Innovative care model case studies

Learning for Chronic Obstructive Pulmonary Disease (COPD) services

NHS England

Introduction

These five case studies have been produced to support Integrated Care Boards (ICBs) in identifying new and innovative service models for the adoption of COPD biologics.

They outline approaches that could be replicated in COPD care by showcasing a range of real-world scenarios of models of care that could be used as a framework for implementation. Innovative examples from both respiratory and non-respiratory cases are included. This is to capture learning and principles from other specialities that have already implemented successful models or have a mature approach to using biologics that could also be put into practice within respiratory.

They cover themes such as:

- Drivers for change
- What the model is and how it was implemented
- Outcomes, benefits and key learnings
- Key figures on workforce inputs, costs and savings

The intention is to provide the reader with a translatable set of principles and numbers that could be adapted and modelled for local scenarios to support design and modelling of services.

These case studies are intended to support and be used in combination with the two further publications which are due to be published on the NHS England website:

- COPD: Commissioning strategies and resources, which outlines best practice for the commissioning of COPD services, and
- Business case guidance for COPD biologics, which provides commissioning leads with information to build robust evidence-based business and investment cases for commissioning COPD biologic therapies in their local areas.

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Introduction (continued)

Where possible, the case studies include data on inputs, metrics on impact and outcomes, as well as wider benefits that have been realised. This includes:

- **Service costs, resources and capacity**: Service requirements including staff, equipment, consumables, clinics and slots, service demand, capacity and activity
- **Patient benefits:** Clinical outcomes, access to services, patient experience and feedback
- **Operational benefits:** Savings, early and accurate diagnoses, reduced demand in inappropriate settings, optimised care, prescribing efficiency and safety
- **System benefits:** Improved ways of working, collaboration, knowledge sharing, upskilling and resource efficiency

We would like to thank the individuals that have contributed to this work, and their respective organisations for sharing their time, insights and learning. A list of leads who have worked with us to provide and shape the case studies is below:

Mona Bafadhel, NIHR Research Professor & Professor of Respiratory Medicine, King's College London

Evelyn Idise, Associate Director Strategic Commissioning for Community Based Care, South East London Integrated Care System

Nazir Hussain, Specialist Respiratory Pharmacist, Dudley Group Hospitals NHS Foundation Trust

Paula Bennett, Chief Nurse and Clinical Director, Health Innovation Manchester

Elizabeth Maher, Senior Communications Manager, Health Innovation Manchester

Jon Kwok, Lead Pharmacist Gastroenterology and Rheumatology, Manchester University NHS Foundation Trust

Rhiannon Clarke, Senior Programme Manager, Health Innovation North West Coast

Robert McCarthy, Lead for Multimorbidity Model of Care Evaluation, South East London Integrated Care Board

Lauren Blum, Project Manager, South East London Integrated Care Board

Irem Patel, Consultant Respiratory Physician, Integrated Care, King's College Hospital NHS Foundation Trust

Case study 1 - One-stop respiratory clinic: a proactive neighbourhood model of respiratory care to address unmet needs within the local population

Communities in the Black Country and West Birmingham are some of the most deprived in the country with high rates of smoking, poor housing conditions, poor air quality and high rates of hospital admissions for COPD. A large proportion are from ethnic minority groups and language barriers and low levels of health literacy make it more difficult for people to access services, and more likely to experience healthcare inequalities.

Nazir Hussain Specialist Respiratory Pharmacist, Dudley Group Hospitals NHS FT

What were the drivers for introducing the change?

- Waits of more than 6 months for spirometry testing and diagnosis
- Misdiagnosis led to patients being put on the wrong treatment plan
- Up to 12 month wait for consultant outpatient appointments
- Unsustainable pressure on general practice and patients' respiratory disease worsening

What is the model and how was it implemented?

The service is delivered by a **respiratory specialist pharmacist** and independent prescriber, offering twice weekly 'one stop' respiratory clinics rotating across 8 GP practices. It works with more complex respiratory cases **without the need to refer to secondary care,** accepting direct referrals from clinicians as well as data-driven case-finding to identify practices and patients who require the most support.

