Integrated Care Pioneer Programme Annual Report 2014

Pioneer Profiles and Case Study Examples

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1 Barnsley Pioneer Programme – Profile

1.1 What is your area like?

The borough of Barnsley has a population of approximately 235,800 residents, with 31% of the population living in the 20% most deprived areas in the country. Deprivation is concentrated in the east of the borough, and 23% of children in Barnsley live in poverty. The health of people in the area is generally worse than the England average, in life expectancy and levels of smoking, obesity, and alcohol harm. There is a gap in life expectancy of 7.4 years for men and 6.3 years for women between the most and least deprived areas. The health and care system in Barnsley is facing significant financial pressures.

1.2 What are you aiming to achieve?

At the start of the pioneer programme, Barnsley had already seeded a range of practice innovations that were resulting in improved experiences and outcomes for individuals and communities. These included comprehensive integrated 'telehealthcare', personalised budgets and multi-agency integrated approach to supporting children and families based on early intervention and the 'Connected Care' model of community-led commissioning.

Our aim for the programme was to take existing initiatives forward with increased pace and early delivery of benefits, and to identify and develop new approaches where needed. The plan to achieve this involved three elements.

- *Inverting the triangle* – a cultural and strategic shift to prevention, early intervention and empowerment through measures such as integrated information and advice, and promotion of self-care and self-management
- *Joining the dots, joining the programmes* – a joint transformation programme to identify where joining up existing activity could add value e.g. improving A&E waiting times by addressing the relationship between alcohol misuse and hospital attendance
- *Fast track enablers* – enablers are key catalysts for wider system change. Two of our cross-cutting enablers were self-management supported through technology such as telehealthcare, and personal health and care budgets

The aspiration remains highly relevant and much work has gone on in the intervening 12 months to further these central themes. The environment in which we are working, however, has changed and some of the pivotal attributes of our original 'pioneer proposition' can be seen, in reality, to have promoted some real challenges. While we have continued to implement the initiatives we planned, we are now reshaping our pioneer programme to better support whole-system integration.

1.3 What have been the highlights of your first year?

- Area governance – co-producing services with local communities to promote more resilience and less reliance on the statutory agencies
- Designing a specification for an integrated health and wellbeing service – Be Well Barnsley

- Establishing a target operating model for adult social care
- Developing informatics connectivity across adult social care with plans to link to the hospital

1.4 Details of the year

Much of our work has involved preparation for major developments which will become operational in 2015. These include:

1.4.1 Universal advice and information (UIA)

The business case for a UIA Strategy was approved by the Promoting Independence Board. Implementation will be progressed in 2015. An important element will be to reduce overlap and duplication to produce a streamlined system. Some specific initiatives in 2014 include:

- Building on Barnsley's care navigation and telehealth service and Making Every Contact Count, the use of 'motivational interviewing' (a technique to help people to resolve their own problems) is being delivered intensively in a GP practice area. This approach is being tested prior to roll out in 2015
- Connect to Barnsley and Connect to Support are now up and running providing online information, advice and signposting and an e-marketplace across health and social care

1.4.2 Area governance

As part of the council's work to further develop its area governance arrangements, six area councils and associated ward alliances have been developed over the past couple of years. These are now commissioning local services for local people throughout the borough.

1.4.3 Be Well Barnsley

This is an integrated and holistic 'Wellbeing for Life' approach being designed by public health. It makes the shift from a model in which people are supported to tackle single unhealthy behaviours such as to stop smoking, to a 'strength' model which enables them to build good health, resilience and independence. The service will cover social determinants of health such as poverty, poor housing and social care needs, and will link with the range of universal and targeted support offered across Barnsley. Procurement will commence in 2015.

1.4.4 Holistic patient care

The Holistic Patient Care project involves establishing an information hub to allow interconnectivity between the information systems in the hospital and in adult social care – covering home care, telecare and reablement. Hospital professionals will have information about the individual's social care history immediately available to allow planning for discharge at point of admission. Workers in the community will get real time alerts to intervene, initially focused on falls prevention and medication compliance, and subsequently extending to dementia and better detection of underlying medical conditions. Interconnectivity across social care will be in place by

March 2015; connecting to the hospital will take place in 2015, dependent on a bid to NHS England Tech Fund 2. See case study: Holistic care project.

1.4.5 Target operating model in adult social care

An independent review to start the development of a target operating model in adult social care reported in April. The model will support Stronger Barnsley Together (a programme with three strands – ageing well, promoting independence and think family) and Inverting the Triangle. A detailed plan for delivery is being developed and this will be supported by project infrastructure and a delivery team during 2015.

1.4.6 Integrated personal commissioning

Twenty-five adults and six children receiving continuing healthcare funding receive a personal health budget in Barnsley. The clinical commissioning group and the council are working closely together on this initiative. The council delivers the personal health budget payments and monitoring service, and commissions continuing healthcare packages working alongside healthcare professionals to ensure that the needs of individuals are met.

We have used many of the lessons learnt from our pioneer work and our experience in the context of personal health budgets to underpin our proposal for Integrated Personal Commissioning. If successful, our programme will develop integrated health and care budgets, support in self-care and crisis support to an initial cohort of people with diabetes with complex support needs. See case study: Developing personal commissioning.

1.5 What has been the most exciting aspect?

The ability to lead at pace and scale the fundamental redesign of health and social care services, to be able to meet the needs of local people and communities in what are extremely challenging fiscal times.

We are also pleased that we have started to reshape our pioneer programme into a much more ambitious and challenging driver for change.

1.6 What has been the most challenging aspect?

A number of circumstances led to us to adjust and evolve how we were approaching the pioneer programme.

- The Better Care Fund (BCF) and latterly NHS Five Year Forward View re-emphasise a direction of travel towards more effective integration of health and care
- The intense focus on BCF planning and managing severe financial constraints, coupled with changes in key personnel, meant that some of the initial understanding of, and commitment to, the pioneer programme was diluted
- Because there was significant overlap between the pioneer programme and the Stronger Barnsley Together programme, our pioneer work was managed within the SBT framework. This relationship is currently being reviewed and it

is expected that, going forward, there will be a positive opportunity to redefine how pioneer is represented within the health and social care landscape locally.

The pioneer programme has been established to develop transformational change over a five to seven year period. The balance of being able to demonstrate tangible outcomes in the first year against a longer term programme is an aspect which needs to be managed.

In light of the above we took stock of our programme and identified that:

- The focus on integrating discrete areas of service was beneficial, but needs to be scaled up
- The message about the importance of the pioneer programme had not been embedded consistently across all key functions of our organisations
- We would have benefited from the programme having a distinct identity

Senior leaders across Barnsley have come together to review the programme, facilitated by the pioneer leadership programme. When completed, this will result in a more robust and coherent response to some of the challenges posed by pioneer and associated system transformation.

Another specific challenge, relating to the holistic patient care work, has been delays in the decision about Tech Fund 2. Important developments are, to some extent on hold, pending this decision. This reflects the wider challenge of ensuring that pioneers are supported in their endeavours through coherent and timely decisions whenever there is interaction with relevant national programmes.

1.7 What are you planning to do next year?

In 2015 work on integration activity to Invert the Triangle will continue. And much of the work that has been in development will start to come to fruition. Our road map will be shaped and finalised early in 2015, but will contain the following elements:

- Review progress against the delivery of the Health and Wellbeing Strategy
- Economic modelling across the partners on key system-wide challenges and opportunities, looking at resources, collective ambitions and financial tensions in the system – the BCF will be a lever for change in this work
- Co-design of how the system should look like in three to five years with all stakeholders in Barnsley
- A clear joint governance system through the Health and Wellbeing Board
- A strategy for communication and engagement to promote understanding and ownership of the integration programme

1.8 What is your advice for other areas starting on their own integration journey?

Our learning is that when implementing an ambitious programme it is important to have a clear governance process and good communication networks in place from

the start. This means that any problems or drift in a programme can be picked up and tackled quickly, and that stakeholders will be engaged. A sense of shared ownership and commitment across all the partners is critical.

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2   Case study: Barnsley – Developing personal commissioning

Barnsley is currently piloting personal health budgets for people receiving continuing healthcare funding. Currently 25 adults and six children are in receipt of a personal health budget/direct payment to meet their health and social care needs. Generally the budgets are being used to employ personal assistants.

The clinical commissioning group (CCG) and the council are working closely together on this initiative. The council delivers the personal health budget payments and monitoring service, and commissions continuing healthcare packages working alongside healthcare professionals to ensure that the needs of individuals are met. The Promoting Independence Programme Board oversees this work.

In 2015/16, Barnsley intends to extend personal health budgets for people with mental health problems and people with learning disabilities and is currently working with providers and third sector organisations to start to plan how this can take place.

Barnsley is seeking to extend the experience gained in the personal health budget pilot into Integrated Personalised Commissioning and has submitted an application to become a demonstrator site. This application is supported by the CCG, council and the local user lead organisation within the community and voluntary sector.

The initial cohort identified for this work is people who receive support to manage diabetes, with a focus on those who have the most contact with acute services, and those with complex and difficult to manage diabetes and other clinical conditions. The prevalence of diabetes in Barnsley is 6.8% of the population, compared with 5.9% in similar CCGs; this equates to 13,692 people aged 17 and above. Prevalence of diabetes is higher in areas experiencing deprivation. Data shows that spending on prescriptions to treat diabetes cost more per adult compared to other areas in England. Further detailed analysis will be undertaken to establish the number of people within the chosen cohort and to establish the level of social care funding that is accessed by them. It is envisaged that the personalised care element of the programme will be available to all people identified, with the offer of a personal integrated health and social care budget being available to the focus group.

