



**RCN Policy and International Department**  
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# Integrated Health and Social Care in England: the 14 Pioneer Programmes

A guide for nursing staff

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## **Integrated health and social care pioneer programmes**

This briefing paper is part of a series of RCN documents examining integrated health and social care. It provides an overview of the 14 pioneer programmes introduced throughout England in 2013, and looks at some of the ways nursing staff are reportedly working within the programmes, as well as how the pioneers are to be evaluated and learning disseminated.

### **Background**

The government has stated that it is committed to making evidence-based integrated health and social care the norm over the next five years. 'NHS England and Monitor have statutory duties, to promote and enable integrated care. Local authorities have a statutory duty to improve the public's health. Clinical commissioning groups (CCGs) and health and wellbeing boards (HWBs) also have statutory duties, respectively, to promote and encourage the delivery and advancement of integration within their local areas at scale and pace.'<sup>1</sup>

In May 2013 the National Collaboration for Integrated Care and Support, which at the time was made up of fourteen key organisations from across the health and social care system, published their shared commitment<sup>2</sup> on how they will help local areas integrate services. As part of this commitment, the 'national partners announced the 'pioneers' programme, inviting local areas to demonstrate the use of ambitious and innovative approaches to deliver person-centred, co-ordinated care and support. Over 100 expressions of interest to become a pioneer from across England were received, with the final selection of the pioneers being made by a panel of UK and international experts'.<sup>3</sup> Fourteen integrated care pioneer programmes were selected and announced on 1 November 2013.

The government has stressed that these pioneers are not pilots and should be seen as 'an opportunity to inform the rest of the system about how integrated care can be practically implemented with learning to be disseminated across the NHS'<sup>4</sup>. See Appendix 1 for a full list of the current National Collaboration for Integrated Care and Support partners, which has now risen to almost forty organisations, with support co-ordinated through NHS Improving quality (NHSIQ).

### **The 14 pioneer programmes**

Almost all pioneer initiatives state their aim as being to make health and social care services work together to provide better support at home and earlier treatment in the community to prevent people needing emergency care. Over half of the programmes

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<sup>1</sup>[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/198748/DEFINITIVE\\_FINAL\\_VERSION\\_Integrated\\_Care\\_and\\_Support\\_-\\_Our\\_Shared\\_Commitment\\_2013-05-13.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf)

<sup>2</sup>[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/198748/DEFINITIVE\\_FINAL\\_VERSION\\_Integrated\\_Care\\_and\\_Support\\_-\\_Our\\_Shared\\_Commitment\\_2013-05-13.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf)

<sup>3</sup> <http://www.nhs.uk/improvement-programmes/long-term-conditions-and-integrated-care/integrated-care.aspx>

<sup>4</sup> <http://www.hsj.co.uk/news/policy/analysed-lambs-integration-pioneers/5064989.article>

involve GPs; two programmes will provide seven day services and one will use 'telehealth' and 'telecare' technology. New models of commissioning and new payment arrangements will also be tested by some programmes; these will be of particular interest considering the difficulties of encouraging integrated care within an environment that is increasingly made up of markets and subject to competition. The pioneers vary in size with the largest, North West London, involving eight CCGs, seven local authorities and nine NHS provider trusts. Full details of the pioneer programmes are provided in Appendix 2.

### **The Better Care Fund**

Announced in the summer of 2013 and initially called the integration transformation fund, the Better Care Fund (BCF) - £1 billion in 2014/15 rising to £3.8 billion per annum from 2015/16 - is a pooled fund intended to be used for partnership working between the NHS and social care, to get more people cared for in the community and therefore, in theory, save the health service money. However, this is not new money and 'for most CCGs finding money for the BCF will involve redeploying funds from existing NHS services'<sup>5</sup>.

### **Better Care plans**

It should be noted that while the BCF has close links with the Pioneers they are not the same thing; BCF funds are available to all areas submitting a Better Care Plan. Local councils and CCGs will jointly develop plans for how the BCF should be spent. According to Monitor, it is hoped that 'lessons learned and notable practice demonstrated by the pioneers will help inform the joint plans that all localities must produce for spending the fund'<sup>6</sup>. Final BCF plans were submitted to NHS England in April 2014. Commenting on the quality of the initial Better Care plans the Minister for Care and Support, Norman Lamb, said there was 'inevitable variation - some brilliant, some less well developed.' He went on to say that NHS England and the Department of Health would work to improve the poorer plans, while being as 'collaborative as possible'.<sup>7</sup>

However, the lack of credible data about how savings would be delivered in many of the plans, coupled with concern that local councils and CCGs did not consult with hospitals enough when drawing them up, has now prompted a review of the BCF plan process. It is expected that tougher tests will be introduced to ensure individual plans' proposals are underpinned with robust evidence.