The clinic prioritises identification and support for **high-risk respiratory patients** who are not under the care of a respiratory consultant or at risk of seeking unplanned, emergency care or hospital admissions. Diagnostics for asthma and COPD are then provided using spirometry and Fractional Exhaled Nitric Oxide (FeNO) tests, allowing patients to have **same day diagnosis and treatment plan initiation**. Patients are reviewed with post treatment follow up to ensure effectiveness and safety netting. Missed and misdiagnoses are found and addressed, and inappropriate prescribing such as betablockers, high dose inhaled, and oral steroids stopped. Patients are offered bespoke education and self-management techniques, and access to additional pulmonary rehab and smoking cessation services.

A joint satellite multi disciplinary team (MDT) with the difficult asthma centre was set up undertaking proactive patient identification using searches and allowing pharmacists to make direct referrals to consultants. This partnership working delivered an **enhanced referral pathway** with suitable asthma patients being identified and initiated on biologics much quicker.

Benefits to patients:

- Shorter referral to appointment waiting time
- Early & accurate diagnosis of asthma and COPD
- Improved prescribing & management
- Better understanding of their condition
- Improved outcomes & quality of life

Benefits to General Practice (GP):

- Reduced GP workload
- Reduced practice appointments
- Improved prescribing
- Access to specialist advice

Next Steps:

- Train more specialist pharmacists to work in neighbourhoods
- Expand the clinics
- Establish a Hub and Spoke care model

"What we need is a local solution that can work alongside existing services by upskilling the primary care workforce and clinics that are accessible in primary care and surgeries." **Nazir Hussain**

Case study 1 (continued)

	Description	Value (Cost / Saving)
Service costs, resources & capacity	1. 1 whole time equivalent (WTE) B8a Clinical Pharmacist 2. 1 FeNO & 1 spirometer test devices 3. FeNO & spirometer test consumables 4. Waiting time to access service 5. Weekly clinics of up to 24 (30min) slots 6. Patients reviewed / high risk patients seen	1. £55,689 - £62,681 per year 2. £5,000 3. £2,200 per year 4. Same day to 2 weeks 5. 900 (30 min) slots per year 6. 316 / 198
Patient benefits	1. Patient **satisfaction** 2. Reduction in wait times for **spirometry** 3. Reduced wait times for **biologic initiation** 4. Reduced wait times for **patients with difficult to treat symptoms**	1. 100% rated excellent / good 2. From 26-52 weeks to 3 weeks 3. From 63 weeks to 12 weeks 4. From 52 weeks to 4 weeks
Operational benefits	1. **Early & accurate diagnosis**: new diagnoses 2. **Prescribing safety**: patients with inappropriate medications discontinued & SABA inhaler usage reduced 3. **Optimisation and fundamentals of COPD care** 4. **Referrals for difficult to treat patients normally seen in secondary care** managed in one stop shop 5. **Savings from spirometry tests** done in one stop shop	1. 115 2. 41 3. 100% patients seen optimised (inc. 131 inhaler technique corrected, 58 pulmonary rehab. / smoking cessation service referrals) 4. 27 (90% of 30 patients, £8,046 1st outpatient appt.) 5. £16,800
System benefits	1. Collaboration increased across settings and roles; increased resource efficiency from improved referrals 2. Staff – upskilling, confidence building and access to specialist advice 3. 100% GP practices rated the service as excellent	

Key learnings

- Specialists working alongside GP and other clinicians is a model of **neighbourhood care that could be replicated at scale**, reducing the burden on general practice.
- Earlier, proactive and specialist management of patients delivers a service that focusses on **shifting from sickness to prevention**, while improving patient waiting times, experience and outcomes.
- **Access to diagnostic tests within neighbourhood clinics is essential** for providing timely diagnosis and treatment, and identifying and addressing missed and misdiagnoses.
- **Enhanced and proactive patient outreach and education** can reduce healthcare inequalities and empower patients to self-manage.
- A **"one-stop" clinic model delivers overwhelmingly positive** levels of patient experience and satisfaction.
- **Improved quality of referrals to secondary care** can be achieved using advice and guidance from specialists working in neighbourhood GP practices using defined sets of referral guidelines.
- **Collaborating across traditional boundaries and roles** e.g. in joint satellite MDTs results in effective use of resources and a quicker, more efficient pathway for patient access to biologics.

