RCN Policy and International Department
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Update on England's 14 integrated health and social care pioneer programmes: viewpoints of RCN members

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Introduction

With a membership of over 420,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

Background

In 2013 the government stated that it was committed to making evidence-based integrated health and social care the norm over the next five years.[1] '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.'[2]

Fourteen integrated care pioneer programmes were selected and announced on 1st November 2013. The government 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'[3]. The 14 pioneers were chosen from 111 applicants, some areas were not selected because they either covered a very small area or were really starting from a 'blank piece of paper'. The 14 selected had a good track record, including good local relationships and had engaged properly with patients and service users and had sufficiently concrete plans that could see them get off the ground quite quickly.[4] More details of the 14 pioneer programmes are provided in Appendix 1.

Expansion of the Integrated Pioneer Programme

In October 2014 Norman Lamb announced the expansion of the integrated pioneer programme at the Kings Fund Integrated Care Summit. The application process for the second wave of ten pioneers closed in November 2014, with successful sites being announced early 2015. "The achievements of the first wave of pioneers were showcased at the summit in a presentation from colleagues in Greenwich demonstrating how they have reduced emergency hospital admissions by targeting high risk groups in the population. In Greenwich and elsewhere priority is being given to intervening early to support these groups through closer integration of health and social care."[5]

[1] https://www.gov.uk/government/news/people-will-see-health-and-social-care-fully-joined-up-by-2018
[2] 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
[3] http://www.hsj.co.uk/news/policy/analysed-lambs-integration-pioneers/5064989.article
[4] http://www.pulsetoday.co.uk/news/commissioning-news/fourteen-areas-gain-integration-pioneer-status/20004910.article
[5] http://www.kingsfund.org.uk/blog/2014/10/parallel-universes-integrated-care-process-change-important-content

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Nursing roles in integrated care

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[6].

The RCN has always stated that 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 is 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 so in order to gain an understanding of the initial thoughts and viewpoints of those nursing staff involved in the 14 pioneer programmes the RCN sent a brief questionnaire to its members.

This briefing paper is part of a series of RCN documents examining integrated health and social care. It presents the findings of the member survey carried out in September 2014.

The survey design and sample size

A simple online questionnaire was designed and sent by email to all members within the 14 geographical areas where pioneers are located, this was to ensure the best coverage and therefore highest probability of reaching those members involved in the pioneers; a total of 201,829 invitations were sent. To ensure that we only received feedback from those involved in the pioneers the first question simply asked *1: Are you, or have you been involved in one of the 14 integrated care pioneer programmes?* Only a ‘yes’ answer to this first question allowed further access to the remaining survey questions online:

2: Which of the 14 pioneers are/were you involved with?
3: Please provide the job title you had while working within the pioneer programme
4: Please provide a brief description of your role and responsibilities within the pioneer programme
5: What do you think works well?
6: What do you think doesn't work?
7: What do/did you like about the pioneer programme?
8: What do/did you not like about the pioneer programme?
9: Please add any further comments about the integrated care pioneer programmes you may wish to make

Results

Seventy nine respondents answered ‘yes’ to question one, of these nine failed to provide any further details so were discarded leaving 70 complete questionnaires. In order to ensure

[6] http://www.rcn.org.uk/__data/assets/pdf_file/0008/78704/003051.pdf

anonymity, no feedback or comment will be attributed to a specific role and/or an individual pioneer site.

Responses were received for each of the 14 pioneer sites except Islington. Chart 1 shows the number of respondents by pioneer site and Chart 2 self reported role within the pioneer programme.

Chart 1:

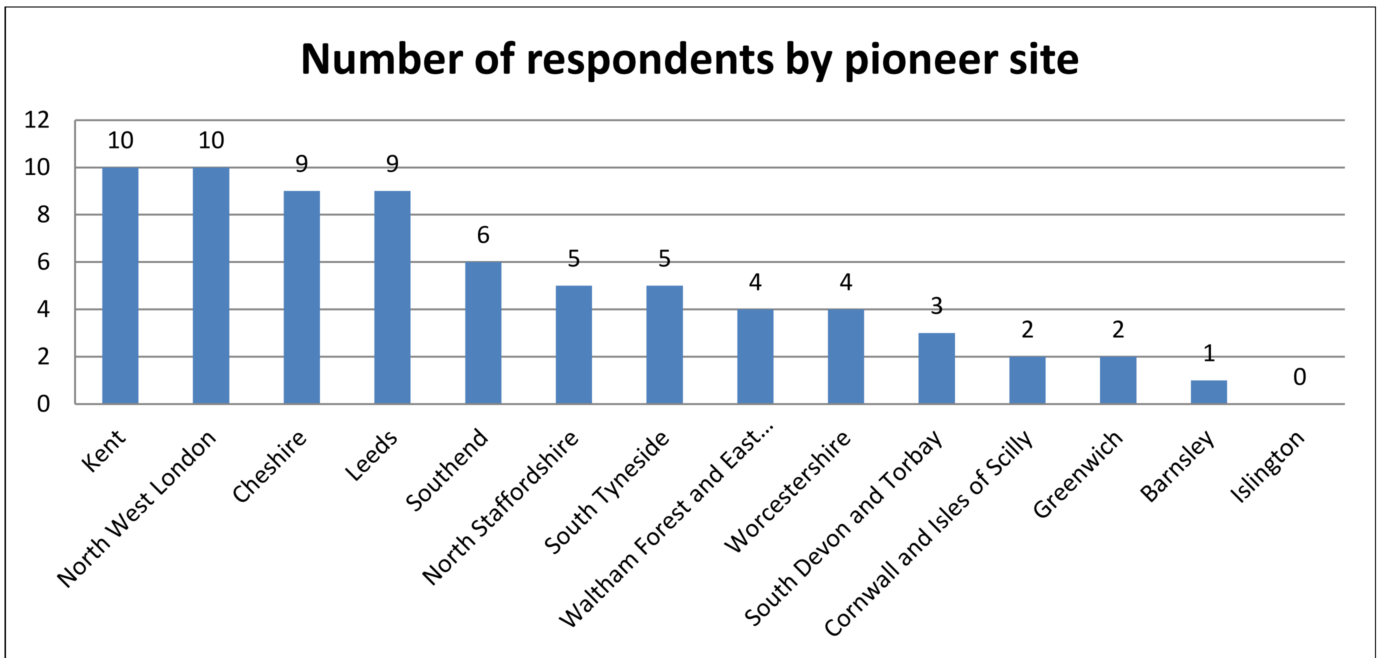
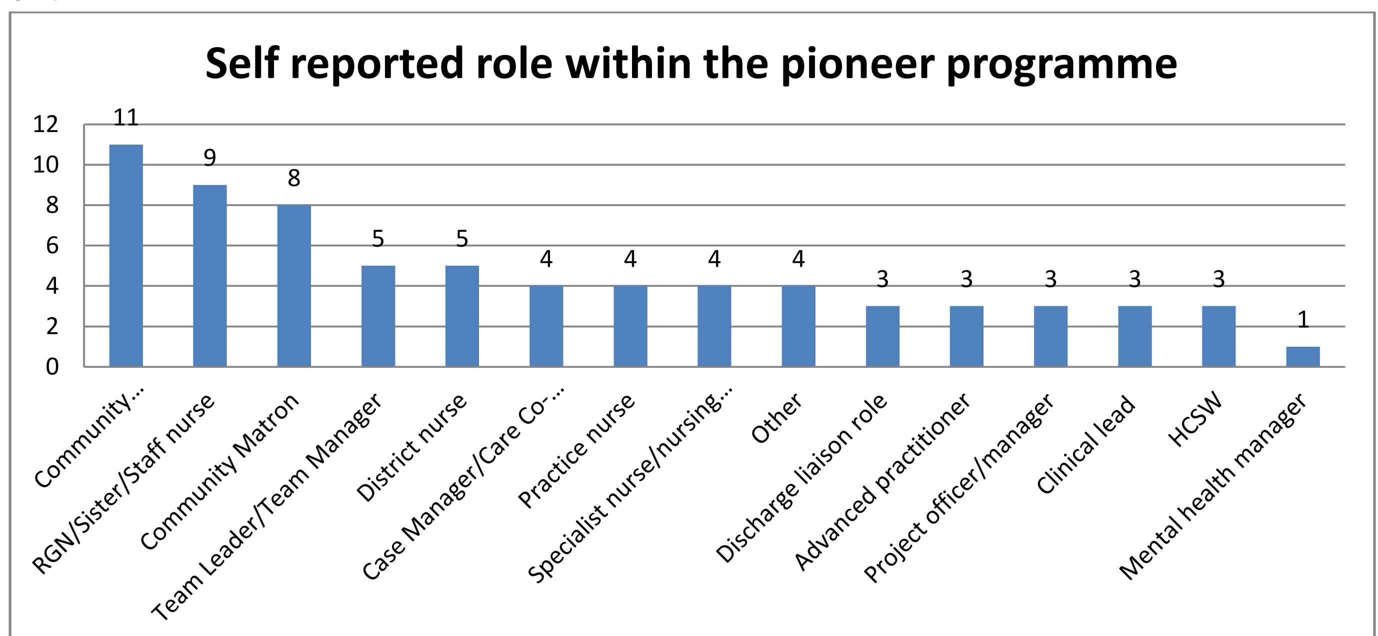