It is interesting to note that in some areas, Councils and NHS Commissioners are pooling more money than the minimum sum required. The Health Services Journal (HSJ) reports Sunderland, Oxfordshire and several areas in the West Midlands pooling more than a third over and above the amount they are required to under the

<sup>5</sup> <http://www.kingsfund.org.uk/publications/making-best-use-better-care-fund>

<sup>6</sup> <http://www.monitor.gov.uk/regulating-health-care-providers-commissioners/enabling-integrated-care/integration-pioneers>

<sup>7</sup> [http://www.hsj.co.uk/5068994.article?WT.tsrc=Email&WT.mc\\_id=EditEmailStory&referrer=e2](http://www.hsj.co.uk/5068994.article?WT.tsrc=Email&WT.mc_id=EditEmailStory&referrer=e2)

policy - see table 1 for details. While its sister title **Local Government Chronicle** highlights the findings of a Local Government Association study of draft health and care integration plans which shows that '57 of 135 health and wellbeing boards plan to share more cash than the government requires.'<sup>8</sup>

Table 1: Areas pooling more money than required for the Better Care Fund

| POOLING NHS AND ADULT CARE RESOURCES          |                                    |   |   |                |                    |  |
|---|------------------------------------|---|---|----------------|--------------------|--|
|   | Better care fund share for 2015-16 | Proposed council contribution   | Proposed CCG contribution                                 | Total pool     | Potential % uplift | Services included  |
| Birmingham (starting April 2015)              | £80m                               | Entire elderly care budget. For 2014-15 this is £150m.  | Some or all elderly care spending. Figures not available. | At least £200m | 150% +             | Elderly care (over 65s). Learning disabilities and mental health already pooled.   |
| Sunderland (starting on/before 1 April 2015)  | £25m                               | £80m: Entire adult care budget for community services. Possible extra £50m.   | £70m: Majority of community health budget.                | £150m-£200m    | 500% +             | Elderly care, mental health, learning disabilities, physical disabilities. An extra £50m could be added from health visiting, children's services and some mental health services. |
| London "tri-borough" (aspiration for 2015-16) | £47m                               | Up to £69m for 2015-16, although the split between councils and CCGs is not confirmed. Ambition to increase to £445m in future years. |   | Up to £445m    | Up to 849%         | Residential and nursing homes, domiciliary care, community healthcare and the emergency patient pathway.   |
| Oxfordshire (starting April 2015)             | £38m                               | Just over £150m   | Just under £150m  | £300m          | 689%               | £200m for older people. Extra funds for learning disabilities and mental health.   |

Source: <http://www.hsj.co.uk/news/exclusive-councils-boost-care-fund-pools/5067710.article>

## Nursing roles in the pioneer programmes

Nursing staff are vital to delivering integrated care, as care co-ordinators they often work at the interface of health and social care systems and services. District nurses and community matrons are notable examples of where nurses take the lead in co-ordinating care and case management. They can and frequently do work across boundaries, and often collaborate with social services and secondary health care staff in the planning, managing and co-ordinating of care for people with complex long-term conditions and high intensity needs<sup>9</sup>.

The successful bids for pioneer status, as well as recent updates provided by the programmes, help to highlight how nursing staff are, or were proposed to be, involved in the pioneers.

## Kent

In Kent, where the pioneer programme is providing patients with access to 24/7 community based care, their recent update reports:

'Canterbury & Coastal CCG have agreed funding for community nursing support, to embed and enhance the work of organisations involved in the local Care Home Project. This work includes joint visits to care homes by GPs, Geriatricians and a Long Term Conditions (LTC) nurse from the Neighbourhood Care Team, to develop individual care plans for residents to avoid unnecessary admissions to hospital. This

<sup>8</sup> [http://www.hsj.co.uk/5069815.article?WT\\_tsrc=Email&WT.mc\\_id=EditEmailStory&referrer=e40](http://www.hsj.co.uk/5069815.article?WT_tsrc=Email&WT.mc_id=EditEmailStory&referrer=e40)

<sup>9</sup> [http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0008/78704/003051.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0008/78704/003051.pdf)

will give Care Homes access to 24/7 advice from a LTC nurse to encourage and support the use of care plans.

