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# The Role of Vanguards in the Development of New NHS Commissioning Structures

A report from NHiS Commissioning Excellence

# Acknowledgements

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This report is based on the discussions at a meeting involving representatives of eight vanguard sites. The first draft was written by Jemma Lough, Independent Medical Writer, on behalf of NHiS Commissioning Excellence.

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# Introduction

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The NHS has seen dramatic changes in recent years, resulting in improved outcomes for conditions such as cancer and cardiovascular disease, reduced waiting times, and better patient satisfaction. Despite these improvements, the quality of care remains variable across the country, preventable diseases are still widespread, and our ageing population is increasingly complex.<sup>1</sup>

NHS England introduced the 'Five Year Forward View' (FYFV) to change the commissioning landscape and take advantage of opportunities such as advances in science and technologies to better meet the needs of the future population.<sup>1</sup> The FYFV also aims to break down barriers between the so-called funding 'silos' in the NHS through integration of policies between different organisations within and outside the NHS.

**FYFV aims to change the commissioning landscape, taking advantage of opportunities such as advances in science and technologies to better meet the needs of the future population, and to break down barriers to so-called funding 'silos' in the NHS.**

The FYFV's 'Vanguard' programme encourages creative, ambitious and innovative solutions tailored to local circumstances, as well as long-term investment to improve population health and reduce pressure on services. In March 2016, with many vanguard sites up and running for a year, an advisory panel meeting was organised to discuss the objectives and planned initiatives of some of the 50 vanguard sites<sup>1-7</sup> in order to:

- share challenges they are facing
  - consider emerging good practice
  - determine what kind of initiatives provide good value and should be prioritised
  - assess the feasibility of partnerships between the NHS and industry
  - identify opportunities that could benefit from effective partnership.
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The FYFV's 'Vanguard' programme encourages creative and ambitious innovative solutions tailored to local circumstances, as well as long-term investment to improve population health and reduce pressure on services.

The vanguards represented at the advisory panel meeting included:

- a strategic partnership with a combined budget for health and social care
- four multispecialty community providers
- a single local GP partnership
- a GP super-practice
- an acute care collaboration

This report is drawn from the presentations and discussions at the advisory panel meeting.

# NHS Vanguards: The commissioning perspective

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**"Devolution is a mechanism, not the master...[it] can be the trigger for greater and necessary positive reform"<sup>8</sup>**

## Novel care pathways

Care pathways have remained largely unchanged for many years, with recent updates generally acting as 'bolt-ons' to existing services and pathways, without fundamental changes to the underlying framework. Vanguards are able to be more creative, breaking down the existing pathways and going back to the basics. To achieve this they need to take a considered approach to competing priorities, drivers for national targets and policy recommendations, while also taking a potentially significant financial risk in terms of aggregate balance in order to address patients' needs locally.

**Vanguards are able to be more creative, breaking down the existing pathways and going back to the basics.**

With many emergency departments in acute hospitals overwhelmed by patients (who often use them inappropriately for non-acute issues) and consequently struggling to meet waiting time targets, one GP super-practice has placed senior primary care clinicians in its emergency departments to provide a triage system that redirects non-emergency patients to appropriate services – e.g. pharmacies or GPs. This has cut down average waiting times to an hour and is minimising the number of breaches. Standard operating protocols are vital to cover all eventualities, so that everyone involved in the process understands what is expected and can refer patients to the appropriate responsible team member or care pathway. Children and elderly people are the biggest drivers of attendance at emergency departments; new pathways have meant they can be offered a community- or home-based care package rather than being admitted. In another organisation, clear structured pathways for stroke patients have led to significant reductions in length of stay.

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**Immense pressure on emergency departments means that new ways of working, such as in-hospital GP triage, are vital to improve outcomes and patient experience and to meet national and local targets.**

A target for many organisations is to bring care closer to the patient and so the focus is shifting from acute hospital care to provision in the community. Many GP practices and clinical commissioning groups (CCGs) are introducing specialised services facilitated through cooperation between practices within an area. For example, one partnership is aiming to provide community outpatient and diagnostic services from a single large practice. They will expand a range of local social, mental and hospital services, to provide a single point of access to community care, including nursing, dialysis and chemotherapy in the home.