"I could have the test in the surgery within a week…I was diagnosed with asthma [that] same day and started on treatment that completely transformed my life."
One stop shop respiratory patient representative

For further information please contact nazirhussain@nhs.net

Case study 2 – Increasing access to novel therapies for people with high cholesterol: using a framework approach

Health Innovation Manchester serving a population of 2.8m people in Greater Manchester, have continuously evolved their operating model and method for how they deploy innovation within the Greater Manchester health and care system. Cardiovascular disease is evidenced as being the largest area where the NHS can save significant numbers of lives. This is particularly relevant for Greater Manchester, where the prevalence and consequence of cardiovascular disease is significant.

Paula Bennett

Chief Nurse & Clinical Director (interim), Health Innovation Manchester

What were the drivers for introducing the change?

- Greater Manchester has the highest cardiovascular disease mortality rate in England, with approximately 5,500 cardiovascular disease related deaths annually, double the national average
- The economic and societal costs are significant; it is estimated that cardiovascular disease costs Greater Manchester £2.3 billion each year

What was the model and how was it implemented?

The understand, reimagine, implement framework was used as a structured method to support deploying access to standard and novel therapies to lower cholesterol levels aligned to National Institute for Health and Care Excellence (NICE) guidance. Health Innovation Manchester utilised population level data to identify patients with high cholesterol enabling risk stratification for targeted review and treatment optimisation. The following activities were carried out between partners:

- **Understand**

Using data to understand cohorts and the current state by developing a **case finding tool for GP practices** to easily identify patients who required a review. The tool integrated with practice clinical systems and searches replicated in the Greater Manchester Care Record allowing **real-time tracking of progress and uptake of new therapies.**

- **Reimagine**

Using findings to redesign pathways and services by **publishing a suite of resources to support clinicians**, including lipid management guidelines, a prescribing toolkit, and a secondary prevention pathway. Creating a range of **primary care delivery** models (to identify and invite patients for a review); working at standard general practice level, out-sourcing this with an external provider for a finite period (private or local federation) and working with primary care providers at scale (at primary care network level).

- **Implement**

Working with front-line staff to implement the new way of working and responding to early findings to adapt the approach where needed. **Tracking uptake and outcomes via population health data**, which enabled the real-world evaluation of the impact of standard and novel therapies. The cohort finding approach enabled **targeting of additional support** for underserved communities and data tracked outcomes across all communities (including Pakistani, Black Caribbean and diverse communities in the north of Manchester).

Benefits to patients:

- Earlier identification of high-risk underserved groups
- Improved prescribing & medicines management
- Improved patient outcomes

Benefits to General Practice:

- Clarity for when it is best to refer onwards with the new clinical pathway in place
- Improved confidence in managing patients

Next Steps:

- Continuous review of the methodology and learning from its application
- Extend use to other clinical areas such as respiratory

Case study 2 (continued)

"We are working together with our partners to deliver a new pathway for the treatment of cardiovascular disease including broad and rapid access to novel treatments in primary and secondary care." **Tracey Vell, Medical Director at Health Innovation Manchester**

Key Achievements

- This programme has resulted in **identifying 22,207 high-risk patients over time**, 2,759 (12%) of which **accessed novel therapy**.
- An estimated projected **savings of £8 million** (if all 22,207 optimised) through avoided CVD events and reduced medication costs.

Key learnings

- It takes time to map and assess existing pathways, evidence for change and potential barriers to adoption. **Emphasising the importance of the time, capability and capacity needed** for a comprehensive "Understand" phase to senior leaders is critical.
- Sustained uptake of innovation must be based in a **whole pathway approach** alongside other interdependent elements of care.
- Working in **collaboration** with the local system, staff and patients to co-design the solution maximises the chances of successful implementation.
- **Clear deliverables, performance targets** and **near-live data reporting** helps to drive uptake. Using logic models supports planning, reporting, clarity and focusing on outcomes and impact.
- Clear and persistent **strategic communication and education** is required for rollout at scale. A senior accountable officer in the system is key to champion the initiative and unblock delivery challenges, as well as strong clinical leadership to support new ways of working.
- Ensure your project team has the **range of skills/capabilities** required; clinical, user-led design, data analysis, operational, financial.