West Kent Mental Health Awareness training is being rolled out to community matrons, cottage hospitals within Kent Community NHS Health Trust, Kent County Council case managers and Kent Hospices. Part of these sessions will focus on Mental Capacity Act case studies, and training to develop person centred formulation care plans that focus on behaviours that staff find challenging, to evidence best practice and collaborative working.<sup>10</sup>

### **South Devon and Torbay**

South Devon and Torbay already had an integrated approach to health and social care prior to becoming a pioneer site, their bid describes how they propose to expand joined up care across the whole spectrum of services, including mental health and GP services.

‘Their existing diabetes service is to be used as the model for managing long term conditions, which brings together consultants, specialist nurses, dieticians and primary care in a community based model founded on education.

With dementia care they plan to pilot integrated extended out-of-hours support to match demand, with community psychiatric and district nursing, social care and medical services working together.

To reduce unplanned hospital visits from care homes, they plan to extend a jointly-funded secondary care outreach pilot, originally launched in December 2012, whereby nurses from the hospital Medical Admissions team provide an integrated approach between the hospital and care home. They offer an acute nursing service, with advice, guidance and nursing support, and some acute nursing treatments such as intravenous treatments and blood transfusions.

Improving integrated end of life care is also a goal with the CCG supporting a 24/7 hospice at home service, an existing provider, Rowcroft Hospice, delivers this through a team of specialist nurses and senior healthcare assistants, with a rapid response service and dedicated night drivers.<sup>11</sup>

### **Greenwich**

Greenwich’s bid was similar in that it also presented a vision for future development of pre-existing integrated services. Their initiative was already delivering co-ordinated services for older people and people with physical disabilities; they proposed extending integration to co-ordinate resources across health (acute, primary, community services), social care and the third sector to build a ‘team

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<sup>10</sup> [http://www.icaso.org.uk/pg/cv\\_content/content/view/102693](http://www.icaso.org.uk/pg/cv_content/content/view/102693)

<sup>11</sup> [http://www.icaso.org.uk/pg/cv\\_content/content/view/97244](http://www.icaso.org.uk/pg/cv_content/content/view/97244)

around the person' for individuals with complex health and social care needs and rebase health and social care delivery around clusters of GP practices.

'Each cluster will have a core team that will consist of GPs, clinical nurse team lead, district nursing, community matrons, continence, podiatry, IAPT, memory services, social care, housing, telecare/telehealth, domiciliary care, physiotherapists, occupational therapists and community psychiatric nurses (CPNs). Referrals to professionals will be via a single point of access.'<sup>12</sup>

## **Programme evaluation and learning dissemination**

### **National evaluation**

The Department of Health commissioned the Policy Innovation Research Unit (PIRU) based at London School of Hygiene and Tropical Medicine,<sup>13</sup> to carry out two short-term projects.

The first was a very quick review of potential performance indicators on integration (using existing datasets) that Pioneers may wish to adopt to monitor progress over time. This list of indicators is available on the PIRU website.<sup>14</sup>

The second is to undertake an early process evaluation of the 14 Pioneers, looking at reasons for becoming a pioneer, models of integration being adopted, barriers and facilitators of integration, progress over the first 12-15 months, etc. This is due to be completed in June 2015. Given the number and diversity of Pioneers and the short time frame, it will be a high level look at what the pioneers are doing and how they are progressing during the first 15 months or so of their five year term, as well as the first year (2014/15) of the Better Care Fund. Proposals for a longer-term evaluation which will incorporate measuring outcomes will also be discussed during this period.

The primary audience for this work is the Pioneer communities, their CCGs, Local Authorities, providers of care services, HWBs and local branches of Health Watch.

### **Local evaluations**

Local evaluations will be arranged by the individual pioneers, they have at their disposal the performance indicators compiled by PIRU that can be applied to their local care economies, and guidance and support is available via NHSIQ, for example, an expert in healthcare evaluation and research, is able to offer support to pioneers with their local evaluation work.