**Many organisations are shifting care from acute hospital to community and introducing specialised services to primary care.**

With so many people affected by preventable conditions such as diabetes and obesity, the focus of care needs to shift from managing ill health to preventing it developing in the first place, where possible. This will require investment in strategies to identify patients at risk to facilitate earlier diagnosis and intervention, and may involve joint working with employers and the third sector.

**The focus of care needs to shift from managing ill health to preventing it developing in the first place.**

Some GP practices are updating their appointment systems, introducing triage approaches involving telephone consultations with the option of a face-to-face consultation based on the initial assessment. GPs are encouraged to use latest technologies for appointments including telephone appointments, Skype and online booking. In one GP super-practice, low-risk patients with simple problems are assigned the usual 5- or 10-minute appointment. Those considered to be at high risk, vulnerable or with complex care needs, perhaps due to comorbidities or polypharmacy, are offered hour-long appointments. This has led to savings by reducing unnecessary follow up and increasing the number of people that can be seen in a risk-targeted manner.

**Risk stratification is important to prioritise patient care in the primary care setting, helping to identify patients with complex needs who require more time with their clinician and to stratify for onward specialist referral.**

### Physical and mental health

Physical and mental health need to be managed together in order to achieve parity of esteem, reduce the gap in life expectancy for patients with mental health conditions, and ensure that treatments for mental health do not have a detrimental impact on physical health. Implementation of parity of esteem is extremely challenging and so whether it is an achievable outcome is doubtful. Prevention is the key focus towards achieving parity of esteem. It is recognised that health and social care must work more closely together to do this, as mentioned in the FYFV. Additional funding has been agreed for the next five years to ensure mental health and wellbeing is one of the top priorities. One area, where patients repeatedly presented to the emergency department due to mental health issues, set up a multidisciplinary group to identify the reasons and develop solutions (Box 1). With silo working no longer feasible for many providers, one mental health vanguard involving a collaboration of four acute trusts has addressed the issue of crisis care for patients with psychiatric needs (Box 2).

**Box 1**  
*Case study –  
Repeat attendances for  
mental health issues*

An area with high repeat attendances at emergency departments by people with mental health conditions formed a multidisciplinary team of representatives from the acute trust, voluntary sector, local authority, police, ambulance service, probation service, schools, education providers, and the job centre to review the mental health policy and strategy to identify why patients become repeat attenders. This has raised the profile of mental health, and stakeholders are beginning to understand the relationship between mental and physical health and social standing.

Patients with low-level mental health issues are offered cognitive behavioural therapies, while potential underlying causative factors are also now assessed, including physical health contributors such as breathlessness related to chronic obstructive pulmonary disease (COPD) and isolation of housebound elderly patients. This has led to initiatives including early intervention in community hubs, holistic support outside of hospital, and assessment of mental health issues in residents of housing association properties. A care home vanguard has been working on holistic assessment and appropriate tools for patients with mental health issues living in care homes. A parallel transformation programme has also been assessing ways to reduce demand for acute beds and secondary care services by focusing on barriers to recovery, with an urgent and emergency care vanguard identifying best practice in terms of mental health and acute care and how that can be expanded to offer more beds on a larger geographic scale. One of the keys to these approaches has been encouraging providers to work collaboratively to deliver system-wide changes.

**Box 2**  
*Case study –  
Crisis care for patients  
with psychiatric needs*

A collaboration of four acute trusts has resulted in a mental health vanguard to address the issue of crisis care for patients with psychiatric needs. The aim has been to improve crisis care and reduce four-hour breaches through liaison with psychiatry, joint referral pathways and seven-day working. Patients who present with psychiatric needs have onsite psychiatric referral, primary care is involved as part of the recovery process, and public health has also been involved from a prevention perspective.

An onsite psychiatric team is available to prevent four-hour breaches by undertaking timely mental health assessments and making necessary ongoing referral if appropriate. Engagement forums have been set up to share practice across the sites, facilitating commissioning at a wider level. A separate reference group is also seeking patients' views on the vanguard's activities. The pilot has been successful, but there have been workforce issues upskilling staff to take on other areas within primary care, and it has been difficult to coordinate four CCGs with individual budgets and individual governance boards, so joint working has its own challenges.