Key requirements for successful deployment of novel medication

- Tailored **workforce support** according to the level of provider readiness
- **User-led codesign for asset development** is key (with both staff and patients), process map to support; case finding, coding and redesigning operational processes.
- **Clear escalation route** for clinical guidance/support when developing products such as pathways and redesigning services.

"I now after having the treatment feel more energetic – I have started doing small simple exercises and I have started walking more… all those things are making me feel very proud, very strong. Me and my family are feeling very hopeful for the future. " **Cardiovascular disease patient feedback**

For further information please contact corporateoffice@healthinnovationmanchester.com

Case study 3 – Redesigning biologic prescribing in rheumatoid arthritis: the virtual biologic clinic approach

A virtual biologics clinic was introduced at Manchester Royal Infirmary as part of a quality improvement project. The initiative aimed to streamline and standardise the delivery of biologic therapy for rheumatoid arthritis patients aligning with the newly established regional pathway.

Jon Kwok

Lead Pharmacist Gastroenterology and Rheumatology, Manchester University NHS FT

What were the drivers for introducing the change?

A lack of consistency in how biologics were initiated led to:

- Missed essential pre-biologic screening tests
- Delays in treatment because missing tests were only noticed at the point of prescription
- Inconsistent standards of care
- Increased workload and confusion for nurses managing patients with varying levels of readiness for treatment

What is the model and how was it implemented?

The virtual biologic clinic is run by a clinical team, typically consisting of a consultant and a pharmacist or nurse. The team reviews a list of referred patients to assess their suitability for biologic treatment using a **standardised quality improvement approach, through plan–do–study–act cycles**. Referring consultants complete a template detailing the patient's disease history, current disease activity, previous treatments, and presenting symptoms. During the review, the virtual biologic clinic team ensures patients meet national guidance and eligibility criteria, that all necessary screening tests are completed, and that appropriate documentation and funding forms are in place. This is done using a checklist and a protocol for biologic initiation. Once a decision is made to initiate treatment, the virtual biologic clinic team generates a letter for the patient and their GP informing of the planned treatment. The consultant or prescribing nurse is contacted to complete the prescription. Moreover, patients are referred to a counselling clinic for education about their medication, followed by treatment initiation. The clinic ensures adherence to the rheumatoid arthritis biologics pathway, assesses safety and research eligibility, and issues prescriptions accordingly. Outcomes are monitored at weekly intervals assessing the impact of the clinic and refining operational and clinical processes.

How is this model more effective than traditional routes?

The virtual biologic clinic streamlines care by **completing all checks and documentation in a single review**, using standardised templates and plan-do-study-act cycles. Direct communication with clinicians and GPs prevents delays, and clear communication to keep everyone informed. This coordinated approach improves safety, ensures compliance with national guidance, and **enables treatment within four weeks**. Ongoing monitoring drives continuous improvement, making care faster and more consistent than traditional pathways.

Benefits to patients:

- Reduced delays in starting biologic therapy
- Reduced hospital visits
- Improved patient safety

Benefits to workforce:

- Streamlined workflow
- Easier follow-up & patient counselling
- Improved auditability & service governance
- Better coordination across multidisciplinary team, reducing variability in care delivery

Next Steps:

- Scale the model to other specialties
- Formal evaluation of long-term patient outcomes & cost-effectiveness

"The key benefit is a streamlined, standardised process where essential tests are done in one visit, reducing delays, unnecessary appointments, and supporting nurses and pharmacists in delivering consistent care" **Jon Kwok**

Case study 3 (continued)