The overall aims of the programme are:

- To reduce demand on acute care, including hospital admissions, by supporting people to keep well by using self-management and crisis prevention
- People will report improved outcomes in their health and quality of life through better self-care

There will be a number of key elements in delivering the programme:

- People will be supported to become experts in managing their own health and care
- There will be an increase in people who receive a personalised integrated

care plan, including the integration of health and social care budgets

- People who self-manage their condition will be supported to share their experiences with others using peer support groups
- There will be a greater choice and range of support for people to choose, promoting an increase in the quality of support available through indirect competition
- A joint approach to assessment and resource allocation approval will be developed
- Processes will be strengthened to allow the pooling of resources, with the blending of health and social care funding streams
- Once this programme is demonstrating outcomes the learning from this will be used to support other cohorts to develop Integrated Personalised Commissioning

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3 Case study: Barnsley – Holistic Care Project

One of the core elements of a sustainable, integrated health and care model is for information to be accessible to the right people at the right time so they can act on it swiftly. This means delivering interoperable systems that allow data to be shared safely by all who need it.

In the Holistic Care Project, Barnsley is seeking to connect the hospital (Lorenzo) adult social care (Liquidlogic), CACI, and Jontek systems. This would connect patient information across hospital, home care, telecare and reablement services through an information hub.

Some 7,000 people use Barnsley telecare services (such as having a falls detector), and around half of these also receive services such as home care, reablement and community healthcare. Connecting care provision in hospital to care in people's homes gives a direct link which can be used to identify and address problems at an early stage. In particular:

- Hospital professionals will have information about the individual's social care history immediately available to allow planning for discharge at point of admission
- Workers in the community will get real time alerts to intervene, initially focused on falls prevention and medication compliance, and subsequently extending to dementia and better detection of underlying medical conditions

The diagram below shows how interoperability can result in improved care practices and outcomes.

Falls
Ted, 69

Current Patient Experience
Ted has a Fall at home picked up by his falls detector with the ILAHS Monitoring Centre. He is visited by the Telecare Home Services Assistants within 30 minutes and is assisted, before they repeat the same process with the next client.

Future Patient Experience
Ted's fall alert creates a visit activity on a reablement support worker's Smartphone. A protocol ensures that within 48 hours, the reablement service visit Ted to check on his wellbeing, undertake a slips, trips and falls risk assessment.

Confusion
Mary, 69

Current Patient Experience
Mary has low level mental health issues and, anxious, visited Accident & Emergency. The hospital didn't have information about the Community Care Services Mary receives and admitted her into hospital.

Future Patient Experience
The hospital had access to vital information to see that Mary is in receipt of a 24/7 Telecare monitoring and response services. They contacted the Telecare service to seek reassurances that Mary would be socially safe at home.

COPD
Wendy, 76

Current Patient Experience
Wendy was admitted to hospital as a result of COPD. Hospital staff didn't have access to information about her 24/7 Telecare monitoring and her contact with the Long Term Conditions team. Wendy was readmitted to hospital 10 days later.

Future Patient Experience
The hospital was able to see Wendy was in receipt of 24/7 monitoring and was under the care of the Long Term Conditions Team. Hospital staff were able to inform Telecare of imminent discharge allowing them to make a safety check post discharge.

Access to digital care information is expected to bring about many improved outcomes in terms of individuals' improved experience of services and better health, wellbeing and independence. It is also expected to reduce hospital admissions, speed discharge, and reduce bed days. As such, it contributes to Barnsley's Better Care Fund plan.

An evaluation is planned to identify the impact that the project has on the range of outcomes.

Over time, the growing volume of information on care processes and outcomes available from the hub will be used to support future service developments.

This work is fully supported by Barnsley pioneer partners, through leadership, commitment to managing change, funding and governance. It builds on a track record of joint work on informatics such as information governance and extensive use of the NHS patient number as primary identifier.

The following diagram shows the systems and services involved and the extent of the challenge.
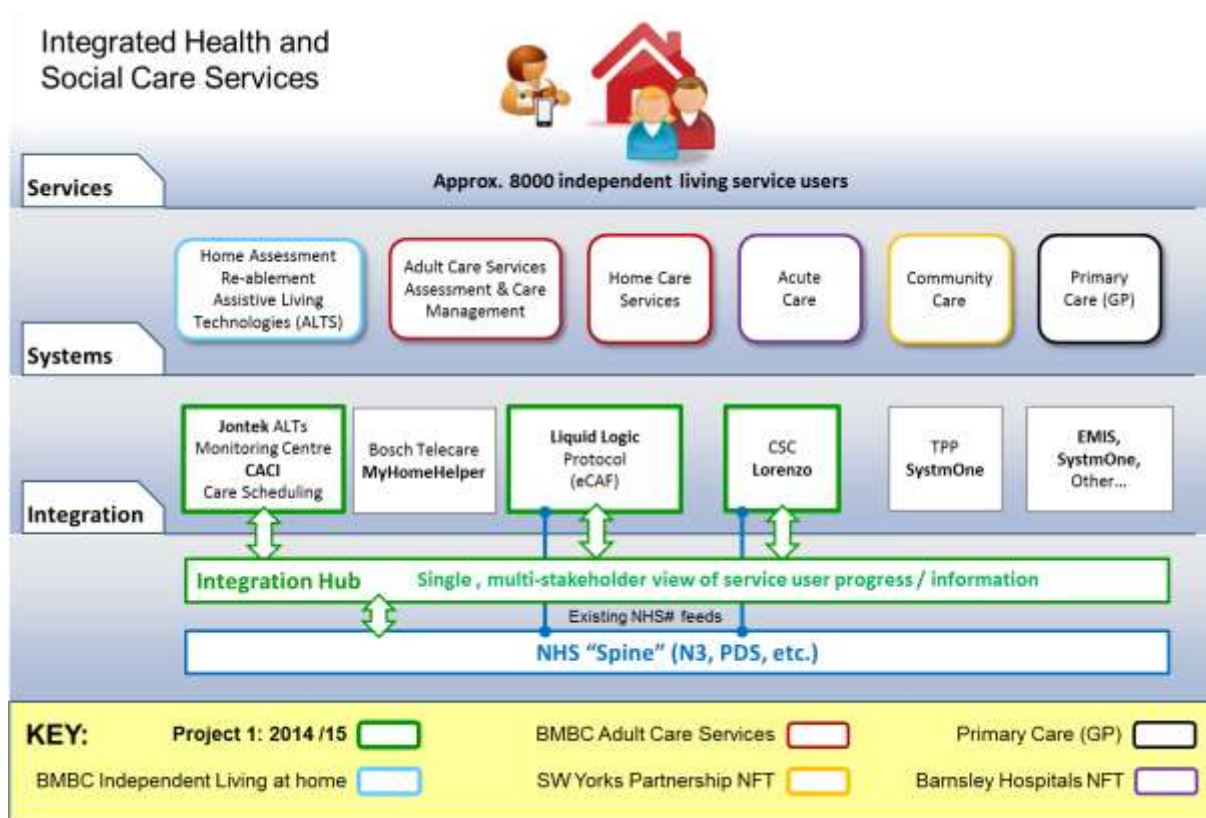
The project will be implemented in several stages:

- Initial readiness for the Information hub will be in place by March 2015 when interoperability across telecare, reablement and home care will be established and tested

- Connecting the hospital to the hub is hoped to take place from April 2015. However, this stage is dependent on Barnsley receiving funding from NHS England Tech 2 fund
- Future plans for this work include extending the integration hub to full system integration, including primary and community healthcare

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4 Cheshire Pioneer Programme – Profile

4.1 What is your area like?

Cheshire covers a geographical area of 800 square miles with a population of 700,000 residents. It has a rich diversity of urban centres, market towns and large rural areas. Across the area there are large variations in deprivation and affluence, and large differences in levels of health. The population of people over 65 and over 85 is growing swiftly across Cheshire, leading to a financial growth pressure of around £19m in the west over the coming five years and £36m in the east in the next three years.