**Parity of esteem for physical and mental health is an important goal, but whether it is feasible to achieve in widespread practice remains to be seen.**

## Cancer

The incidence of cancer is high and still rising, but advances have led to increased survival for many patients, who will live beyond cancer but often facing the consequences and complications of the condition or its treatment. Despite some improvements in survival, the UK is lagging far behind the EU in terms of clinical and patient outcomes.<sup>9</sup> Many cancers present too late to achieve good outcomes, either because patients fail to present with symptoms or for screening or because

the condition is not detected when they do present because symptoms can be vague and indiscriminate. Indeed, referral rates and outcomes across the UK are highly variable, even within CCGs; only one in 12 CCGs have installed GP decision software that is available to identify patients presenting with alarm symptoms for cancer. Commissioners also find it difficult to hold providers to account for outcomes due to the lack of mechanisms by which to do so. A cancer vanguard was set up in one area but there was too much focus on secondary care and limited emphasis on prevention and living beyond cancer, as there was no single body being responsible for the entire cancer pathway (Box 3). With early treatment so crucial for many cancers, decision support software that helps to identify at-risk patients with warning signs and symptoms will help to facilitate earlier detection and thus improve outcomes.

**Box 3**  
*Case study –  
Cancer vanguard*

In one area, where no single body was responsible for the entire cancer pathway or for cancer outcomes and patient experience, there was too much focus on secondary care treatment and limited emphasis on prevention and living beyond cancer. Services were not designed around what matters to those affected by cancer and funding was locked in budgets based on activity not outcomes. In order to address these issues and provide a more effective cancer pathway, a unique cancer vanguard was created by bringing together three different organisations. Although it has been difficult to agree a service redesign with three committees involved, this approach does have advantages, bringing together people with different experiences and ideas.

The vanguard aims to focus on outcomes rather than hospital procedures; release resources to focus on prevention, early detection, early diagnosis and living with and beyond cancer; commission whole pathways, streamline and coordinate commissioning; and ensure that safety and clinical effectiveness have parity in the patient experience, along with support around work, social issues and psychosocial health. The vanguard has

engaged with large numbers of patients affected by cancer to identify some of the organisational barriers that need to be broken down to improve the patient experience. Cancers are most likely to present in primary care, but it can be difficult for generalist primary care clinicians to identify cancer due to the often vague symptoms, so some transformation funding may be used to install decision support software that will identify those patients who should be referred to secondary care. Although the vanguard is not expecting to have a massive impact on the incidence of cancers, it is hoped that the rate of growth in cancer incidence will be reduced.

**Earlier detection and referral and more patient-focused pathways are needed for the UK to catch up with the rest of Europe in terms of clinical and patient outcomes, and decision support software will be useful to achieve this.**

### Alcohol misuse

Wider social issues also need to be addressed.<sup>8</sup> Misuse of alcohol is an increasingly important issue for the whole country, but particularly among young people. Initiatives such as RADAR (Box 4) are taking a new approach to managing patients with alcohol-related issues, reducing their impact on healthcare resources so money and time can be redirected to those with other health issues.

#### **Box 4**

##### *Case study – RADAR<sup>®</sup>*

In order to tackle the burden of alcohol on the healthcare system, one vanguard has instituted a system for rapid assessment, identification and diversion/transfer of patients presenting to hospital who want to stop drinking and require detoxification who would otherwise have been admitted

to an acute bed.<sup>8</sup> In this system, patients from acute hospitals across Greater Manchester have rapid access to medically managed detoxification at a specialist facility 24 hours a day. This has involved closer working with alcohol nurse specialists within acute hospitals, who provide gate keeping and referrals, a 5–7-day admission multi-disciplinary team, 24-hour hospital at night, and medical support for specialist individual and group psychosocial interventions, with an emphasis on supporting engagement in aftercare and recovery communities. Although the money invested has not yet been recouped, the programme is expected to result in savings to the local health economy of about £2million over a 12-month period. The RADAR programme won the Royal College of Psychiatrists' Non-age Specific Psychiatric Team of the Year award in 2014.