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<sup>12</sup> [http://www.icaso.org.uk/pg/cv\\_content/content/view/88639](http://www.icaso.org.uk/pg/cv_content/content/view/88639)

<sup>13</sup> The Policy Innovation Research Unit (PIRU) is a collaboration between the London School of Hygiene & Tropical Medicine (LSHTM), the Personal Social Services Research Unit (PSSRU) at the London School of Economics and Political Science (LSE), and the Health and Care Infrastructure Research and Innovation Centre (HaCIRIC) at Imperial College London Business School plus RAND Europe and the Nuffield Trust. It brings together leading health and social care expertise to improve evidence-based policy-making and its implementation across the National Health Service, social care and public health. The Unit is funded by the Policy Research Programme of the Department of Health.

<sup>14</sup> <http://www.piru.ac.uk/assets/files/IC%20and%20support%20Pioneers-Indicators.pdf>



## **Learning dissemination**

Learning will be disseminated via the Integrated Care and Support Exchange (ICASE) website - <http://www.icaso.org.uk>. Pioneers are encouraged to use the site not only to share information about what they are doing but also to actively seek out advice from others by asking if anyone else has experience or expertise in a particular area of work. NHS IQ are also running workshops and similar events to disseminate and share learning among the Pioneers. According to the ICASE:

“experience from the pioneers will be key to helping develop policy based on solid evidence of integrated care in practice. Collaborating and sharing learning will be very important to ensure that we can collectively know what sites are doing and saying in different parts of the country to change working practices and influence behaviour – and harness it. We need to know what’s working and what isn’t, which means moving beyond sharing ‘what we made earlier that worked’ to sharing ‘what we’re trying out now’ in real time.”<sup>15</sup>

## **Conclusion and further work**

The RCN is in principle supportive of integrated health and social care but is mindful of the impact its implementation will have on nursing; in particular on roles and workload, workforce planning and funding arrangements. Ongoing learning dissemination and formal evaluations of the pioneers will therefore be essential to gauge this impact but with the preliminary national evaluation not due to end until mid 2015 it will be some time before its findings are made available. It will also be interesting to see if integration continues as small scale locally tailored initiatives or whether the pooling of complete budgets will prompt a more standardised national adoption of a basic integrated way of working between the two sectors. We will monitor the evaluation and feedback process closely but in the meantime plan to survey our members who are involved in the pioneers to gain the nursing staff perspective of how integrated health and social services are developing in practice.

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<sup>15</sup> [http://www.icaso.org.uk/pg/cv\\_content/content/view/100256](http://www.icaso.org.uk/pg/cv_content/content/view/100256)



**Appendix 1: National Collaboration for Integrated Care and Support partners** [www.icaso.org.uk/dl/cv\\_content/96160](http://www.icaso.org.uk/dl/cv_content/96160)

|   |   |  |
|---|---|--|
| Action for Long term conditions (Working Title)   | Healthwatch England                               | NHS England Northern Clinical Network and Senate   |
| Action on Hearing Loss (AOHL)                     | HomeCareDirect                                    | NHS Improving Quality  |
| Advancing Quality Alliance (Aqua)                 | Housing Learning and Improvement Network          | Office for Public Management Ltd (OPM)   |
| Age UK  | Innovation Unit                                   | Public Health England  |
| Association of Directors of Adult Social Services | Local Government Association                      | Public Service Transformation Network  |
| BT Global Health                                  | MacMillan Cancer Support                          | Skills for Care Ltd  |
| Care Quality Commission                           | Marie Curie Cancer Care                           | Social Care Institute of Excellence (SCIE)   |
| CSC Computer Sciences Ltd                         | Medvivo Group Ltd                                 | Sue Ryder  |
| Department of Health                              | Monitor   | Telecare Learning and Improvement Network  |
| Education for Health                              | National Care Forum                               | Telecare Services Association  |
| Health and Social Care Information Centre         | National Institute for Health and care Excellence | NHS England Personal Health Budget Delivery Team and Think Local Act Personal (hosted by SCIE) |
| Health Education England                          | National Voices                                   | Year of Care Partnerships  |
| HealthVision UK Ltd                               | NHS England                                       |  |

