equitable experience of care and support Patients and carers experience effective joined-up working and co-ordinated care and feel involved in the planning of their care Patients have access to information in an appropriate way, when they need it Patients and their carers feel supported to manage in the community and maintain their independence and wellbeing, reducing social isolation	Percentage of patients and their Carers who are in contact with services and report that they are treated with respect and dignity by all staff involved in their care Participation in all relevant national patient experience surveys, with action plans for improvement Patient and Carer Satisfaction Survey Percentage of patients and Carers who: • report that they felt those involved with their care worked as a team (including communication, sharing information and coordinating care) • report that they know who the first point of contact or lead professional was for all aspects of their care • agree they have been actively involved in the planning of their care and can access their own plans/records • feel informed and involved in decisions about their care Percentage of patients and their carers who report they were told about other services that were available, including voluntary sector services, LA services , housing providers and local community support or activities

Safety	Outcome	Measure
Avoidance of exposure to potential health care acquired infections through more care in the community and a reduction in admissions to hospital	Reduction in HCAI against baseline Reduction of C difficile cases per quarter	Infection control quarterly report including assurance of systems and measures for Infection Prevention and Control
Proactive Medication Reviews through dedicated Pharmacist input	Medicines management is optimised and medication adherence is improved	Incidence of medication errors causing serious harm
Shared electronic record system will reduce duplication and allow clinicians and social care to access and record clinical information and systems at the point of care delivery	Effective information sharing and IT systems are in place and valued by staff across all local provider organisations	Staff survey to report that they collaborate with each
The risk of falls will be reduced and provision made to minimise them through adaptations to patients' homes	Reduction in repeat falls Maintaining confidence after a fall	Percentage of individuals aged 60 and over that have experienced a fall that experience another fall which results in injury within six months Measurement of confidence and level of fear for an individual after a fall in people aged 65 and over
Accessible & responsive care	Outcome	Measure
The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.	High patient and carer satisfaction with services	Evidence of patient engagement design workshops, patient attendee numbers and feedback given. Friends and Family scores for service Results from patient audits and satisfaction surveys
Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.	Patients and their Carers, have an overall excellent and equitable experience of care and support	Written evidence of choice offered within patients medical record Results of equality impact assessment undertaken during the design and further development of services
Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.	Patients are offered timely treatment in accordance with their condition and level of urgency	Service response times (e.g. referral to treatment..)

7.2 Evaluation

Work began to develop our evaluation approach in the early 2015 with support from two consultancies under the NHSE Accelerate Programme. This has provided a foundation which we will develop further with support provided by our local AHSN. The areas we have outlined with them are as follows:

- **Developing our Evaluation Framework and KPI's**
  - Scope and design an evaluation framework for the Vanguard programme as a whole, incorporating Enhanced Primary Care and Extensive Care Services.
  - Work with all partners to determine appropriate and relevant Key Performance Indicators, which interface with core data sets already in production where possible.
  - Identify additional measures and methods of collection for each element.

- **Evaluating the impact of Vanguard on Health and Care Outcomes for Fylde Coast Local Population**
  - Delivery of an academically led research programme to provide evidence of impact on outcomes for the local population in line with the scope agreed in our evaluation framework.
  - To commence with baseline data analysis followed by a longitudinal study addressing each of the agreed outcomes.

- **Evaluating Approach to Implementation**
  - Delivery of a research based programme to review effectiveness of programme delivery. Qualitative interviews with all partners and review of implementation plans and delivery against these to inform effectiveness of programme management and implementation arrangements.
  - Provide an evaluation of the approaches available to organisational forms and their associated benefits and dis-benefits to effective service delivery.

- **Understanding Capacity and Activity Flows in the new Care System**
  - Use of data modelling tool(s) to identify activity, capacity and workforce implications of implementing the proposed new models of care.
  - Evaluating the impact of these changes and building these into the assumptions within the Vanguard for redesign and realignment of financial and workforce resources providing the ability to inform future commissioning intentions.

8 Communications & Engagement

Communication and engagement is a fundamental component of the successful implementation of New Models of Care on the Fylde Coast as it is an ambitious programme of change that will radically transform patient pathways. Our communication and engagement strategy will be coordinated by the Programme Team with support from communications and engagement teams in all 6 partner organisations. We will ensure that communications and engagement is threaded throughout every layer of the implementation, ensuring overall cohesion across the programme.

The programme will require extensive engagement with a range of stakeholders from all partner organisations to ensure both the right design of new services and enable true integration between multi-disciplinary teams. This will be undertaken throughout the entirety of the programme to ensure learning and feedback is continually feed into the implementation of the new care models.