**With alcohol misuse a significant problem in the UK, new approaches are needed to reduce its impact on healthcare resources so money and time can be redirected to other health issues.**

## Finances

Where new programmes and initiatives require joint involvement of different health and social care organisations, finances can become a sticking point, so cost–benefit analyses are important to identify how much each participating organisation is currently spending to deal with the issue in question and which organisation is likely to make savings when the problem is resolved. In cases of joint working, it may be necessary to pool resources and for one organisation to take over the entire budget, which can be a huge step for the party handing over control, especially given the potential financial risk if the scheme is not successful, so a degree of trust is also required.

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Although funding is available for vanguard sites, some have chosen not to accept this investment in order to avoid the bureaucracy and strings attached to the money. Primary care vanguards that have not accepted NHS funding, can be run on a more commercial basis. They can decide how to structure their budgets and how to assign funding to individual patients, as well as focusing their investment on services that matter for the frontline in their area rather than those dictated by health economists looking at the bigger national picture from the offices at Whitehall. Decisions can be made quickly, as there is no need for proposals to pass through the complicated and lengthy processes entrenched within the NHS. Savings made through increased efficiency and productivity can be reinvested in the organisation or used to employ specialists so that patients can benefit from specialist care closer to home and remote monitoring.

One vanguard is aiming to build sustainable services across its health economy by developing a new contracting model focusing on value-based care. The simple premise is that it should be possible through joint commissioning and an outcomes-based model of care to achieve the best possible clinical, social and mental health outcomes for patients while minimising costs. This cannot be achieved by one provider alone, so the idea is for providers to work together to minimise costs by focusing on prevention and early intervention to reduce downstream costs associated with acute care and to break down barriers between the different organisations. As part of this approach, it is important to segment the population in line with their different needs so that care can be better targeted and to assess outcomes in three tiers: health status, recovery process, and sustainability of health. This vanguard has also been looking at moving away from the supply-based model to a pooled capitation budget that will take into account the outcomes framework with weightings for different outcomes as an alternative way to structure and incentivise the system. The ultimate aim is to shift the profile of the whole population towards a healthier position.

**With organisations within the NHS under continued pressure to make further savings, new financial models and approaches are needed.**

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## Managing public expectations

Although patient choice is important, the pendulum may well have swung too far in this direction, with patients expecting, even demanding, to be treated even if their condition is brought on by an unhealthy lifestyle, or to override professional advice or decisions based on their personal choice, even when the treatment is inappropriate for their circumstances. Many organisations have fostered a different, more honest and didactic relationship with the public, trying to help them understand the reality of the current situation within the NHS, why they must take control of their own health through self-monitoring or self-management, and why it is sometimes necessary to prioritise some services over others, which can lead to difficult conversations.

- Some areas have made the tough decision to require children with learning disabilities to be taken to school by their parents so that money can be diverted towards providing vital respite for families caring for children with disabilities in order to prevent carer breakdown and collapse. Such an outcome can have serious knock-on effects for families and health and social care.
- Expensive interventions for conditions like as obesity, such as gastric band surgery, are also contentious, as they cannot be funded for all. Healthcare organisations need to take a more pragmatic approach and be more direct with the public when there is no underlying causative pathology, or if psychological interventions may be more appropriate.
- Fertility treatments are another cause of disagreement, with some organisations having to choose between offering multiple cycles of in-vitro fertilisation to a limited number of patients or single cycles to more patients.
- To emphasise the demarcation between professionals and patients, some organisations have taken the decision to empower professionals to be professionals again by expecting all staff, even specialists, to wear white

coats or uniforms. This allows clinicians to hold a more authoritative conversation with their patients and helps with organisational 'branding'.

- Some CCGs have dedicated engagement teams who work closely with the local public, patients and carers to educate them on local preventative services and raise awareness of self-help.

**Patient choice is important, but public expectations need to be managed, requiring a different and more honest conversation between the NHS and its patients.**

### Information technology

Investment in new hardware and software will be key to many innovative service design projects, and technologies that offer risk stratification, early detection, appropriate intervention and remote monitoring will be the lynchpin of many such schemes. For example, clinicians in one GP super-practice have access to the entire electronic patient record, including primary and secondary care notes and results of imaging and laboratory tests, which means they can make fully informed decisions about each patient's care.