## Appendix 2: The 14 integration pioneer sites

| Locality and programme description  | Partners, population  | Client Group  | Key Features   |
|---|---|---|--|
| <p><b>Devon and Torbay</b> - South Devon and Torbay already has well co-ordinated or integrated health and social care but as a Pioneer site now plans to offer people joined up care across the whole spectrum of services, by including mental health and GP services. They are looking at ways to move towards seven day services so that care on a Sunday is as good as care on a Monday – and patients are always in the place that’s best for them. The teams want to ensure that mental health services are every bit as good and easy to get as other health services and co-ordinate care so that people only have to tell their story once, whether they need health, social care, GP or mental health services.</p> <p>Having integrated health and social care teams has meant patients having faster access to services; previously, getting in touch with a social worker, district nurse, physiotherapist and occupational therapist required multiple phone calls, but now all of these services can be accessed through a single call. In addition, patients needing</p> | <p>Torbay Council, Devon County Council, South Devon Healthcare NHS Foundation Trust, Torbay and Southern Devon health and Care Trust, Devon Partnership NHS Trust, Rowcroft Hospice; population 1.2 million.</p> | <p>Original work focused on frail elderly. Now looking to roll out to wider population.</p> | <p>Young people: primary mental health worker in GP practices, targeted screening, preventive work in classrooms; community based model for managing long term conditions, plan to extend from 0.5 per cent to five per cent of those most at risk (includes virtual ward and hospital at home); health and wellbeing for carers; Delivered through community hubs, with seven day services across all health and care services.</p> |

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| <p>physiotherapy only need to wait 48 hours for an appointment – an improvement from an eight week waiting time.</p> <p>A joint engagement on mental health is bringing changes and improvements even as the engagement continues – for instance, people wanted an alternative to inpatient admissions so we are piloting a crisis house, where they can get intensive support.</p> <p>An integrated service for people with severe alcohol problems frequently attending A&amp;E, is offering holistic support. The service might help sort out housing problems rather than merely offer detox. 84 per cent report improvements. ‘The people helping me have been my lifesavers. I shall never, ever forget them.’ – Patient, alcohol service.</p> |   |  |   |
| <p><b>North West London</b> - The care of North West London’s two million residents is set to improve with a new drive to integrate health and social care across the eight London boroughs.</p> <p>Local people will be supported by GPs who will work with community practitioners, to</p>   | <p>Led by North West London collaboration of CCGs (8). Supported by North West London local authorities (7), NHS provider trusts (9) wider partner organisations.<br/>Population 2.2 million.</p> | <p>Older people, children, mental health, learning disability.</p> | <p>Overarching programme to deliver an integrated care system to deliver better outcomes for local populations. Lead role for GP’s who will be the hub of co-ordinated care delivery.</p> |

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| <p>help residents remain independent. People will be given a single point of contact who will work with them to plan all aspects of their care taking into account all physical, mental and social care needs.</p> <p>Prevention and early intervention will be central – by bringing together health and social care far more residents will be cared for at or closer to home reducing the number of unplanned emergency admissions to hospitals. The outcomes for patients and their experiences of care are also expected to increase. Financial savings are also expected with the money saved from keeping people out of hospital unnecessarily being ploughed back into community and social care services.</p> |   |  |  |
| <p><b>Worcestershire</b> - The Well Connected programme brings together all the local NHS organisations (Worcestershire Acute NHS Trust, Worcestershire Health and Care NHS Trust and the Clinical Commissioning Groups), Worcestershire County Council and key representatives from the voluntary sector. The aim is to better join up and co-ordinate health and care for people and support them to stay healthy, recover quickly from an illness and ensure that care and</p>  | <p>Worcestershire CCGs, Worcestershire County Council, Age UK Herefordshire and Worcestershire. Population 570,000.</p> | <p>Older people, mental health. Learning disability.</p> | <p>Comprehensive programme of service integration focusing on community provision to promote health and well-being and support people with long term conditions. Clustering of services around GP hubs. Defined role for the voluntary sector.</p> |