4.2 What are you aiming to achieve?

Connecting Care in Cheshire brings together two councils and four clinical commissioning groups (CCGs) in three localities, with a combined budget of £1.3bn, working through two health and wellbeing boards, Cheshire East and Cheshire West and Chester, and with a range of providers from all sectors. The Cheshire pioneer programme is an ambitious one and covers the integration plans of the three localities namely:

- Cheshire East – Caring Together Programme
- Central Cheshire – Connecting Care in Central Cheshire Programme
- West Cheshire – The West Cheshire Way Programme
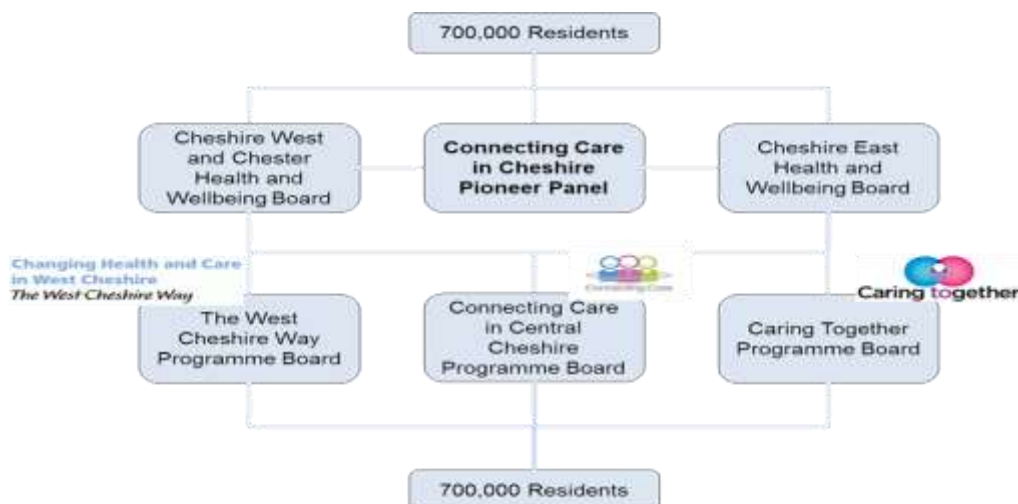
Pioneer partners across Cheshire are committed to a model of collaborative leadership, through which shared visions and outcomes will allow organisations to establish a common direction of travel and to provide a platform for making joint decisions. A Pioneer Panel, which comprises leaders from all key partner organisations, has been established to help coordinate integration activity across the Cheshire pioneer area where appropriate.

Our vision for the Connecting Care in Cheshire programme is that within three years the residents of Cheshire will enjoy a better standard of health and wellbeing. We anticipate that this approach will place less demand on more costly public services through the implementation of ground-breaking models of care. As every community in Cheshire is different, local solutions will reflect local challenges but our actions are united around four shared commitments namely:

- Integrated communities
- Integrated case management
- Integrated commissioning
- Integrated enablers

We identified five key workstreams that were common areas of work to each of the transformation programmes and agreed to deliver these in partnership across the Cheshire footprint. These areas of work are supported by six enablers as highlighted within the diagram below:
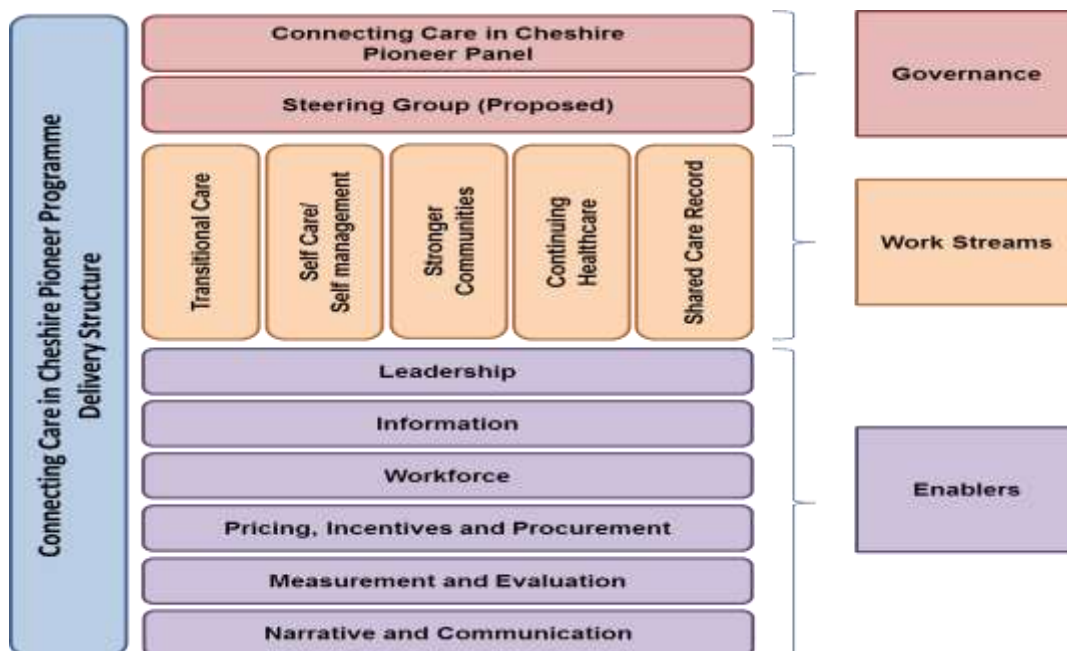
4.3 What have been the highlights of your first year?

- Submission of joint bid to Tech Fund 2 to develop a digital shared care record across Cheshire
- Joint planning to integrate continuing healthcare
- Joint work and shared learning on intermediate care and personal commissioning

4.4 Details of the year

4.4.1 Developing the Connecting Care in Cheshire programme – joint workstreams

4.4.1.1 Transitional care

We currently have two programmes of work to develop integrated, personalised intermediate care services – the STAIRRS project and the Care Category framework. We are sharing learning as these services develop and, while localities may have different systems, these will be linked to shared principles and outcomes, so that people across Cheshire receive the same high standards of service. See case study: Developing transitional care models.

4.4.1.2 Self-care/stronger communities

We are scoping a self-empowered work programme to commence in 2015 led by the two directors of public health across Cheshire. Through a successful application to the Integrated Personal Commissioning Initiative we will focus on introducing personal health budgets for people with learning disabilities.

4.4.1.3 Continuing healthcare

We are planning to implement a new operating model to drive a change in the provision of continuing healthcare commissioning support services. The intended outcome of this programme is to ensure that the services that are commissioned are safe for service users and that service users and their families are fully involved in decision making.

4.4.1.4 Shared care record

We have recognised the need to establish an infrastructure that enables the flow of high-quality, comprehensive and up-to-date information between care professionals across Cheshire. In 2013/14 the West Cheshire programme developed a digital patient record, supported by NHS England Tech Fund 1, and is piloting this in A&E and GP practices. Building on this, in September 2014 a joint bid was submitted to Tech 2 which will roll out this initiative across remaining partners in Cheshire. See case study: Setting up a pan-Cheshire integrated digital care record.

4.4.2 Joint enablers

4.4.2.1 Leadership

Supported by the national pioneer programme, we had a joint 'disruption event' with Cornwall pioneer where we learned more about the Energy for Change model and how we can lead change in the system. We have agreed to continue to work on shared leadership through an ongoing series of events that give space and time to share and progress ideas.

4.4.2.2 Workforce

We have recognised that delivery of our three ambitious integrated health and care transformation programmes will hinge on the availability of an effective, engaged workforce that feel supported by strong leadership; have opportunities to create strong and active relationships across organisations; and have access to appropriate education and training opportunities. We are working with national support partners

to scope the size and complexity of the workforce challenge and to deliver a five-year Integrated Workforce Strategy.

4.4.3 Locality integration programmes – highlights of the first year

4.4.3.1 *Caring Together – East Cheshire*

In the Caring Together Programme commissioners and providers have been working to co-design a new integrated system of care, with an emphasis on outcomes-based specifications and innovation. This includes:

- Scoping the introduction of five caring together community teams
- Developing a new care co-ordination hub, supporting case management
- Introducing supported self-management techniques
- Commitment to delivering the three million lives project (assistive technologies)
- Piloting specialist community in-reach services

4.4.3.2 *Connecting Care in Central Cheshire*

Partners in Central Cheshire have been preparing the landscape for change to support the move to increasing levels of collaboration and integration. This includes:

- Established shared vision, leadership and governance arrangements to support whole-system working and delivery of integration outcomes
- Baseline mapping of all integrated work in progress or planned
- Increased pooled resources
- Agreed delivery model for integrated care
- Testing new contracting approaches such as a collaborative provider 'alliance' contract

4.4.3.3 *West Cheshire Way*

The West Cheshire Way is based on designing services around the needs of the whole person. The programme will improve self-care, support people in the community, and ensure services are coordinated. First year highlights include:

- Nine integrated teams are operational, six of which are already co-located
- A shared care record pilot commenced in A&E
- A single access gateway covering mental health, physical healthcare in GP practices and hospitals and social care is being developed
- A centre for healthy ageing hub is being developed
- Frailty clinics have been established with further links planned between community geriatricians, GP practices, integrated care teams and community services
- A team of commissioners and providers visited the Jonkoping health and care system in Sweden to understand their patient centred approach, their leadership, innovativeness, impact on health improvement, and to see how we can use this in our local area

4.5 What has been the most exciting aspect?

Achieving transformational change across a complex but achievable geography without implementing structural change continues to be an exciting aspect of the programme. One of the most crucial aspects in achieving this has been the development of authentic working relationships across the health and care economy between key partners: CCGs, acute trusts, mental health and community trust, primary care and local authorities. This has happened not only at the most senior level between clinical and management leaders but also throughout organisations, and has enabled the transformation vision to be owned by those who are going to be crucial to delivering it.

The implementation of the integrated teams in West Cheshire has been a fundamental aspect in forming the building blocks of the future system. We have learnt that it then takes time for those teams to embed in order to work effectively together including working through the alignment of processes.

4.6 What has been the most challenging aspect?

The rising tide of demand has made it difficult to shift resources into the community away from the acute sector sooner than we were hoping. This is not unique to this health economy, but due to the demographics of our population we believe we are feeling it acutely.