**Technologies that offer risk stratification, early detection, appropriate intervention and remote monitoring will be the backbone of many schemes.**

# Achieving NHS planning guidance 2016-17

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The NHS planning guidance to help organisations deliver the FYFV for 2016/17–2020/21, outlines nine ‘must-dos’ for 2016/17 (Box 5).<sup>10</sup> In general, vanguard commissioners felt that these were somewhat arbitrary, particularly those based on targets. For example, neither the four-hour wait target for the emergency department nor the 18-week referral target are evidence based, and most patients do not need to be seen within these timeframes.

Overall, however, the first three ‘must-dos’ – sustainability and transformations plans (STPs), aggregate financial balance, and sustainability and quality of general practice – are felt to be most important as they support the delivery of the other six:

- Work on STPs is in progress, with some vanguards having already submitted plans.
- The lack of transparency around finances, particularly in secondary and tertiary care settings, can make it difficult to untangle how money is being spent across different care pathways, even with population-based budgets, and consequently to identify ways to increase efficiency and productivity and reduce costs to make organisations financially viable. Furthermore, the relationship between commissioner and provider needs to change, with the provider being held more to account.
- Some commissioners feel that the greatest proportion of money should be invested in primary care, which provides the vast majority of care and has the greatest accountability and responsibility. Change at the grass roots of primary and community care to deepen, broaden and build on existing skillsets and services, such as increasing diagnostics in primary care, is pivotal to unlocking transformation across the NHS. Money also needs to be spent on prevention by investing in other areas that impact indirectly on health, such as housing, obesity and alcohol misuse.

**Box 5**

*Nine 'must dos' for 2016/17 for every local system<sup>10</sup>*

1. Develop a high quality and agreed sustainability and transformation plan (STP), and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the forward view.
2. Return the system to aggregate financial balance. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.
3. Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues.
4. Get back on track with access standards for A&E and ambulance waits, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.
5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice.
6. Deliver the NHS Constitution 62 day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make

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progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

7. Achieve and maintain the two new mental health access standards: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.
8. Deliver actions set out in local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.
9. Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of avoidable mortality rates by individual trusts.

The NHS nine 'must-dos' for 2016/17 are somewhat arbitrary, but STPs, aggregate financial balance and sustainability of general practice are most important as they support delivery of the other six.

# Challenges for vanguards

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Vanguards face a variety of different challenges.

Decisions on the best management approach for a patient should be made by the clinician, in discussion with their patient, taking into account their particular circumstances. Increasingly, decisions are made on a financial basis, often due to pressure from organisations responsible for budgets. Until decisions made are based primarily on clinical grounds (with some consideration for financial issues), it will be difficult to make significant progress in patient outcomes.

**Until decisions made are based primarily on clinical grounds (with some consideration for financial issues), it will be difficult to make significant progress in patient outcomes.**

Risk stratification will be increasingly vital to differentiate the complex patients most in need of a multidisciplinary approach and proactive hospital care from those who are suitable for a more community-based intervention. Risk stratification also has a major role to play in the outpatient follow-up system, as patients are often automatically brought back for appointments at six months, whether or not they have good control of their disease or condition. Some form of risk stratification would ensure that those who are most unwell and at highest risk are seen more frequently than those who are not, although the low-risk patients would still need a way to access care quickly should their situation change – for example, through contact with a specialist nurse. In some cases, clinicians may be reluctant to discharge patients due to financial pressures related to the payments their department receives while patients remain under their care. Indeed, staff willingness to change at all levels is an obstacle in general, as people are always afraid of moving away from the status quo, and it can be difficult even to bring people together to discuss change as the reality of organisational change is huge.

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**Risk stratification will be increasingly vital to direct patients to appropriate care pathways and management strategies; decision support software will be useful in this regard.**

Despite programme budgeting, many outcomes remain variable, with some organisations that spend less achieving good outcomes and others spending more but with worse results. The situation improved with the introduction of the national service framework (NSF), which made a massive difference in terms of outcomes. Targets can be an obstacle to change, as they will usually take priority over a service reconfiguration, so integrated care with shared accountability will be crucial to improving outcomes.