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| <p>treatment is received in the most appropriate place. It is hoped this will lead to a reduction in avoidable hospital admissions and the length of time people who are admitted to hospital need to stay there.</p> <p>A more connected and joined up approach has reduced unnecessary hospital admissions for patients.</p>   |  |  |   |
| <p><b>Cornwall &amp; the Isles of Scilly</b> - Fifteen organisations from across health and social care, including local councils, charities, GPs, social workers and community service will come together to transform the way health, social care and the voluntary and community sector work together. This is about relieving pressures on the system and making sure patients are treated in the right place. Teams will come together to prevent people from falling through the gaps between organisations.</p> <p>Instead of waiting for people to fall into ill-health and a cycle of dependency, the pioneer team will work proactively to support people to improve their health and wellbeing. The pioneer will measure success by asking patients about their experiences of care and</p> | <p>Cornwall County Council, NHS Kernow, Council of the Isles of Scilly, Royal Cornwall Hospitals Trust, Cornwall Partnership Foundation Trust, Peninsula Community Health, Peninsula Medical School, HealthWatch Cornwall, HealthWatch Isles of Scilly, South Western Ambulance Service, BT Cornwall, Volunteer Cornwall, Cornwall Carers Service. Population covered 116,000.</p> | <p>1) People with long term illnesses/the frail elderly.<br/>2) People at the early stages of illness or frailty (for example, dementia).<br/>3) people at risk from inequalities and lifestyle choices.</p> | <p>GP led, with integrated care teams structured around locality groups of GPs. Newquay Pathfinder piloted the approach. Care shifted from dependency on acute to community/VCS involvement. For 1) Whole system model for intensive support and rapid response including frailty pathway, urgent care, rapid access eldercare, virtual care homes. For 2) dementia service, early intervention, community, falls prevention to test whole system model in a locality. For 3) (slower track) review existing services and spend then co-design new service.</p> |

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| <p>measuring falls and injuries in the over 65s.</p>  |  |   |   |
| <p><b>Islington</b> - Islington Clinical Commissioning Group and Islington Council are working together to ensure local patients benefit from better health outcomes. They are working with people to develop individual care plans, looking at their goals and wishes around care and incorporating this into how they receive care. They have already established an integrated care organisation at Whittingdon Health better aligning acute and community provision.</p> <p>Patients will benefit from having a single point of contact rather than dealing with different contacts, providing different services. Patients will feel better supported and listened to.</p> | <p>Islington CCG and Islington Council.<br/>Population size 220,000. Target population 58,000.</p>   | <p>Older people and mental health.</p>  | <p>Support for people with long term conditions and mental health needs to be involved in the development of and receive personalised care and support services. Focus on addressing wider determinants of health and using community assets. Key role for public health.</p>   |
| <p><b>London WELC</b> - The Waltham Forest, East London and City (WELC) Integrated Care Programme is about putting the patient in control of their health and wellbeing. The vision is for people to live well for longer leading more socially active independent lives, reducing admissions to hospital, and enabling access to treatment more quickly.</p> <p>Older people across Newham, Tower Hamlets and Waltham Forest will be given a</p>   | <p>Waltham Forest, East London and City Care Collaborative. Three CCGs, three London boroughs, Bart's Health, MH trusts, UCL Partners.</p> | <p>20 per cent of population as defined through risk stratification. Combining physical, mental health and social care. (Strong mental health</p> | <p>Care navigation, one navigator for each patient. Interventions cover self-care, care co-ordination and ensuring people are in the most appropriate setting. Essential components include information sharing platform, joint assessments, creation of new roles in the workforce and organisation of GP practices into networks.</p> |

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| <p>single point of contact that will be responsible for co-ordinating their entire healthcare needs. This will mean residents will no longer face the frustration and difficulty of having to explain their health issues repeatedly to different services.</p>  |   | <p>component).</p>  |   |
| <p><b>Greenwich</b> - Teams of nurses, social workers, occupational therapists and physiotherapists work together to provide a multidisciplinary response to emergencies arising within the community which require a response within 24 hours. The team responds to emergencies they are alerted to within the community at care homes, A&amp;E and through GP surgeries, and handle those of which could be dealt with through treatment at home or through short term residential care.</p> <p>Over 2,000 patient admissions were avoided due to immediate intervention from the Joint Emergency Team (JET). There were no delayed discharges for patients over 65 and over £1m has been saved from the social care budget.</p> | <p>Royal Borough of Greenwich; Greenwich Action for Voluntary Services; Oxleas NHS Foundation Trust; Greenwich CCG; Healthwatch Greenwich; Lewisham Healthcare NHS Trust; borough population 254,000; test site in Eltham 54,000.</p> | <p>Mental health fully embedded. Advanced dementia service links community and mental health teams.</p> | <p>Integration in all health and social care services, based around a hub of GP practices. Will co-ordinate resources across health, (acute, primary, community) and social care. Comprehensive service in place in test site by April 2014; rolled out thereafter. Model has already been shown to have reduced hospital admissions.</p> |
| <p><b>Leeds</b> - Leeds is all about aiming to go 'further and faster' to ensure that adults and children in Leeds experience high quality and</p>   | <p>Leeds City Council. Large number of partners across</p>  | <p>Integration focused on wellbeing,</p>  | <p>Young children: 'Early Start Service' in 25 localities for health, social care and early education. Adults: 12 co-located</p>  |