Due to the Cheshire geography, communicating our success and learning across our footprint has been difficult, but, to address this issue, a pioneer website has been developed which will be used as a vehicle of communication and networking. A pioneer network of senior commissioners has also been set up which will ensure joint commissioning opportunities become a reality.

4.7 What are you planning to do next year?

4.7.1 Connecting Care in Cheshire

- The major initiatives that commenced in 2014 (above) will continue to be progressed
- We will deliver a 'challenge session' to tackle hard conversations about finance, and barriers to joint work, such as national tariff, with providers and national pioneer partners including DCLG, NHS England and Monitor
- In 2015/16 we will be working with the national Integrated Personal Commissioning Team to introduce personal health budgets for learning disabilities

4.7.2 Caring Together – East Cheshire

- The further development of a joint commissioning specification for a more integrated health and social care system, focusing on rewarding outcomes and maintaining standards
- The ongoing facilitation of horizontally and vertically integrating our health providers, through transitional arrangements and leadership development

- Work in partnership across the pioneer partners to commission and implement the new integrated digital shared record
- Establish the local infrastructure and investment required for Caring Together integrated community teams, integrated rapid response services and improved capacity and access to primary care
- Working with Cheshire East Council as the lead partner ensure the Caring Together Empowered Individual ambitions and work programme is developed and implemented across the pioneer footprint
- Complete and implement across Cheshire a new improved model of care for patients with continuing healthcare needs

4.7.3 Connecting Care in Central Cheshire

- Build capacity and capability of the workforce to lead improvements, challenge existing practice and systems and to implement and evaluate change
- Utilise the workforce effectively and be open to innovation in skill-mix, staff substitution, new roles, hybrid roles, 7-day working and roles that span organisational boundaries
- Put 'Listening into Action' – to re-engage our workforce to drive and own the changes needed as part of an ethos of continuous improvement
- Create a 'learning network' and 'central Cheshire academy' to support cultural and behavioural changes required to deliver new models of care

4.7.4 West Cheshire Way

- Work with neighbouring localities across Cheshire to implement a new improved model of care for patients with Continuing Healthcare needs
- Develop a comprehensive workforce strategy that both supports front-line clinicians to improve current ways of working as well as developing the skills for the future, cutting across traditional organisational boundaries
- Set out on the road map towards the realisation of an accountable care organisation through further development of the accountable lead provider for intermediate care and the integrated provider hub for mental health and learning disability
- Implement the 'House of Care' model for long term conditions to shift the majority of care to be based around the supported and empowered individual in their own community
- Test and roll out radically different models of general practice to support the transformation of the rest of the health and care system
- Fully implement the new integrated digital shared care record

4.8 What is your advice for areas starting on their own integration journey?

The individual is at the centre of all the work that we do; we need to continually keep bringing ourselves back to this thought.

It is important to create a compelling story which everyone at all levels across the economy can associate with and take themselves back to when they are facing a challenging situation to remind themselves this is why we are on this journey.

Establishing good relationships is fundamental to joint working and should not be underestimated; listening to others, trust, openness all need to be nurtured.

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5 Case study: Cheshire – Developing transitional care models

5.1 Short Term Assessment Intervention Recovery & Rehabilitation Service (STAIRRS)

Eastern and Southern Cheshire have identified the need for an integrated community rapid response service, with community based assessments and timely access to a range of short-term personalised support services. The integrated service will improve patient outcomes, reduce the need for hospital admissions and speed safe hospital discharge.

The service will be delivered through the redesign of existing intermediate care, reablement and other community support services. Redesign will address the following issues.

- Services are often discrete, reactive and protected by strict access criteria
- The hospital discharge service is fragmented, and people with complex need often receive multiple assessments by different professionals
- Patients report a disconnect between services and a lack of coordination
- A lack of sufficient specific provision for people with dementia
- Limited networking across intermediate care type services, and information does not flow easily
- Limited networks with other health, care and community support; people not seen in the context of their social and wellbeing needs
- Limited rapid response capacity to provide an alternative to hospital

The new model is based on local audits and national research into best practice in intermediate care. It has the following key features:

- It is based on individual health and social care patient needs, rather than prescribed service criteria, offering choice to patients and carers and providing alternatives to traditional hospital and intermediate care bed based services
- It will be accessed through a single hub where skilled health and social care assessors have access to a variety of integrated services and resources
- A risk profiling tool will identify people at high risk of needing more intensive services; the hub will have an advance care plan for this group which can be activated in a crisis

5.2 Improving transitional care

West Cheshire is developing its transitional care services; many of the issues for improvement are the same as those identified in East and South Cheshire. The aim of the redesign project is to bring together existing intermediate care, reablement and other community support services to shift the balance of provision from acute hospital services to community step-up and home-based health and social care support. This will improve patient outcomes and deliver more cost effective, sustainable care.

In the new model, patients with complex needs, and carers where necessary, can expect rapid access to an integrated health and social care assessment. A new system for integrated community support will be based on:

- Step-up beds – community intervention beds
- Step-down beds – transitional care

A number of additional step-up beds will be commissioned in the community for GPs to use to prevent hospital admission; as well as GPs, referrals can be made by community nurses, emergency departments or medical assessment units, but GPs must agree any admission. Step-up beds will also be used by a specific cohort of patients, such as people with complex wound care needs, who require a short-term period of 24/7 care where this cannot be delivered in the home, and hospital admission is not required.

The transitional care service is bed-based in the community and allows patients to rest and recuperate with support from GPs, physiotherapy, occupational therapy, dietician, social services care management and pharmacy.

5.3 Pan-Cheshire approach

Through Connecting Care in Cheshire, partners are sharing learning as these services develop and, while localities may have different systems, these will be linked to shared principles and outcomes, so that people across Cheshire receive the same high standards of service. The principles are:

- a function rather than a discreet service
- seamless and holistic care for patients
- short term, timely and patient goal focused
- linked to other services where ongoing support needs are required
- recognise recovery is linked to choice and control as well as physical functioning

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6 Case study: Cheshire – Setting up a pan-Cheshire integrated digital care record

Cheshire integration pioneer covers two unitary councils and four clinical commissioning groups (CCGs) working in three localities: Central, East and West. The overall population of Cheshire is 750,000.

The pioneer programme includes the integration plans of the three localities and also the Connecting Cheshire plan which aims to learn from the best work of the three localities and apply this on a Cheshire-wide basis. The pan-Cheshire integrated digital care record (IDCR) was the first major priority that the Cheshire partners realised would achieve significant improved patient outcomes and value for money.

Shared digital care records allow care professionals to access the same quality, comprehensive and up-to-date information about an individual so they have a clear picture of their needs and can act quickly to support them, for instance sharing information across a multi-disciplinary team to plan for hospital discharge. At a strategic level, shared intelligence allows organisations to plan improved patient pathways and services.

Cheshire partners are funding the programme but have applied to Tech Fund 2 for start-up costs.

6.1 Reasons for a Cheshire-wide care record

- Patient flows across the health economy often cross-organisational boundaries
- Four NHS providers operate within Cheshire, and together provide a comprehensive range of acute, community and mental health services
- 90 GP practices operate in Cheshire
- The model will result in more consistency for individuals
- The model will result in economies of scale for organisations. The long-term financial benefits of the programme are estimated at £5.3m over four years

6.2 Reasons for extending the West Cheshire model across Cheshire

The pioneer partners have undertaken an options appraisal to determine the most effective option going forward. The West Cheshire model has been found to offer the most comprehensive data set, provide greater geographic coverage and include the ability to develop forms within the IDCR.

The West Cheshire Care Record already includes data from the following organisations:

- 37 GP practices
- Acute care (one foundation trust)
- Mental health partnership trust (Cheshire wide)
- Community partnership trust (Cheshire wide)

- Social care (West)
- Tertiary (cancer centre – Cheshire wide).

In light of this, it was decided to link data from all organisations to the West Cheshire Care Record.

The new Cheshire organisations to be included, and the sharing of data, is shown in the diagram below.
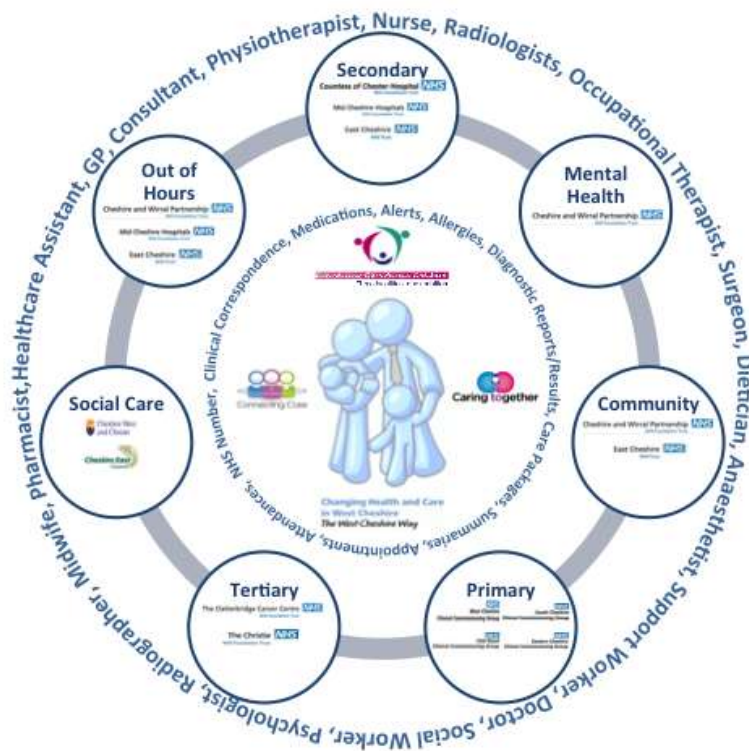
6.2.1.1 What next

Dependent on the Tech 2 Bid, Cheshire has a plan in place to establish and test summary health and social care data, and to deliver the information governance required for the programme. Pilots will then be undertaken in primary, acute, social, community and tertiary care to demonstrate the usability of the solution and deliver benefits to clinicians within six months of commencing the programme.