The financial situation means that it is impossible for every recommendation made by the National Institute for Care and Health Excellence (NICE) to be implemented. Indeed, the single intervention and condition approach taken by NICE is not always logical or optimal in our increasingly complex world of mixed conditions and an ageing population with multiple comorbidities.

**Implementation of NICE recommendations is challenging in the current financial climate, especially given the organisation's single intervention and condition approach.**

In some areas, mental health services for children have been a particular issue; insufficient local Child and Adolescent Mental Health Services (CAMHS) beds are available. This needs to be addressed urgently, as some areas are reporting that children are having to be sent to beds at opposite ends of the country. It is noted that current discussions may result in the commissioning of CAMHS beds returning from NHS England to CCGs.

The lack of contemporaneous and accurate data is a real challenge for decision making. It is difficult to draw up confident plans based on out-of-date and incomplete information: the coding data upon which much analysis relies is often extremely variable, inaccurate and therefore unreliable. Furthermore, there is still great reluctance to share data, even between NHS organisations. Most importantly, however, although a plethora of data is available to commissioners, NHS staff do not have the tools, skills or time to be able to translate those data into tangible insights to identify top priorities for improvement. Unmet needs include data interpretation/insight, risk stratification for high admission acute cohorts, and the remote multidisciplinary team 'primary care' model. Training events to upskill staff to better record and analyse data, bespoke software and outside support from industry may all be beneficial in this regard.

**Lack of contemporaneous and accurate data is a real challenge for decision making, but, more importantly, NHS staff do not have the tools, skills or time to translate available data into tangible insights, so outside support from industry may be helpful.**

With time pressures still an issue, new services will need to take advantage of modern technologies to provide alternatives to the traditional face-to-face consultations and remove barriers to communication between different services. Many areas already provide telephone triage in primary care and others are now offering call-in consultant services that allow GPs to talk directly to consultants and obtain advice without having to send the patient to the hospital. Skype consultations offer similar benefits, and some dermatology services now provide a consultation service based on photographs taken and shared via camera phones. Again, honest conversations with the public will also be necessary to ensure their expectations of the NHS are more realistic and they understand how the NHS should be used appropriately in order for it to survive.

**New services will need to take advantage of modern technologies such as smartphones and Skype consultations to provide alternatives to traditional face-to-face consultations and remove communication barriers between services.**

There is an emerging risk with workforce levels, particularly in areas where the number of people coming through the training pipeline is not aligned with the increasing demand. This means that either a service has to be transformed so that it is not reliant on a narrow pipeline of individuals or a completely different approach is needed. Endoscopy, which is often required for early diagnosis of potentially life-threatening conditions, is an excellent example of this dilemma. There is plentiful equipment to cover demand but not enough qualified staff to operate that equipment. The situation is similar for laparoscopic procedures, which are generally quick, have fewer complications and shorter recovery times, benefiting patients and the NHS, but insufficient staff are trained in laparoscopy, so many patients often still undergo unnecessary invasive procedures. Consequently, the NHS is likely to employ fewer doctors and instead recruit other healthcare professionals involved in patient care.

**There is an emerging risk with workforce levels, particularly in areas where the number of people coming through the training pipeline is not aligned with the increasing demand.**

Simplification of the NHS landscape is important, as many areas run the same services, with different standards and practices and best practice rarely is rarely shared. New strategies are needed to facilitate sharing and collaboration to maximise benefits while minimising work, which could involve the use of new technologies to provide routes for cross-organisational discussion and sharing of best practice. As healthcare and social care serve the same population, there is an appetite for the two to work together to commission and deliver services jointly for their patients and the local population.

New strategies are needed to facilitate sharing and collaboration which could involve the use of new technologies to provide routes for cross-organisational discussion and sharing of best practice.

It will be a challenge to position the vanguard changes as 'business as usual', especially with the transition from vanguard to 'normal practice' in the future. There is also a risk that vanguards may be trapped by the bureaucracy and reporting requirements needed to justify the transformation or that when only a proportion of the funding is awarded there is no decrease in expectation of what can be achieved with that reduced investment.