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| <p>seamless care.</p> <p>Twelve health and social care teams now work in Leeds to co-ordinate the care for older people and those with long-term conditions.</p> <p>The NHS and local authority have opened a new joint recovery centre offering rehabilitative care – to prevent hospital admission, facilitate earlier discharge and promote independence. In its first month of operation, it saw a 50 per cent reduction in length of stay at hospital.</p> <p>Leeds has set up a programme to integrate health visiting and children’s centres into a new Early Start Service across 25 local teams in the city. Children and families now experience one service, supporting their health, social care and early educational needs, championing the importance of early intervention. Since the service has been in operation, the increase in face-to-face antenatal contacts has risen from 46 per cent to 94 per cent and the number of looked after children has dropped from 443 to 414.</p> <p>Patients will also benefit from an innovative</p> | <p>commissioning, providers, local and third sector, PPI, Unions. Population 800,000.</p> | <p>prevention and early intervention. All adults and children (focus on those with complex needs).</p> | <p>integrated health and social care neighbourhood teams for needs of older people and those with LTCs. Link to GP clusters, focus on those identified through risk stratification as most likely to benefit from early intervention to prevent deterioration of health.</p> |
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| <p>approach which will enable people to access their information online.</p>   |  |  |   |
| <p><b>South Tyneside</b> - People in South Tyneside are going to have the opportunity to benefit from a range of support to help them look after themselves more effectively, live more independently and make changes in their lives earlier.</p> <p>In future GPs and care staff, for example, will have different conversations with their patients and clients, starting with how they can help the person to help themselves and then providing a different range of options including increased family and carer support, voluntary sector support and technical support to help that person self-manage their care.</p> <p>In order to do this there will be changes in the way partners organise, develop and support their own workforces to deliver this and a greater role for voluntary sector networks.</p> | <p>Led by South Tyneside Council. Supported by South Tyneside's CCG, NHS Foundation Trust and Northumberland Tyne and Wear NHS Foundation Trust.</p> <p>Population size 148,000 with target group of 24,400.</p> | <p>Older people</p>  | <p>Developing new approaches to early help, prevention, self-care, and integrated support services. Aim to comprehensively implement: risk stratification tools in primary care, lifestyle support programmes, recovery services and integrated support models.</p> |
| <p><b>North Staffs</b> - Five of Staffordshire's Clinical Commissioning Groups (CCGs) are teaming up with Macmillan Cancer Support to transform the way people with cancer or those at the end of their lives are cared for</p>  | <p>Macmillan Cancer Support; North Staffordshire CCG; Stoke on Trent CCG; East Staffordshire CCG;</p>  | <p>Cancer and end of life care (all long term conditions).</p> | <p>Redesign of pathway for cancer and end of life care, bringing together most specialist with community/primary care. Earlier diagnosis, better prognosis, choice of place of death; carer support, control.</p>   |

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| <p>and supported.</p> <p>The project will look at commissioning services in a new way – so that there would be one principal organisation responsible for the overall provision of cancer care and one for end of life care.</p>  | <p>Stafford and surrounds CCG; population one million.</p>  |  |  |
| <p><b>Southend</b> - Southend's health and social care partners will be making practical, ground level changes that will have a real impact on the lives of local people.</p> <p>They will improve the way that services are commissioned and contracted to achieve better value for money for local people with a specific focus on support for the frail elderly and those with long term conditions. They will also look to reduce the demand for urgent care at hospitals so that resources can be used much more effectively. Wherever possible they will reduce reliance on institutional care by helping people maintain their much-valued independence.</p> <p>By 2016 they will have better integrated services, which local people will find simpler to access and systems that share information and knowledge between partners far more effectively. There will be a renewed focus on</p> | <p>Led by Southend on Sea Borough Council. Supported by Southend CCG, South Essex and Southend Foundations Trusts. Population coverage 176,000.</p> | <p>Older people, mental health, learning disability.</p> | <p>Integrated service delivery model underpinned by single access and referral routes and multi-disciplinary teams in primary care. Development of community based services to avoid the need for hospital care.</p> |