Equally, the programme will require a specific patient engagement plan to ensure the patient is at the centre of changes to services and that their views and perspective is embedded throughout the changes that new care models will bring. This will include a series of tailored events throughout the three-year period and will build upon existing work that has already been undertaken such as our simulation events for Extensive Care Services.

We have requested that our local AHSN provide us with some support in building resilient communities. Our intention is that we will devise an approach to social marketing, which targets the objectives of our new models of care and works with local communities to build their resilience.

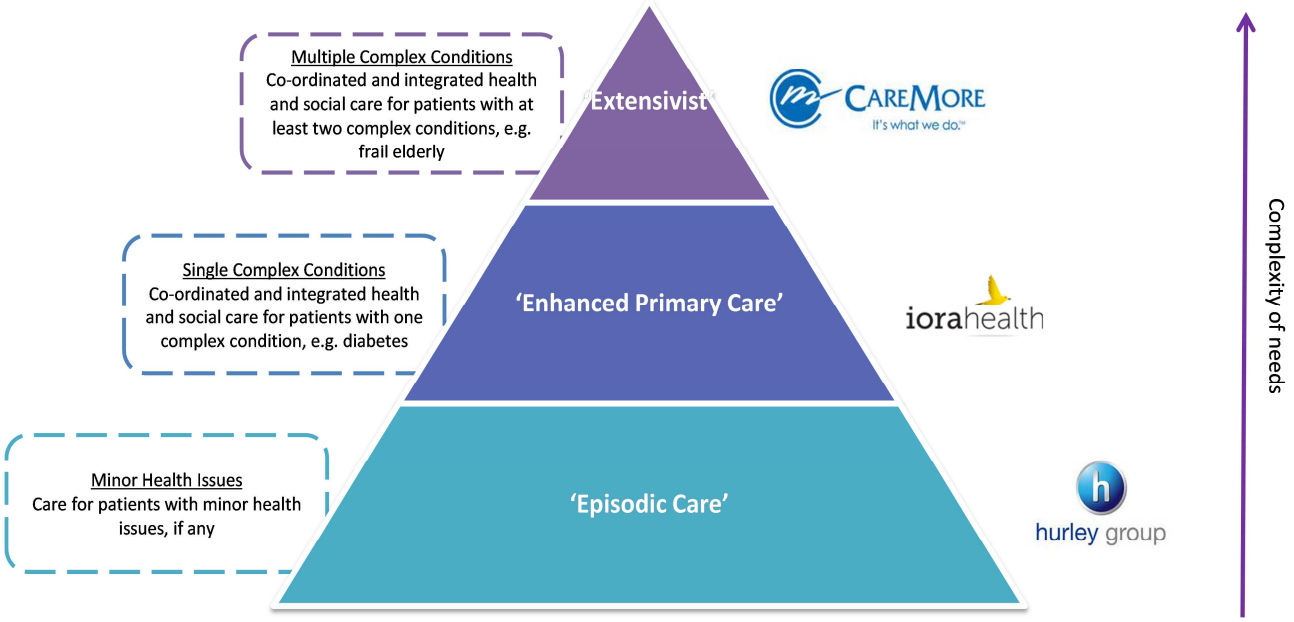
The programme will further develop a tailored communication plan for the rollout of both Enhanced Primary Care and Extensive Care Services across the Fylde Coast footprint. This will encompass all partner organisations and be a targeted communication at multi-organisational levels. This will include national branding where appropriate and create both new mediums of communication and use existing channels. This will facilitate identification and agreement of key messages and behaviours, which the programme seeks to influence and develop a programme of local interventions and activities.

Appendix 1 - International Evidence Base

The Fylde Coast is reflective of nearly all health systems in that a substantial proportion of the healthcare budget is accounted for by relatively few patients, many of whom have multiple long-term conditions (LTCs), are elderly/frail or have serious lifestyle issues. The proportion of these populations is increasing expenditure, putting pressure on budgets and requiring health and social care professionals to consider radically different approaches to delivering effective care.

Partners across the Fylde Coast recognise that continuing to deliver more care in its current form will not make the required step change improvements in variation and quality that the local population deserves. Stakeholders and sponsors have established agreement through the Fylde Coast Commissioning Advisory Board to design and implement a range of patient centric models. This is based on solid evidence from other global health economies, provided by the Oliver Wyman analysis, showing new models of care that could drive improved outcomes and quality through predictive, integrated services.