Chart 2:



Question four asked for a brief description of their roles and responsibilities within the pioneer programmes. In addition to their regular nursing duties and caseload management, many respondents described the wider range of professionals they now have to liaise and interact with, which is to be expected due to the very nature of integration and multidisciplinary team working. Those in management roles are now managing staff from both the health and social care sectors. Some roles specifically focus on discharge planning, whether supporting patients discharged from hospital until a package of care from social services starts, to presenting cases and requesting care packages or periods in rehabilitation/supported living, to the borough's panel of commissioners. Another respondent described their main role as assisting CCGs to deliver on integration plans. The increase in paperwork is a concern however:

'As well as my nursing duties, I also have to implement social care packages, complete all relevant paperwork and then submit for funding by completing direct payments or individual budgets.......my concern is, there is clinical risk involved in trying to adhere to all [the] paperwork required'.

Questions five and seven both asked for any positive viewpoints - what worked well or what they liked - about the programme; responses included the following main points:

Communication

- Improved communication within the multidisciplinary teams
- Co-location of staff - having all professionals/disciplines together in the one place
- Shared electronic patient information
- Closer working with the community hospitals is good, as it means we can transfer people more easily if they need more intensive rehabilitation.
- Single point of referral

Quality of care

- Providing enhanced patient care - having the ability to send the most appropriate health professional to complete an assessment or provide care is important
- Patient getting the best person for their care in the right place at the right time
- Clients and families are well supported and can access service via single point of access 7 days a week, 365 days a year giving them more confidence
- The ability of patients to be responsible for their own treatment on a more personal level.
- Improved access to support for people at home
- Speedier assessments
- More meaningful services wrapped around nursing teams

Culture/roles/ownership

- Breaks down organisational barriers
- Gaining knowledge of what other professionals/disciplines (e.g. social work) do
- Better working relationships/acceptance of judgements across organisations

- The vision, the organisations working to a clear goal and commitment
- I enjoy being an autonomous practitioner whilst being part of combined decision making team.

Questions six and eight asked respondents to provide any negative viewpoints about the programme - what they felt didn't work or what they didn't like, which gleaned:

Communication

- Not all surgeries are signed up to shared patient records with community nursing service
- Using different systems e.g. systems that don't "speak" to each other so it is still difficult to share information
- Poor communication

Workload/workforce/leadership

- The amount of extra pressures that have been added to our roles with no extra staffing
- Not enough admin support
- Little access to social care after 2200 or 2300 hrs
- Managers always at meetings and never there for their staff
- Most ideas were imposed – a pretence at consultation - no prior discussion about how it was going to be rolled out and what time/training should be offered
- Complaints by staff and patients are not being listened to
- Clinicians' time is primarily taken up with writing and reviewing applications for social care
- No training was done as promised in the pioneer proposal paper, nurses were thrown in at the deep end and the senior staff had to take on extra work on top of own caseload

Culture/roles/ownership

- Removing social workers and replacing them with nurses I feel increases risks
- We are all working together but do the GPs?
- It has been difficult because integration has not been welcomed by the staff, no ownership
- Having a social worker manage a nursing service is bonkers, as is doing it the other way round
- NHS staff seconded to Local Authorities have to abide by both sets of policies which can cause conflict and confusion
- There needs to be more clarification of roles within teams to ensure a seamless delivery as it can be often fragmented
- Tension as to who is in charge, nurses or social workers?
- Established teams, whom have worked together for over 15 years, have been split up
- People asked to carry out roles that they are not necessarily the best qualified to carry out for the sake of keeping the principles of integration

Quality of care

- Problems are not addressed by the most appropriate team

- No single point of referral and no single assessment as separate systems and assessments are still being used