	Description	Value (Cost / Saving)
Service costs, resources & capacity	1. 0.1 WTE B8a Clinical Pharmacist 2. 4 hours per week consultant 3. 1 weekly clinics 4. Patients seen	1. Approximately £6.2k per year using median salary 2. Approximately £11k to £14.5k per year depending on consultant grade 3. 52 slots per year 4. 10-20 patients per week
Patient benefits	1. Improved **patient safety** 2. Reduced **treatment delays** 3. Increased **research involvement** 4. **Streamlined referral and prescribing process**: decreased time to biologic initiation	1. Use of the enhanced safety checklist increased from 50% to 100% 2. Mean treatment delay in all patients reduced from 40.6 to 19 days 3. Recruitment of rheumatoid arthritis patients into research studies increased by 61% 4. Treatment initiated within target of 4 weeks
Operational benefits	1. **Cost effective** drug choices 2. **Adherence to regional biologics pathway** for rheumatoid arthritis	1. Over 6 months £113k cost savings were realised (£23K through pathway adherence and offering cheapest drug first, £90K through enhanced recruitment to research) 2. 90% of patients adhered to the rheumatoid arthritis biologic prescribing pathway
System benefits	1. Collaboration increased across settings and roles; increased resource efficiency from improved referrals 2. Reduced variability in practice across consultants 3. National and NICE guidance adherence	

Key learnings

- Integrating pharmacists into the virtual biologic clinic optimises resources, ensures safe drug monitoring. Patients spend less time travelling, receive treatments tailored to their lifestyle, and can often self-manage biologics under clinic oversight. Experience in rheumatoid arthritis has shown that a **multi-disciplinary team, led by a consultant, can safely assess and initiate biologic therapy while shifting away from the traditional hospital-based consultant clinic model.**
- **Structured processes** can significantly improve consistency and safety in complex treatment pathways. **Simple tools** (e.g., referral templates and checklists) can greatly enhance efficiency and quality. One key recommendation is to standardise the referral pathway and ensure clinicians use **the referral template**, capturing all essential details before discussion **in a single, clearly documented form.** This allows swift and focused discussion during the virtual biologic clinic. It would be helpful to **introduce a checklist for COPD biologics** that includes diagnostics conducted, offer of 5 fundamentals of care (tobacco dependence services, vaccinations, pulmonary rehabilitation, self management plan, comorbidities) and patient eligibility in accordance with NICE criteria.

"People need treatment quickly - time is limited" **Patient representative on access to biologics**

For further information please contact jon.kwok@mft.nhs.uk

Case study 4 – Reducing fuel poverty and improving respiratory health: using data and cross-sector collaboration to target holistic interventions

Fuel poverty is a major public health issue for Cheshire and Merseyside where a third of residents live in the most deprived 20 per cent of neighbourhoods in England. Fuel poverty is particularly dangerous for people with respiratory conditions, significantly increasing their risk of serious complications, unplanned hospitalisations, and premature death.

Rhiannon Clarke

Senior Programme Manager, Health Innovation North West Coast

What were the drivers for introducing the change?

- 14% of Cheshire and Merseyside were in fuel poverty in 2020, rising to an estimated 42% by 2022 with fuel prices increasing
- Cold temperatures and fuel poverty are particularly dangerous for patients with respiratory conditions such as asthma and COPD
- Not all respiratory patients were having their medicines optimised

What is the model and how was it implemented?

Cheshire and Merseyside ICB brought together partners from the NHS, voluntary and community sector and local authority to find innovative ways of supporting people with respiratory illness living in fuel poverty.

Population health management approach: a linked data platform with health and social care data was used to produce a **fuel poverty dashboard identifying those at greatest risk of hospitalisation due to the cold**. Local clinicians and care professionals were invited to a facilitated workshop to understand and interrogate the data and develop targeted interventions to support the at-risk population.

Mapping of community assets: a detailed list of community-based organisations, services and projects that would help engage at risk communities and provide support and interventions for people experiencing fuel poverty.

Multi-disciplinary teams spanning the health and social care sectors worked together to **reach out to these high-risk groups to deliver targeted holistic interventions**. Several methods were used to approach and engage individuals in these groups such as telephone, text messages, letter and knocking directly on doors.

Clinical interventions: included smoking cessation, medicines optimisation, mental health support and inhaler optimisation.

Holistic interventions: included referring to other services to support people beyond their clinical needs such as fixing broken boilers, providing hats and scarfs, reducing damp, treating mould, providing financial support and installing solar panels and new energy efficient lighting.