The programme will be evaluated for clinical effectiveness and impact on patients and service users through Cheshire's 'I' statement based standards for integrated care.

When fully developed the IDCR should include:

- Primary care summary record
- Medications
- Diagnostic results and reports
- Procedure details for the acute trusts
- Allergies/alerts
- Clinical correspondence, summaries and assessments
- Appointment/event details including A&E
- Cancer summary
- mental health summary
- Key contacts
- summary social care records and details of care plans and service providers
- Community appointments and details of care plans and services provided.

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7 Cornwall and the Isles of Scilly Pioneer Programme – Profile

7.1 What is your area like?

Cornwall is a rural county and a popular holiday destination. The health of people in Cornwall is mixed compared with the England average. Deprivation is lower than average. About 17,000 children live in poverty, however. Life expectancy for both men and women is higher than the England average. Life expectancy is 5.9 years lower for men and 5.2 years lower for women in the most deprived areas of Cornwall than in the least deprived areas.

The county's population is growing due to increases in both the population of older people and of migrant workers.

Cornwall has the highest volunteering rates in the country (about one in three people).

The joint health and wellbeing strategy (JHWS) for Cornwall is focused on three long-term outcomes:

- Helping people live longer, healthier lives
- Improving the quality of people's lives
- Fairer life chances for all

7.2 What are you aiming to achieve?

Living Well aims to help people who are socially isolated and highly dependent on health and social care services to improve their quality of life. It aims to reconnect people with their communities – facilitating change rather than fixing problems, building on the support infrastructure that's already there. Living Well is a partnership between the voluntary sector, health, social care and local people. All health providers, the clinical commissioning group and the council are signed up. The project team spans health, social care, private and voluntary sectors, and is driven by local GP champions.

Our three specific aims are:

- Improved health and wellbeing
- Improved experience of care and support
- Reduced cost of care and support

Criteria for entry to the programme are:

- A minimum of two long-term conditions from a specified list
- Or a social care package in place meeting a specified list

The building blocks for the work of our integrated teams are:

- Conversation and goal setting
- Aiding recovery with help from volunteers
- Community support and network development
- Specialist support

A model of wraparound care for people with long-term conditions supported by trained volunteers and paid coordinators was tested in a Newquay Pathfinder project beginning in summer 2012. In 2014, Penwith Pioneer Programme was set up on the same model and was expanded into East Cornwall.

Our programme is led and invested in by the voluntary sector. Until very recently none of the public sector has invested in the programme except in terms of time. See case study: According parity of esteem to volunteers.

The Living Well programme is sustainable and replicable. It is based on people and community resources so that each individual and locality can shape their own solutions. Robust, shared performance monitoring ensures we can demonstrate and monitor delivery.

7.3 What have been the highlights of your first year?

- Started Penwith Pioneer Programme in six local practices
- Started Living Well – East in the east of the county in October 2014
- Obtained whole-system sign-up to the Living Well financial model based on linked data
- Developed and agreed outcome measures
- Developed and agreed an evaluation framework
- Developed online repository of information for sharing – the 'Knowledge Bucket': http://knowledgebucket.org
- Information governance agreement signed off by all partners
- Induction training package produced
- Community Line proposal developed and Line in place
- Multi-disciplinary team/care co-ordination proposal developed

7.4 Details of the year

The Newquay pilot demonstrated a 4:1 return on investment (cost of average unplanned hospital admission for the cohort = £2,500, maximum cost of Living Well support per person = £400). The Newquay cohort expanded to 250 in 2014. Also in 2014 we started our Penwith Pioneer programme, drawing on some of the early successes and learning from Newquay. Later in 2014, we started Living Well – East, in the east of Cornwell, focusing on the same triple aims, but with an added focus on hospital discharge, in the form of the Welcome Home programme, led by Volunteer Cornwall.

Each project is overseen by a board drawn from representatives of health, local authority, voluntary sector, HealthWatch Cornwall and local stakeholders. Boards meet monthly with quarterly locality stakeholder groups and an overarching Living Well Chairs Group.

7.4.1 Penwith Pioneer

The service:

- Targeted, wraparound support motivating 'at-risk' older people to achieve their aspirations through a 'guided conversation'
- Individuals supported by an Age UK worker to identify their goals and to co-ordinate a management plan delivered by co-ordinating statutory and community services and support
- Volunteers aim to build people's social networks, community connections and resilience
- Age UK worker is part of a multi-disciplinary team (MDT) which includes GP, district nurse, matron and social workers
- Joint working between partners to develop and agree a joint performance framework, with Age UK being the central data processor
- A conversation became a quiet revolution as practitioners worked across organisational boundaries to focus on the people they were supporting

The people:

- Recruited cohort now at over 800
- 67 volunteers and 12 co-ordinators

The benefits:

An analysis of the first phase of people supported by Living Well in Penwith has shown:

- a 49 per cent reduction in non-elective admissions;
- a 36 per cent reduction in emergency department attendances;
- a 28 per cent reduction in the number of people being admitted to a community hospital;
- a 20 per cent reduction in the length of time people stayed in a community hospital;
- a 20 per cent self-reported improvement in mental wellbeing;
- an eight per cent reduction in social care costs; and
- a four per cent increase in out-patient appointments.

Although we are still in the early months of the support to those people, we are hoping this improvement will continue to be shown by the longer term evaluations we are putting in place.

The programme, methodology and the final results are being evaluated by University of Exeter, Public Health England and Public Health Cornwall, the Academic Health Science Network and The Nuffield Trust.

Beatrice's story

Before
•Diabetes
•Stroke - unable to move right arm
•Partially sighted
•Anxious
•Carers 4x a day, fortnightly GP visits
•Nurse, social care, community mental health

After
•Keen user of telehealth
•Attended a counselling course
•Attends balance and stability class and walks her dog
•Hosts a coffee morning
•Wellbeing score 19/35 ⟶ 29/35
•Reduced her social care package and contact with mental health
•No support from Age UK, she has her own network

7.4.2 Living Well – East

A new project started in the east of the county in October 2014, with funding support from the Cabinet Office.

- Age UK Cornwall team co-located with district nurses
- 350 referrals by November 2014
- Strong relationships developed with community organisations and practitioners
- Work begun around community engagement, awareness raising and MDTs
- MDT guidance developed by Living Well – East board and offered to practices with facilitation and support
- Board is also overseeing the development of guidance for practitioners (including volunteers) on community pharmacy support and how to access it
- Welcome Home advanced discharge planning services now running

7.4.2.1 Community Line proposal

Co-designing the approach with people, practitioners and volunteers identified confused and complicated referral systems, with variable case co-ordination by MDTs. People suggested a community phone line to be manned by the voluntary sector, providing a clear single route 'in' with trusted and shared research and co-ordination, linking people with key workers and a robust MDT system for complex discussions.

Resources were reallocated from Age UK Cornwall, to start a basic line from January 2015, with the intention of reallocating additional resources to grow the line and its functions. All the MDTs in Penwith were mapped and surveyed and this information was used to inform a process to link MDTs to the Community Line. The line is supported with clear guidance and a trained pool of facilitators to support MDTs.

7.4.2.2 The Knowledge Bucket

Funded through Age UK National and NESTA, this is a central place for us all to store and access anything to do with Living Well, from latest news, films, reports, progress, leaflets, case studies and a live form. The first stage went live in December 2014. In the 2015 the site will be expanded to include a public-facing section. We are also working with BT to provide free Skype to people on the programme and also in West of Cornwall Hospital. http://knowledgebucket.org/

7.4.2.3 The evaluation framework

We have developed an evaluation framework based on our three core aims. See case study: An evaluation framework linked to outcomes.

7.5 What has been the most exciting aspect?

It has been great to unleash some of the potential in the front line and see staff working together in a way they've never done before. People from 'back offices' have also been involved in the design process. We have had very challenging conversations with some colleagues but have tried to keep reconnecting with the people we are there to support, for example through videos and stories. It was very gratifying to hear a member of technical staff from the community health organisation say, "This is the first time I've understood the impact of what I do".

It was exciting when we first began to see results both improvements in people's mental wellbeing and reductions in unplanned hospital attendance and admissions. We also saw reductions in social care packages. This was people saying, "I don't want this package of care because I'm busy doing other stuff".

7.6 What has been the most challenging aspect?

A big challenge is in moving from running projects in a small number of areas to ensuring that the work becomes 'business as usual' and is scaled up across a whole health and social care economy. The new model has to be put in place before the old system changes and this is hugely challenging in terms both of time and resources for both commissioners and providers.