**Box 6**

*Top challenges for vanguard sites*

- Management decisions can be made on a financial basis rather than on what is best for patient
- Risk stratification is vital to differentiate patients' needs, for example, hospital care vs community intervention and more frequent vs less frequent follow up
- Staff are often reluctant to change from the status quo and even to discuss such change
- It will be a challenge to position the vanguard changes as 'business as usual' with the shift from vanguard to 'normal practice' in the future
- Financial pressures make it impossible to implement all NICE recommendations
- NICE's single intervention and condition approach is not always logical or optimal in the increasingly complex world of multiple comorbidities and our ageing population

- Achieving targets often takes priority over service reconfiguration
- The current CAMHS model is impractical in terms of locations of beds for children
- The lack of contemporaneous and accurate data is a challenge for decision making
- There is still reluctance to share data, even between organisations within the NHS
- A plethora of data is available to commissioners, but NHS staff do not have the tools, skills or time to translate data into tangible insights to identify top priorities for improvement
- Pressure on services means that alternatives to traditional face-to-face consultations are needed
- Barriers often complicate communication between different services
- Public expectations are often unrealistic and unachievable
- Workforce issues are an emerging risk in the current organisation set up, with lack of staff more of an issue than lack of equipment
- Innovative work is often duplicated and best practice is rarely shared
- Vanguards may be trapped between bureaucracy and reporting requirements needed to justify the transformation
- Vanguards may be expected to achieve similar outcomes to those they proposed but with reduced investment

# Conclusion

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At the centre of the FYFV programme is the recognition that one size does not fit all when it comes to organisational change within the NHS. Different vanguard sites are tackling different issues and at different levels. For some areas, it has been important to look at ways to integrate healthcare and social care, dealing with them side by side. For others, devolution of powers has been the trigger for greater and necessary positive reform, although devolution should not be implemented for the sake of it – only when it is the best approach to solve local problems. In some areas, GP practices have broadened their activities to take on more specialist roles, while multiple GP practices in other areas have combined to create super-practices, enabling provision of specialist services within the community for the wider population of many thousands of patients. The concept of individualising patient management is still an aspiration. Despite these differences, some themes are common to most if not all vanguard sites. Box 7 shows the top ten priorities identified across the board; by addressing these issues using modern technologies such as smartphones, Skype, and decision support and risk stratification software to facilitate many of the changes, the NHS will be in a stronger position to care for the health of individuals and the population as a whole not only now but also in the future.

## **Box 7**

### *Top priorities for vanguard sites*

- Making the finances work
- Ensuring the workforce is balanced and appropriate
- Realising insight from available data
- Identifying ways to stratify risk
- Developing appropriate hardware/information technology
- Encouraging self-management
- Sharing best practice
- Designing novel care pathways
- Managing public expectations
- Increased focus on primary care
- Shifting the focus from treatment to prevention
- Shifting the focus from outputs to outcomes

# References

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- 1** NHS. Five year forward view. London: NHS 2014
- 2** NHS England. Acute care collaboration vanguards sites. London: NHS England; 2016 Available from: <https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/acute-care-collaboration/>
- 3** NHS England. New care models – Vanguard sites London: NHS England; 2016 Available from: <https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/>
- 4** NHS England. Urgent and emergency care vanguard sites London: NHS England; 2016 Available from: <https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/uec/>
- 5** NHS England. Multispecialty community providers vanguard sites London: NHS England; 2016 Available from: <https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/community-sites/#eighteen>
- 6** NHS England. Integrated primary and acute care systems vanguard sites London: NHS England; 2016 Available from: <https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/primary-acute-sites/>
- 7** NHS England. Enhanced health in care homes vanguard sites London: NHS England; 2016 Available from: <https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/care-homes-sites/>
- 8** Greater Manchester Combined Authority. 'Devo Manc' & Mental Health as part of the plan for growth and reform in GM: what is it, impact locally/wider and what MH services will look like? Manchester: GMCA.
- 9** De Angelis Roberta, Sant Milena, Coleman Michel Pet al. Cancer survival in Europe 1999–2007 by country and age: results of EUROCARE-5 – a population-based study. Lancet Oncology 2014; 15(1):23–34.
- 10** NHS. Delivering the forward view: NHS planning guidance 2016/17 – 2020/21. London: NHS, 2015.

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