Benefits to patients:

- Highest risk patients identified
- Reduced exacerbations, fuel poverty debt & anxiety
- Improved adherence & effectiveness of inhaler technique
- Signposting to other health / support services
- Tailored intervention

Benefits to NHS:

- Improved achievement of quality & outcomes framework targets
- Reduced GP visits
- Reduced Accident & Emergency attendances & hospital admissions

Next steps: Fuel poverty toolkit to replicate this approach by identifying the most clinically vulnerable people living in fuel poverty

"These trailblazer projects show what can be achieved if you combine smart data with strong and active collaboration between the NHS and local partners…there's no reason why we can't apply the same principles to other health challenges in future. It's been invaluable to us." **Sarah Sibley, Respiratory lead for Cheshire and Merseyside ICB**

Case study 4 (continued)

	Description	Value (Cost / Saving)
Service costs, resources & capacity	1. 0.4 WTE care coordinator, B4 for performing searches 2. Monthly MDT meetings (NHS staff costs only, B4, B6, B8a) 3. Room hire for workshops 4. Number of patients identified and put on the pathway	1. Approx. £11,500 for 6 months using median salary 2. Approx. £402 for monthly meetings over initial 6 months, using median salary 3. £0 as used primary care network, Trust and University locations 4. Over 900 patients
Patient benefits	1. Number of patients having their **medicines optimised** 2. Patient **satisfaction**	1. Over 600 patients 2. 100% of patients surveyed
Operational benefits	1. Reduction in **GP appointments** 2. Estimated **savings from reduction in GP appointments** 3. **Informed decision making** enabled through fuel poverty dashboard	1. 14.3% over 12 months 2. £22,570 over 12 months 3. 100% of staff surveyed agree
System benefits	1. Knowledge sharing: on social determinants of health through population health management 2. Staff satisfaction and confidence: improved in remote identification of patients 3. Collaboration and resource efficiency: across sectors and community assets	

Key learnings

- A **population health management approach** can successfully tackle healthcare inequalities, and the fuel poverty project model is **scalable and transferable to other determinates of health.**
- Ensure all stakeholders can **access, understand and interrogate the relevant data by delivering training and providing guidance** for them (including non-NHS staff).
- **Having a single point of contact for the project has helped build the care-coordinator and patient relationship** through open and consistent communication as patients share more information about issues they are experiencing affecting their physical or mental health.
- Contact or interventions through proactive outreach, particularly from non-NHS organisations could be seen with a level of scepticism. **Patient information leaflets prior to appointments** have been helpful to reduce this, manage expectations and provide assurance.
- **Build on existing knowledge** by working with your existing community services - **where you need to make new relationships, ensure you plan enough time** to build interest and buy-in, identify common goals and refine a delivery plan (e.g. through workshops).
- Ensure **primary care data is complete and up to date** e.g. COPD diagnosis and vaccination status, as this can affect quality of information pulled through to the fuel poverty or any other population health management dashboard and increase administrative time.

"It's been a choice between heating my home or using my oxygen." **Cheshire and Merseyside patient**

For further information please contact rhiannon.clarke@healthinnovationnwc.nhs.uk

Case study 5 – Integrated care through neighbourhood teams: addressing gaps in care for people with multiple long-term conditions

Lauren Blum, Project Manager, South East London ICS

300,000 people in South-East London Integrated Care System (ICS) live with multiple long-term conditions. High prevalence of cardiometabolic disease means 350,000 people with hypertension, diabetes or both are also at heightened risk of chronic kidney disease. Care pathways for multiple long term condition patients are fragmented with inefficiencies in service coordination, and the ICS has substantial financial challenges with a large system deficit.

What were the drivers for introducing the change?

- Significant health inequalities, increased risk of hospitalisation, and poorer health outcomes
- Only half of expected prevalent population identified on chronic kidney disease registers
- Double mortality rate for chronic kidney disease patients not coded
- Double risk of prescribing contra-indicated nephrotoxic medicines
- Need for financial and operational sustainability, integrating services and development of a neighbourhood health service

What is the model and how was it implemented?

The ICS developed a multimorbidity model of care to address significant gaps for people with multiple long term conditions, specifically renal cardiometabolic conditions, through **integrated neighbourhood teams** (INTs) integrating primary, secondary and community services. These teams comprise multi-disciplinary staff with clinical and non-clinical roles **working across service boundaries to care for patients within a defined neighbourhood**.