7.7 What are you planning to do next year?

- Assuming that funding is confirmed, we expect the total cohort benefiting Living Well to increase to 1,000 by spring 2015
- Throughout the course of the year we expect five new sites for the Living Well programme to go live in preparation for the rest of the county going live in 2016
- We will be expanding the frontline teams to include police, troubled families workers and housing

We saw some great examples in Denmark and Sweden, where a hospital discharge programme offering people a supportive visit within hours of discharge showed a marked reduction in readmissions and an improved quality of life. This approach is being developed as part of the winter resilience programme, Welcome Home.

Elsewhere we are looking at new models for future care delivery, from accountable care organisations in the USA to social impact bonds in Peterborough.

7.8 What is your advice for areas starting on their own integration journey?

The success of Living Well has been dependent on a number of enablers of cultural change – traditional methods of project management just won't deliver. Chief among enablers we would highlight:

- Pull together a design team from many sectors – no one person here has the word 'pioneer' in their job title. This means that the work will be sustainable when the pioneer programme is over
- Building trust – spending time engaging and building the multi-disciplinary team as well as sharing learning and using informal social events is vital to ensure effective working and case management. The level of trust in our programme is shown by the fact that all the providers for health and social care have opened their financial books to enable financial planning
- The power of language – creating a new language to overcome organisational and cultural boundaries – we talk about people and practitioners, not patients and professionals
- Real people's stories to demonstrate the impact which stops the focus being all about the money
- Empowering frontline practitioners, including fostering strong GP buy-in – to redesign services around the individual, putting people first
- Focus on what people can do – treating people as active participants, not passive recipients of care
- Our funding was set up on the principles of a social impact bond – we believe that if the work is shown to be 'investor ready' it is also 'commissioner ready'
- Developing shared outcomes and measures
- Agreeing a methodology for cost/benefit data analysis up front and define an evaluation framework at the start
- Using information governance as an enabler not a blocker

We have worked to the following principles that we would commend to other areas:

- Stop creating new layers – support existing groups and connect people together
- Communicate what's available and where in a way that people find useful
- Encourage local leadership and engagement
- Be bold and brave!

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8 Case study: Cornwall – According parity of esteem to volunteers

The Penwith Pioneer project is part of the county-wide Living Well programme, aiming to support people who are socially isolated and highly dependent on health and social care services. There are 67 volunteers recruited by Age UK and Volunteer Cornwall, which carries out disclosure and barring checking and makes connections with local voluntary organisations such as British Red Cross and Penwith Community Development Trust. In fact, the total number of volunteers involved in this approach is actually much more than 67. It is difficult to quantify the whole time equivalent number as volunteers offer their time alongside other commitment, such as caring roles. The time given would cost £1.7m at minimum wage. In many cases people supported by the project have become volunteers themselves, either formally (through an agency like Age UK) or informally (offering regular support to someone who needs it).

Potential volunteers who show an interest start by having a conversation with the team leader or a member of staff at their GP practice, to get a better feel for the role. There is a formal recruitment and induction process managed by Volunteer Cornwall. The interview process draws out the sorts of skills that a volunteer has to offer and they can be matched to a range of opportunities, including Living Well.

Each volunteer is under the supervision of the co-ordinator assigned to the GP practice. There are volunteer team meetings, plus regular contact and feedback. At the moment the support is offered by volunteers Monday to Friday during office hours. Some volunteers, however, give their time outside of those hours. Their expenses are reimbursed.

The volunteer involvement is not intended to be a cheaper version of services that already exist, nor is it an add-on service to refer to. It involves a fundamental change in practice by every member of the care team, in which the volunteer worker is an equal partner and each member has skills and expertise to offer. It is not about shifting jobs from one team to another, but about creating unique support for each individual, based on what matters most to them. What volunteers do depends entirely on what the person they support identifies, through a guided conversation, as the things they want to achieve, the things that matter most to them. Below are the words of one volunteer which give an indication of the range of issues that need to be addressed and the commitment of the volunteers.

"*The co-ordinator introduced me to a lady with severely ulcerated legs who may have had gangrene – there was a question about whether her foot or toes should be amputated. She'd been rushed to hospital previously. She'd got in trouble for non-payment of council tax and her house needed deep cleaning. We managed to get her a bank account established and her bills are being paid. She is beginning to take an interest. She had cancelled 2 operations in the past because she couldn't find anyone to look after her cats. I took her to hospital because she was asked to be there at 7.30 in the morning. I went and got her and took her in. It took an hour and a half for someone to come and talk to her. Then they wouldn't do the op because she hadn't arranged for someone to look after her overnight, so I took her home again.*

She's now got another date – this time she's agreed to stay in overnight because we've found a way to look after her cats and I've arranged a relief carer for my wife so that I can take her in again. The co-ordinator arranged for an advocate to deal with her council tax – she had had bailiffs around several times but they'd gone again because there was nothing there of any value. The forms to fill in to claim exemption due to her depression were 42 pages long. The form itself frightens her, it literally frightens her. Her hands are trembling – that's why she doesn't open her post. She is now worried that the GP will not sign the form because the form says 'severe mental impairment', but she doesn't want to say that she is severely mentally impaired because she's worried that they will put her away somewhere. We're trying to be the catalyst to connect bits of the system around her, to deal with the council and get the operation done. No-one was otherwise helping her in a way that would help her deal with all those problems, and she couldn't deal with them herself."

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9 Case study: Cornwall – An evaluation framework linked to outcomes

The triple aims of the Cornwall Living Well project are:

- Improved health and wellbeing
- Improved experience of care
- Reduced cost of care

The Living Well team believes that one of the programme's strength's is the robustness of its metrics and evaluations: "We want to have a debate about what the numbers are telling us, not whether they're accurate."

An outcomes framework, linked to the three aims, has been developed. The Living Well team believes it is important to focus on all three aims and to develop metrics and evaluation methodology for each. An evaluation framework linked to the outcomes has been agreed by all the partners involved in the project. The evaluation framework includes a quality of life tool, practitioner survey and financial modelling to understand the cost impact. The table below shows the components of the framework, timescales and the organisations that will be involved in delivering it.

Question to answer	How we will answer it?	By whom?	Timescale	Funded by
Have we delivered improved heath and wellbeing?	Locally produced analysis of Outcome 1 metrics	Public Health Cornwall	April 2015	Public Health Cornwall
Have we delivered Improved experience of care and support?	Qualitative locally produced analysis of people and carers experience of the Pioneer intervention	External researcher	April 2015	NHS England Regional Innovation Fund
	Survey based analysis of practitioners experience of the intervention and new ways of working		January 2015	
Have we delivered reduced cost of care and support?	Locally produced financial analysis and modelling	Cornwall Pioneer team	April 2015	NHS Kernow
	Acute healthcare utilisation for people receiving Age UK services in Cornwall and elsewhere comparing their patterns of acute NHS care to a matched control group	Nuffield Trust	November 2015	Age UK National
	Pathway costing and evaluating various initiatives in each area (Cornwall, South Devon and Torbay, Somerset)	Academic Health Science Network	TBC	Academic Health Science Network
How have we achieved change?	Qualitative realistic research project	University of Exeter	March 2015	NESTA

| How does volunteering impact on volunteers? | Small in-depth, qualitative study focused on volunteers and how to build capacity in communities for social care for older people. Exploring people's energy and motivation to become volunteers. | University of Exeter | February 2015 | University of Exeter |

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10 Greenwich Pioneer Programme – Profile

10.1 What is your area like?

Royal Greenwich is a borough of contrasts, with an ethnically and culturally diverse population of 260,000. Pockets of relative affluence, largely associated with the borough's royal and maritime heritage, co-exist with areas of entrenched deprivation, the legacy of industrial decline in the decades following the Second World War. There have been recent improvements but life expectancy is 78.5 years for men against an England average of 79.2 and 82.2 years for women, against an England average of 83.0.

While Greenwich is the 19th most deprived borough in England, over the past 10 to 15 years new investment in physical regeneration, including housing and transport infrastructure, has significantly improved the prospects for economic growth in the borough and considerable inroads have been made in helping people access employment; however there is still significant inequality and poverty in the borough.

The demographic composition of the borough makes equal and easy access to health and social care services an absolute priority and services must be delivered in acceptable ways for Greenwich's multi-ethnic community

The Greenwich Health and Well-Being Strategy identifies three key imperatives; a focus on prevention as the most cost effective approach to health and wellbeing; the need for new approaches to tackling health inequalities and greater integration in the commissioning and delivery of local services.

The partners involved in this programme are:

- The Royal Borough of Greenwich
- NHS Greenwich Clinical Commissioning Group
- Oxleas NHS Foundation Trust (community health, mental health and learning disability services)
- Greenwich Action for Voluntary Services
- Local Healthwatch
- Lewisham and Greenwich NHS Trust
- Greenwich NHS General Practices

Together these organisations constitute Greenwich Co-ordinated Care (GCC). Our programme of integration is overseen by a project board with representation from all the partners.