Other

- Trying to work in very cramped/noisy conditions
- Lots of conversations but frustrations still lie with silo commissioning, contracts and budgets which hinder this way of working
- Some services are not adjusting to meet the changes, such as housing for certain groups of service users
- Rate of change – too slow in some areas too fast in others
- No real drive to combine budgets, each service will only commit to the low or no cost option, as no one organisation wants to risk their budget
- It's statistic based not patient centred

The final question asked for any further comments respondents wished to make, and included the following comments:

- The integrated care team is a good for patients and their carers and could be developed further with the right leadership and funding of staff to truly integrate with secondary care - and create a truly seamless service between all sectors.
- No one is truly addressing IT issues so each organisation has its own systems and will not commit to jointly commissioning a system fit for purpose of data sharing.
- Our service is now often run by agency staff. Recruitment is proving difficult and we are getting community naive people into post who need lots of support but with very few permanent staff to give it, consequently new staff are not adequately supported and leave
- Vast improvement to previous situation, would hate to return to "as before"
- Integrated care will only work if all staff in all teams are involved and informed and consulted. This has failed to happen and so initial phases of integration have been difficult and challenging and most definitely not in the best interest of our patients.
- Integrated care plans have become a tick box exercise to ensure practice income
- GPs are too busy and practice nurses are too few. There needs to be more community nurse recruitment and training to make this work
- These programmes will not work unless organisations properly amalgamate, have the same systems, same managers, single assessment and single point of contact/referral.
- As an experienced practitioner involved in the programme since the beginning I feel this is the way forward and is giving sound, holistic, supportive care to clients as has proved successful in avoiding hospital admissions

Conclusion

While brief, this qualitative survey has provided some timely initial insight into the viewpoints of frontline nursing staff working in the integrated pioneer programmes. Common complaints such as lack of staff/support, increased workload, and lack of ownership and clarification of roles, coupled

with broader issues such as separate IT systems not being able to speak to each other as well as lack of GP engagement are perhaps the most noteworthy - the latter two points are highlighted by the King's Fund as common challenges to integrated care[7].

However, the polarisation of respondents' opinions suggests fundamental differences in how the 14 programmes are developing and performing to date. Implementation is being described as too slow in some places and too fast in others. Positive views such as the benefits of co-location and improved communication are countered by negative feedback regarding working in cramped and noisy conditions and poor communication, the latter perhaps most starkly highlighted by the following comment:

'I had not even realised we were part of the pioneer programme so I suppose that says it all'.

Similarly with feedback highlighting changes in patient care, some reported the benefits of patients getting the best person for their care in the right place at the right time, and having a single point of referral, while others highlighted the lack of a single point of referral and people being asked to carry out roles that they are not necessarily the best qualified to do. For almost every positive statement there appears to be an opposite experience elsewhere; some programmes seem to be working well, others not so well. It will be interesting to see if this is reflected in the more in-depth formal evaluations currently underway and moreover whether the dissemination and learning processes that have been put in place are able to deliver the spread of best practice.

[7] http://www.kingsfund.org.uk/publications/co-ordinated-care-people-complex-chronic-conditions

Appendix 1 **Locality and programme description**	**Partners, population**	**Client Group**	**Key Features**
Devon and Torbay - 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 coordinate care so that people only have to tell their story once, whether they need health, social care, GP or mental health services. 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 physiotherapy only need to wait 48 hours for an appointment – an improvement from an 8 week waiting time. A joint engagement on mental health is bringing changes and improvements even as	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	Original work focused on frail elderly. Now looking to roll out to wider population	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% to 5% of those most at risk (includes virtual ward and hospital at home); health and wellbeing for carers; Delivered through community hubs, with 7 day services across all health and care services.

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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 An integrated service for people with severe alcohol problems frequently attending A&E, is offering holistic support. The service might help sort out housing problems rather merely offer detox. 84% report improvements. "The people helping me have been my lifesavers. I shall never, ever forget them." – Patient, alcohol service.			
North West London - The care of North West London's 2 million residents is set to improve with a new drive to integrate health and social care across the eight London boroughs. Local people will be supported by GPs who will work with community practitioners, to 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. Prevention and early intervention will be central – by bringing together health and social care far more residents will be cared	Led by North West London collaboration of CCGs (8). Supported by North West London local authorities (7), NHS provider trusts (9) wider partner organisations. Population size 2.2 million	Older people, children, mental health, learning disability	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 coordinated care delivery.