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| <p>preventing conditions before they become more acute and fostering a local atmosphere of individual responsibility, where people are able to take more control of their health and wellbeing.</p>  |   |   |  |
| <p><b>Cheshire</b> - Connecting Care across Cheshire will join up local health and social care services around the needs of local people and take away the organisational boundaries that can get in the way of good care.</p> <p>Local people will only have to tell their story once – rather than facing repetition, duplication and confusion. Also the programme will tackle issues at an earlier stage before they escalate to more costly crisis services.</p> <p>There will be a particular focus on older people with long-term conditions and families with complex needs.</p> | <p>Led by Cheshire West and Chester Council. Supported by Cheshire East Council, South Cheshire, Vale Royal and West Cheshire CCG's. Population coverage 699,000.</p> | <p>Older people, mental health, learning disability.</p>                                | <p>Build an integrated communities approach and a service delivery model of integrated case management.</p>  |
| <p><b>Barnsley</b> - The aim of the Stronger Barnsley Together initiative is to make sure that the health and care needs of local people are met in the face of an increasingly difficult climate. Population changes, public sector cuts and welfare reforms, have had an impact on how Barnsley delivers these</p>   | <p>HWB, Barnsley CCG, Barnsley MBC, Barnsley Hospital NHS FT, SW Yorks Partnership FT, NHSE LAT, South Yorks and Bassetlaw; HealthWatch Barnsley;</p>                 | <p>Services to all client groups, including stronger families and troubled families</p> | <p>Three elements: 'Inverting the triangle' to shift focus to prevention and early integration; joining individual integration elements; 'Fast track enablers', including telehealth and telecare; supporting families; community level bringing together voluntary services and residents</p> |

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| <p>services, and they cannot afford to continue with the existing system as it is. A new centralised monitoring centre has been set up. When the centre is alerted about an emergency case, it is assessed within one of three categories (individual, families, and communities) and the right kind of help is delivered. This will help ensure that the right help is dispatched quickly to the relevant patient.</p> <p>Patients will receive tailored care to suit their requirements, whether this is day to day support to enable people to stay safe, secure and independent, or the dispatch of a mobile response unit for further investigation. This is vitally important to ensure that patients are seen swiftly and receive the care and information they need – whether this is avoiding a return to A&amp;E, getting extra care support for a child’s care needs, or even work to improve the information available explaining how to access to council services.</p> | <p>S Yorks police.<br/>Population 231,900.</p>   | <p>programmes.</p>                                       | <p>to co-produce the specification for services needed.</p>   |
| <p><b>Kent</b> - In Kent, the focus will be around creating an integrated health and social care system which aims to help people live as independent a life as possible, based on their needs and circumstances. By bringing together CCGs, Kent County Council, District Councils, acute services and the voluntary</p>  | <p>Kent County Council, Kent CCGs , East Kent hospitals trust, Kent and Medway commissioning support unit, Kent Community trust, Kent and Medway</p> | <p>Older people, mental health, learning disability.</p> | <p>Redesign of integrated commissioning, maximise opportunities through community budgets, oversee substantial reductions in unscheduled care activity through effective community management of long term conditions</p> |

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| <p>sector, the aim will be to move to care provision that will promote greater independence for patients, whilst reducing care home admissions. In addition, a new workforce with the skills to deliver integrated care will be recruited.</p> <p>Patients will have access to 24/7 community based care, ensuring they are looked after well but do not need to go to hospital. A patient held care record, will ensure the patient is in control of the information they have to manage their condition in the best way possible. Patients will also have greater flexibility and freedom to source the services they need through a fully integrated personal budget covering health and social care services.</p> | <p>commissioning support unit and social care partnership trust, Swale Borough Council.<br/>Population 1,480,200.</p> |  |  |
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<http://www.england.nhs.uk/2013/11/01/interg-care-pioneers/>