10.2 What are you aiming to achieve?

GCC aims to build on three years of prior work to integrate health and social care services. Our established integrated teams (see below) were delivering excellent support to people with acute problems or rehabilitation needs in the community. But they were not addressing the needs of a relatively small group of people with on-going complex health, care and other needs

Greenwich Co-ordinated Care takes the need of individuals as its starting point and embeds a truly person-centre approach in the development and delivery of care plans. We have used local consultation and the work of National Voices to identify what matters most to local people to help shape our vision. They have told us that they want:

- Information about help and support to be more widely available and GPs and other health and social care staff to be better informed about community services
- People who are vulnerable and isolated to be looked after with a strengthened 'human touch' and more psychological support
- Services to be moved from hospitals into the community with agencies working closely together to join up services

We will know that our integrated care system is working effectively when:

- The core team sees itself as responsible for the ongoing treatment, care and support of their population, focusing on intervening early to prevent an escalation in health or social care needs
- The concept of 'discharge back to primary care' is replaced with the expectation of the lifetime management of people's health and social care needs
- People are helped to manage their condition through self-management programmes
- Cluster teams know their patch well and use their local community and voluntary sector resources
- Cluster teams take pride in supporting their population to remain fully engaged, happy citizens

10.3 What have been the highlights of your first year?

We had already developed a vision and begun to implement a plan for co-ordinated care in the year before the Integrated Care Pioneers Programme began. The Royal Borough of Greenwich and Oxleas NHS Foundation Trust had reorganised their rapid response and intermediate care services into integrated health and social care teams. A clear service user pathway was agreed with an emphasis on enabling people, wherever possible, to maximise their independence. The redesigned pathway included the shared use of 52 NHS intermediate care beds and an in-house social care reablement service. We had introduced a single point of access, a joint emergency team to reduce the need for hospital admission, a hospital intervention discharge team and three community assessment and rehabilitation teams. We knew that this model reduced hospital admissions and length of stays, the numbers of long-term care placements and the need for social care packages.

During the first year of the pioneers programme, we built on this model by:

- Extending our integration of rapid response and intermediate care services into integrated health and social care teams to selected residents with complex health and social care needs in two areas of the borough, with plans to extend this model to the whole borough

- Introducing a care navigator role to co-ordinate multi-disciplinary care planning and joint care plans
- Ensuring that mental health services are involved as a central aspect of our approach
- Ensuring that the voluntary and community sector and other key services such as housing are an integral part of the model
- Preparing to retender local authority home care services on a geographical basis that will align with GCC. See case study: [Building the team around the person](#)

10.4 Details of the year

In this second phase of integration which forms the first year of our pioneer work, we have utilised recent research which shows that many people with long-term conditions also have mental health problems, leading to significantly poorer health outcomes and reduced quality of life. We also know that people with serious mental illness have significantly reduced life expectancy and poor physical health. We have redesigned local mental health care pathways so that they can be delivered within the new integrated structure. The full involvement of our mental health services is now a key feature or our work. Individualised care planning has been at the heart of our mental health services for over a decade. We know how to deliver person-centred care.

We have built on our existing health and social care integrated teams developed in phase one prior to the pioneer programme, to ensure that people with complex needs are now also able to benefit from better coordinated care. This includes older people with multiple long-term conditions alongside younger people with physical and mental health problems, drug and alcohol problems and sometimes also housing and financial problems. See case study: [Co-ordinated care – a patient's story](#).

Local services aligned around clusters of GP practices are viewed as 'communities of practice', grouping patients and service users according to their level of risk of deteriorating health and increasing need for services (risk stratification). Those at most risk are intensively supported for a time limited period by a care navigator.

Greenwich Council is preparing to retender its home care service so that providers align with the span of the clusters and core teams. This will enable co-ordinated care teams to work closely with their local home care providers to develop person-centred approaches to care.

Staff have developed their understanding of how they can support people with the most complex needs and have learned more about each organisation's services, including the services offered by multiple voluntary and community organisations. Staff have also learned a new way of talking as part of the Greenwich approach – not "I'll make a referral" but "I'll talk with my colleagues".

10.5 What has been the most exciting aspect?

We enable care planning for each individual that is absolutely centred around the individual's needs and priorities which they themselves have identified, using

personal 'I statements'. The fact that many different services and specialists are involved in our co-ordinated care approach means that people can expect to have attention paid to the things that make them feel better, not just what someone else thinks they need. For example, one individual said that having a downstairs shower so that they could feel clean would make them feel less depressed and more able to cope, whereas in contrast their GP perceived that treatment for their diabetes was their greatest need. The co-ordinated care approach can provide both the shower and the treatment and that is incredibly satisfying.

10.6 What has been the most challenging aspect?

It has not been easy to bring together all the different professional groups to engage with each other and change their professional behaviours to work in a more integrated way, but we had fantastic commonality of purpose and commitment from senior executive in local government, the community trust and commissioners. This meant we had support to work on creating a common vision and purpose.

10.7 What are you planning to do next year?

- Continue to extend our model of integrated care across the borough and adapt the 'test and learn' project into a 2-year project that will enable us to continue with a flexible delivery model. This is expected this to be in place by summer 2015
- An evaluation of the Eltham test and learn project will be completed later in the spring and will report on the impact on use of acute and community services before and after involvement with GCC

We have developed a set of criteria against which to evaluate our success. We are working with local Healthwatch to evaluate people's experience of how GCC has affected the support they receive and their experience. We are also working the public health colleagues to calculate the impact of the new model in terms of the cost of providing care, the processes we have developed and their subsequent outcomes.

10.8 What is your advice for areas starting on their own integration journey?

Develop a common language and understanding across the health and social care community. How we communicate and translate our vision to all the different stakeholders has been an important part of our communication and engagement strategy. Key to this has been developing a common language across all the different disciplines. For example, where appropriate we refer to patients and services users as 'people we care for and support'.

The initial point of contact to services is critical to the success of the whole pathway – interactions with people and their families set the tone for any future service and for others it should provide high-quality advice, information and signposting.

We developed shared critical success factors and we believe that these have led to a stronger relationship between organisations.

We have learned the importance of integrating mental health services with physical health services and social care and of involving other services such as housing and the voluntary sector where these will meet the priorities identified by individuals in their care plans.

Investing time and effort in creating a sense of common endeavour among frontline staff has really paid off. We held workshops from the beginning, engaging staff from across health and social care. Once people had undergone the catharsis of expressing their views on each other's service, they began to discuss how to improve them collaboratively. We took an action learning approach with professional support. We did not create new roles (except in management) or change people's employers and this led to a smoother process of change. We spend time allowing people to understand each other's roles.

We have had strong leadership and commitment from our project board. When the new pathway did present challenges, the integration board was able to act as a change agent to resolve this.

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11 Case study: Greenwich – Building the team around the person

Greenwich Co-ordinated Care teams ensure that care to residents with complex health and care needs is well co-ordinated and personalised. The team has a consistent focus on what patients and their families want to achieve. The care facilitated by the team is shaped by each individual's 'I' statements through which patients describe what would truly make a difference to their lives. This collaborative approach has proved to be very successful and has helped people to turn their lives around.

Using the approach developed by National Voices the patient's aspirations are written as personal 'I statements'. They become the mechanism to explore the system and unlock and reconfigure work in a different way that addresses the individual's personal goals as well as their clinical needs. It also helps to achieve the excellent patient experience that the model strives for. The 'I' statements help not only to plan and deliver care but also to judge whether the intervention has been successful or not. Care arrangements are often entrenched simply because that's the way they have always been done. Care navigators see their role as being creative. They contribute to a new world for a new era of care by bringing together professionals and services to deliver tailored care which addresses the real problems people are experiencing in their lives.

Indications are that people and their families appreciate this approach and are happy with the plans that are put in place for meeting their care needs and aspirations. Greenwich is divided into four areas with, four geographical clusters of GP practices called syndicates. Greenwich Coordinated Care has successfully been tested in one syndicate area and is now being expanded. Each syndicate has a core team consisting of GPs, a clinical integration specialist, care navigators, social workers and a psychologist. Working closely with GPs, this core team around the person lies at the heart of the Greenwich coordinated care model which aims to support people with multiple long term conditions or complex needs. Greenwich Coordinated Care is an approach underpinned by intensive work of the core team involving the care navigators who then draw on a wider array of services specific to the needs of the individual person's care such as district nursing, community matrons, continence, podiatry, IAPT, memory services, social care, housing, telecare/telehealth, domiciliary care, physiotherapists, occupational therapists, community psychiatric nurses and voluntary sector..

In addition, the core team has named links with the patient's established specialist services for example diabetes, **chronic obstructive pulmonary disease** or mental health. They also work closely with a range of well-established integrated health and social care teams focusing on rapid response in the community for clinical deterioration; community assessment and rehabilitation; hospital discharge; support for learning difficulties and reablement services.

After intensive exploration of the individual's needs by their care navigator, opportunities and gaps in care are identified and a care plan is developed after multi-disciplinary team collaboration. The clinical integration specialist draws on the wide

range of services available. There is close liaison between the care navigator and all the agencies involved in their support. This can include liaising with housing and voluntary sector organisations to ensure that the whole 'jigsaw' of care and support fits together and that those involved understand each other's roles. Part of the care navigator's job is to coordinate the interface between an individual's core professional carers and any other service they need.

In the first year of using this approach to coordinate care, there have been 212 referrals to Greenwich Co-ordinated Care. After the first year, people's self-reported ability to cope has increased as has the number of services which they access. The care navigators have also raised awareness among GPs and other community and social care staff of the array of statutory and third sector services in the borough that can contribute to the health and well-being of their patients and clients. GPs have reported an increase in non-GCC patient referrals to the voluntary and statutory services they have learned about through the integrated care pioneer.