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.			
Worcestershire - 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 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. A more connected and joined up approach has reduced unnecessary hospital	Worcestershire CCGs, Worcestershire County Council, Age UK Herefordshire and Worcestershire. Population size 570,000.	Older people, mental health. Learning disability.	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.

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admissions for patients.			
Cornwall & the Isles of Scilly - 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. 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 measuring falls and injuries in the over 65s.	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	1) People with long term illnesses/ the frail elderly 2) People at the early stages of illness or frailty (eg dementia) 3) People at risk from inequalities and lifestyle choices	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
Islington - 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	Islington CCG and Islington Council. Population size 220,000. Target population 58,000>	Older people and mental health.	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

care. They have already established an integrated care organisation at Whittingdon Health better aligning acute and community provision. 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.			health
London WELC - 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. Older people across Newham, Tower Hamlets and Waltham Forest will be given a 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.	Waltham Forest, East London and City Care Collaborative. 3xCCGs, 3xLondon boroughs, Bart's Health, MH trusts, UCL Partners	20% of population as defined through risk stratification. Combining physical, mental health and social care. (Strong mental health component)	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.
Greenwich - Teams of nurses, social workers, occupational therapists and	Royal Borough of Greenwich; Greenwich	Mental health fully	Integration in all health and social care services, based around a hub of GP

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&E and through GP surgeries, and handle those of which could be dealt with through treatment at home or through short term residential care. 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.	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	embedded. Advanced dementia service links community and mental health teams.	practices. Will co-ordinated 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.
Leeds - Leeds is all about aiming to go 'further and faster' to ensure that adults and children in Leeds experience high quality and seamless care. Twelve health and social care teams now work in Leeds to coordinate the care for older people and those with long-term conditions. The NHS and local authority have opened a new joint recovery centre offering rehabilitative care – to prevent hospital admission, facilitate earlier discharge and	Leeds City Council. Large number of partners across commissioning, providers, local and third sector, PPI, Unions. Population size 800,000	Integration focused on wellbeing, prevention and early intervention. All adults and children (focus on those with complex needs).	Young children: 'Early Start Service' in 25 localities for health, social care and early education. Adults: 12 co-located 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

promote independence. In its first month of operation, it saw a 50% reduction in length of stay at hospital. 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% to 94% and the number of looked after children has dropped from 443 to 414. Patients will also benefit from an innovative approach which will enable people to access their information online.			
South Tyneside - 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. In future GPs and care staff, for example, will have different conversations with their patients and clients , starting with how they	Led by South Tyneside Council. Supported by South Tyneside's CCG, NHS Foundation Trust and Northumberland Tyne and Wear NHS Foundation Trust. Population size 148,000 with target group of	Older people	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.

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 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.	24,400.		
North Staffs - 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 and supported. 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.	Macmillan Cancer Support; North Staffordshire CCG; Stoke on Trent CCG; East Staffordshire CCG; Stafford and surrounds CCG; population 1 million	Cancer and end of life care (all long term conditions)	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
Southend - 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. They will improve the way that services are commissioned and contracted to achieve	Led by Southend on Sea Borough Council. Supported by Southend CCG, South Essex and Southend Foundations Trusts. Population	Older people, mental health, learning disability.	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.

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. 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 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.	coverage 176,000		
Cheshire - 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. Local people will only have to tell their story once – rather than facing repetition, duplication and confusion. Also the	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.	Older people, mental health, learning disability.	Build an integrated communities approach and a service delivery model of integrated case management.

programme will tackle issues at an earlier stage before they escalate to more costly crisis services. There will be a particular focus on older people with long-term conditions and families with complex needs.			
Barnsley - 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 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. 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	HWB, Barnsley CCG, Barnsley MBC, Barnsley Hospital NHS FT, SW Yorks Partnership FT, NHSE LAT, South Yorks and Bassetlaw; HealthWatch Barnsley; S. Yorks police. Population size: 231,900	Services to all client groups, including stronger families and troubled families programmes,	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 to co-produce the specification for services needed.

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&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.			
Kent - 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 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. 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	Kent County Council, Kent CCGs ,East Kent hospitals trust, Kent and Medway commissioning support unit, Kent Community trust, Kent and Medway commissioning support unit and social care partnership trust, Swale Borough Council. Population size 1,480,200.	Older people, mental health, learning disability.	Redesign of integrated commissioning , maximise opportunities through community budgets, oversee substantial reductions in unscheduled care activity through effective community management of long term conditions

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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.			

http://www.england.nhs.uk/2013/11/01/interg-care-pioneers/