Patient-centric models that could be implemented in England were reviewed and there were some notable models in America, that were identified by Oliver Wyman. Of particular note was that CareMore that had demonstrated significant benefits of reduced admissions and 20% reduction in cost by implementing Extensivist led, multifunctional teams wrapped around patients with multiple long term conditions. The Oliver Wyman analysis also identified that this opportunity was possible on the Fylde Coast after looking at the co-morbidities in the population and examining the current pattern of expenditure.



The three proactive models of primary care reviewed in Oliver Wyman's analysis are Extensivist, Enhanced Primary Care, and Episodic Care, shown above. Oliver Wyman shared experience and outcomes from models from America and Europe, and undertook an analysis of how these could be applied in the Fylde Coast.

The Fylde Coast CCGs and Blackpool Teaching Hospitals Foundation Trust worked together to examine the possible opportunities with Oliver Wyman. This resulted in the document *'Delivering Proactive Primary Care across the Fylde Coast and Lancashire in 2014/15'* which describes the analysis undertaken and the identification of a new primary care orientated care models.

This analysis suggested that the financial impact of these models will be in the range of between £23m and £29m across the Fylde Coast for the NHS, based on the expected reduction in secondary care.

CCG	Extensivist	EPC	Total
Blackpool	£3m to £4m	£10m to £12m	£13m - £16m
Fylde & Wyre	£2m to £3m	£8m to £10m	£10m - £13m
Fylde Coast LHE Total	**£5m to £7m**	**£18m to £22m**	**£23m - £29m**

Since this initial review, work has continued to develop the approach which most appropriately meets the needs of our population and the UK health and social care system. Partners are confident that the primary care orientated models, Extensive Care (name for Extensivist adopted locally) and Enhanced Primary Care, when effectively implemented, have the potential to have material impacts on quality, outcomes and patient experience and facilitate a less resource intensive need for unplanned care.

Extensive Care: initially modelled on top 3% of population, the work of our Clinical Design Group has further refined the model to 6 specific long term conditions and excluded costs we do not believe can be influenced by new ways of working (e.g. cancer related care) and determined the most appropriate risk stratification. Our care model, resulting activity and financial analysis is detailed in the sections below but our conclusions can be summarised as follows:

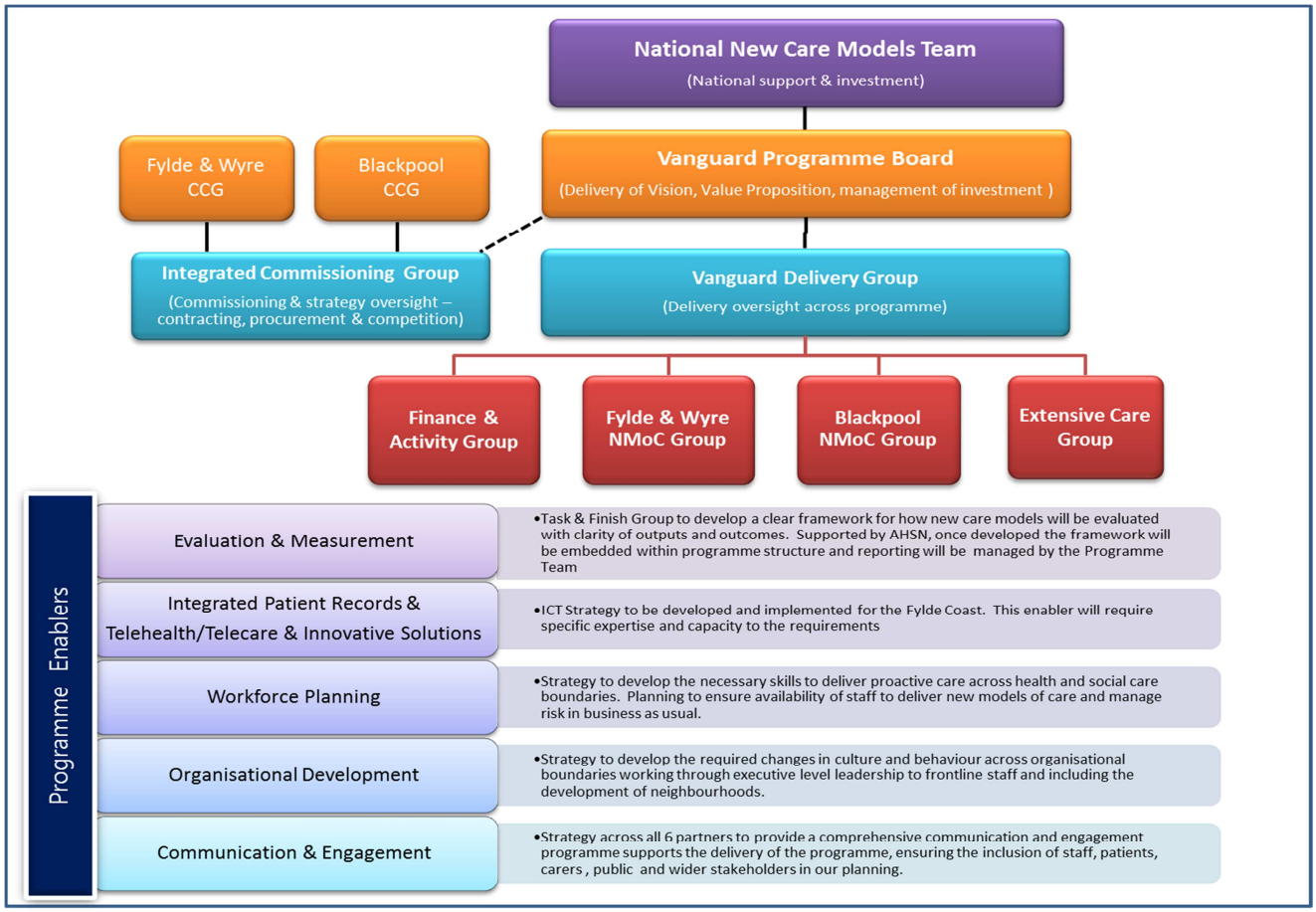
- Refinement of the model and the appropriate clinical presentation has reduced the cohort from 3% to approximately 1.6% of registered populations.
- The proportions of health resource usage for this cohort which is deemed to be influenced by new ways of working has reduced from c. 50% to 11.42%.
- Costs of a locality service have increase marginally from initial assessments but overall investment required remains consistent at £7.2m.
- In spite of the reduction in cohort and associated health expenditure, initial assumptions that the service will breakeven against reductions in secondary care activity have been tested and supported by our Clinical Reference Group.