Initial work focussed on **detecting chronic kidney disease and optimising care delivery** at neighbourhood level to reduce hospital utilisation and improve patient and staff experience. Patient searches were undertaken, and the population was risk stratified to systematically identify relevant cohorts. The model comprised three delivery pillars:

Pillar 1 - Prevention and targeted testing: community outreach for proactive testing, digital remote testing, point of care testing and review of coded and uncoded patients.

Pillar 2 - Case management of complex patients in the community: holistic assessments to encourage patient activation; screen for additional social or mental health needs, unblocking barriers to care, referral onto appropriate integrated neighbourhood team members.

Pillar 3 - Integrated care: acute renal, diabetes and cardiology consultant input into MDT meetings, as well as multi-speciality pharmacists supporting across the integrated neighbourhood team.

Benefits to patients:

- Improved patient experience
- Increased patient involvement in decision making
- Improved communication from healthcare professionals
- Increased appropriate prescribing & medicines optimisation

Benefits to workforce:

- Increased job satisfaction & confidence
- Easier to access support for complex patients

Next Steps:

- Expand integrated neighbourhood teams
- Use learnings to feed wider strategic and population health planning

"It has increased my job satisfaction because working in an integrated manner led to positive patient outcomes." **Staff feedback**

Case study 5 (continued)

	Description	Value (Cost / Saving)
Service costs, resources & capacity	1. a) INT - 12 Primary Care Networks & all boroughs; b) integrated acute investment 2. MDT training and upskilling 3. Project coordination 4. Targeted health inequalities interventions	1. a)£900k for two years; b)£320k for two years 2. £30k for two years 3. £75k for two years 4. £100k for two years
Patient benefits *(March 2024 – February 2025)*	1. Chronic kidney disease **detection rates in participating neighbourhoods** 2. Chronic kidney disease patients **without diabetes with controlled blood pressure in participating neighbourhoods** 3. Patients likely to a) **recommend service**; b) **feel involved** in decisions about their care	1. 4% identification increase 2. 2.4% increase 3. a) 95%; b) 91%
Operational benefits *(March 2024 – February 2025)*	1. **Outpatient attendances**: cardiology, nephrology, and diabetes in participating neighbourhoods 2. **Non-elective** hospital admissions in participating neighbourhoods 3. **Optimised care** in participating neighbourhoods: a) SGLT2i's prescribing; b) SGLT2i's prescribing in patients with chronic kidney disease & diabetes; c) statin prescribing	1. Age-standardised rate reduced from 36 to 22 attendances per 100 patients* 2. Age-standardised rate reduced from 20 to 7 attendances per 100 patients* 3. a) Increase of 8.6%*; b) Increase of 13.9%; c) Increase of 3.8%*
System benefits	1. Collaboration increased across settings and roles; increased resource efficiency from improved referrals 2. Staff - upskilling and confidence building, 80% report increased trust in working within a multi disciplinary team	

Key learnings

- Neighbourhood models of care can deliver earlier detection / intervention, medicines optimisation and closer monitoring to prevent disease progression that **reduces the need for chronic condition specialist support and prevents non-elective hospital admissions.**
- **Population level interventions that use risk stratification** to target interventions are effective for at-risk patients, demonstrating the value of proactive case-finding within integrated neighbourhood teams.
- **Patient engagement increases** when care is closer to home, and services can be accessed within their own neighbourhood.
- Integration of staff in integrated neighbourhood teams **builds and improves working relationships** across primary, secondary and community care, and streamlines care.
- **Primary care additional roles reimbursement scheme staff are essential** to successful neighbourhood models of care and ways of working in integrated neighbourhood teams.
- **Multi speciality pharmacists can support the wider workforce** to deliver improvements in care and medicines optimisation e.g. through participation in multidisciplinary team meetings and running education events aimed at improving confidence in primary care.

"No one has ever explained properly to me about my kidney and last week, the pharmacist explained [it] well to me, talked to me like a person, not just staring at the computer." **Chronic kidney disease patient feedback**

*Patient cohort definition: adults over the age of 18; With an e-GFR measurement over 60 ml/min1.73m2 with microalbuminuria; or with an e-GFR measurement under 60 ml/min1.73m2 with or without microalbuminuria; with/without other LTCs

For further information please contact lauren.blum@nhs.net