Enhanced Primary Care: initially modelled on the 12% of registered populations below Extensive Care, the breadth of the cohort has increased to 36% and our Clinical Design Groups consider this to represent people who will benefit across a continuum of need.

- Our cohort has increased substantially from 12% to 36% of the registered populations.
- The proportions of health resource usage for this cohort which is deemed to be influenced by new ways of working has increased to 52.54%
- Investment estimates were not developed in our early work so it is not possible to make a comparison but savings estimates for our most ambitious scenario are similar to those originally forecast.
- The increase in the cohort indicates the requirement for a phased implementation.

Our current financial modelling suggests that Fylde Coast should expect a reduction of up to £31.5m in secondary care expenditure. Further analysis and details about the assumptions and associated risks are provided in the finance section. Overall our conclusion is that through clinically led, locally developed new models of care a similar level of savings can be delivered in the UK as experienced internationally, albeit that these assumptions still require testing through implementation, evaluation and clinical research.

Appendix 2 - Programme Structure & Governance



Our ***Vanguard Programme Board*** is comprised of executive level membership across all 6 partner organisations and will also include representatives from public health and patient/carer representation. Programme Board operates with delegated authority from all organisation and is the body responsible for the success of the programme, delivery of our Value Proposition and management of investment received from the Transformation Fund.

Vanguard Delivery Group brings together workstream leads in order to ensure that progress is being made as planned and risks and issues are managed across the entirety of the programme. The group provides assurance and reporting to Programme Board, escalating issues as necessary.

Our ***Integrated Commissioning Group*** brings together commissioners across health and social care. Together they will develop the commissioning approach, including areas such are contractual frameworks, procurement and competition.

Our ***Finance and Activity Group*** has thus far developed the financial assumptions and investment requirement. Going forward, this group will begin to look at the whole system economics. This group will be instrumental in analysing business intelligence and evaluation metrics.

Our ***New Models of Care Groups*** and ***Extensive Care Group*** are the forums through which our clinical models are planned and implemented. Substructures exist below these groups to design clinical models and consider other aspects of the work required.

Programme Enablers take a range of forums, some aspects are delivered via task and finish groups, others are ongoing workstreams. All will support the work to design and deliver both Enhanced Primary Care and Extensive Care Services.

Appendix 3 – Patient Cohorts

The diagram below is an example of how risk stratification is being used to analyse needs across the continuum of care in both Extensive Care and Enhanced Primary Care.