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12 Case study: Greenwich – Co-ordinated care – a patient's story

Tom, a 45 year old man from south east London, had been living with diabetes, chronic obstructive pulmonary disease (COPD), and a psychotic disorder for several years. He had gambling problems and lived in an overcrowded flat. This complex mix of issues resulted in him being the highest attender at A&E and a frequent visitor to his GP.

His GP referred him to Greenwich Coordinated Care who worked with him to develop the following I statements:

I would like...

- My medication looked at
- To stop gambling
- Help with damp in bathroom
- To keep house tidy
- To do voluntary work
- To have more mental health team visits

His Greenwich Coordinated Care Navigator organised a multi-disciplinary team meeting to review his care in light of his I statements. This involved his GP, housing, Greenwich Action for Voluntary Services, community mental health team, carers centre, out of hours GP service, psychologist, and London Ambulance Services (LAS).

The care coordinator gathered the information and the multi-disciplinary team looked with fresh eyes working across boundaries. The psychologist learnt about the pattern of A&E from LAS and helped identify how his behaviours led to triggers ie boredom, gambling, anxiety.

The action plan they developed agreed:

- To refer to London fire brigade re hoarding
- Psychologist to support to increase confidence and help with anxiety and triggers
- Housing to look at flat and residence
- Medication to be reviewed and help to manage

This lead to the following outcomes:

- The GP, patient, psychologist further explored triggers for calling an ambulance and the calls reduced to only one a month in the last three months for appropriate physical needs
- His long-term medication management was reviewed with him
- Boredom, gambling and debt were tackled with the support of voluntary services

- Explored recovery through social inclusion
- Housing issue resolved (stepson who was stealing from him moved out after housing did an informal visit; safeguarding issues addressed)
- He attended GP appointments for diabetes more regularly

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13 Islington Pioneer Programme – Profile

13.1 What is your area like?

Although Islington has a reputation as a wealthy borough with some of the highest house prices in the country, it is a borough of contrasts, with rich and poor living side by side.

- It is the 5th most deprived borough in London and 14th most deprived in England
- 13% of the population live with one or more long-term condition
- More than 30,000 adults have a mental health problem, with the highest incidence of psychotic disorders in England
- A seven-year gap in life expectancy between men in the highest income group and those in the lowest
- A 10% gap in attainment between the most affluent and least affluent children by the time they leave primary school
- One of the highest levels of child poverty in the country

13.2 What are you aiming to achieve?

Islington's vision, "Working together to deliver better care with the people of Islington", reflects a desire to develop more co-ordinated and person-centred care for our residents and to use integrated care to improve the overall health of our population.

Key aspects of our vision for better care include:

- Greater prevention and early intervention to prevent people becoming acutely ill or losing their independence
- Planning within a life course approach
- Supporting people to manage their own health conditions
- Personalised services with care designed around the individual
- A locality offer that brings integrated care closer to communities
- Improving care pathways, eg for long-term conditions, children, mental health and last years of life
- Facilitating those aspects of our work that make the vision possible – workforce development, contract form and information technology

We will know we have succeeded when we have:

- Improved patient/user experience
- Improved health and care outcomes and reduced health inequalities
- A sustainable health and care system with an efficient locality-based model of care and a lean acute provider sector
- A system that can manage growing demand so that our residents receive the right care, in the right place at the right time

The business case for integrated care focuses on 28,000 people or the **intensive users** of services with the following features:

- Over half are under 75 years old
- Saving £11m through reducing acute activity
- Investing £8.7m for the first three years to build community capacity
- Investment to develop new services for co-ordinated home and community care, earlier diagnosis and better management
- In years 2-5 evaluate impact, and where successful scale up across the system

13.3 What have been the highlights of your first year?

- **Understanding the local system** through risk stratification, systems resilience planning, collaborative work and a robust Better Care Fund (BCF) plan
- **Developing new ways of working** including proactive ambulatory care, an integrated community ageing team, proactive work with care homes across health and care , an integrated psychiatric liaison and assessment team, locality navigators and community paediatric nurses
- **Developing co-production and personal approaches** by linking personalised health and social care budgets, co-production, collaborative care planning and self-management
- **Developing a locality offer** learning from local pilots and eight 'test and learn' sites
- **Developing our enablers** including integrated information technology, a Community Education Provider Network (CEPN)
- **Developing new commissioning approaches**, for example value-based commissioning for diabetes and psychosis

13.4 Details of the year

Integrated care is one of four key strategies for Islington Clinical Commissioning Group (CCG). We have a board that meets bi-monthly with representation from across the CCG, the council, providers, local Healthwatch and the co-chair of the Making it Real Board (overseeing personalisation of social care) who is a patient and user of local services.

The headings below describe progress over the past year in a number of key areas.

13.4.1 Understanding the local system

- We have used a tool to risk stratify our population and agreed the target cohort. This is the top 2% at risk of hospital admission or long-term care plus those where clinical judgement highlights benefits from co-ordination
- Through our systems resilience planning we have "walked through" patient journeys from A&E, to wards and discharge to understand how patient flow works in our local system. This has led us to understand bottlenecks and to manage flow

- We have developed a collaborative approach across health and social care – bringing frontline staff together for learning as well as undertaking more detailed analysis when things go wrong
- Our BCF plan was developed in line with our integrated care plans

13.4.2 New ways of working

A proactive model of ambulatory care with pathways into the community enables people to be cared for at home instead of hospital, for example by administering IV antibiotics at home, a virtual ward and rapid response function. This has increased system resilience, for example, A&E performance in 2014/15 has been maintained at 2013/14 levels within the Whittington health economy.

New services to support integrated working include:

- The Integrated Community Ageing Team (ICAT) delivering a community geriatrician service. This is now extending from care homes to supporting older people in their homes.

Monthly total admissions to Whittington from Care Homes
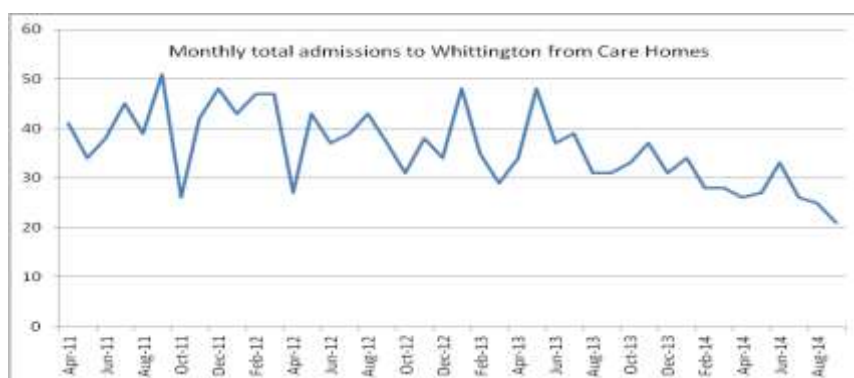
- Integrated Liaison and Assessment Team (ILAT) providing access to mental health assessment and treatment at A&E and on the wards, showing an excellent impact on length of stay and a downward trend in admissions and readmissions:

Oct 2014 - Sep 2015	Whittington Baseline (any MH diagnosis)	ILAT intervention
AVLOS (days)	5.56	2.59
Readmission rate	10.22%	2.27%

- Locality navigators – beginning January 2014, providing low-level support, advice and signposting to community services.

Building capacity in primary care including:

- Paediatric nurses providing support and advice to practices. Special areas include asthma, gastro-oesophageal reflux, constipation
- Community pharmacists employed to support medicines management for older people in the community – plans now in place to bring pharmacists into GP practices.

13.4.3 Developing co-production and personalised approaches

We have worked with social care colleagues to develop one point of contact across health and care for the personal health budget (PHB) offer. We now have 20 people using PHBs, the majority with continuing healthcare needs although mental health is now building. Eight GP champions have worked with us to develop our approach and to promote the offer to patients.

The joint Council/CCG Making it Real Board has operated for over a year and is co-chaired by a service user and the service director for Adult Social Care. An important part of this first year has been training up experts by experience. An action plan sets out key priorities for the group for 2015.

A new locally commissioned service covers all long-term conditions with the intention of expanding collaborative care planning and promoting supported self-management. This is using the principles of the House of Care framework that we believe has already made an impact (measured through the LTC6 questionnaire).

We have also rolled out of Patient Activation Measures (PAM) to help us to understand our population, people's ability to manage their conditions and to consider how to target interventions most effectively.

13.4.4 Developing a locality offer

- In 2014 we evaluated our multi-disciplinary (MDT) teleconferences in operation, discussing around 500 patients since November 2012. Early findings included:
    - 27% reduction in A&E attendances,
    - 25% reduction in inpatient admissions
    - 4% decrease in outpatient appointments
    - Evidence of patients feeling heard
- Piloting new approaches, for example, bringing together social care and community therapists to deliver co-ordinated care in the N19 postcode area, leading to a reduction in the number of 'handoffs' in the system and improved patient/user and staff satisfaction. See case study: N19.
- Developing a model of integrated health and care teams based on in eight GP practice test and learn sites. See case study: Locality model of integrated health and care.
- Developing a home from hospital model for children with agreed pathways into hospital services when needed.
- Through a mixture of quantitative and qualitative assessment we are trying to use a process of continuous quality improvement to understand what is working well.

13.4.5 Developing our enablers

- We want to develop three local IT solutions namely:

    - Integrated digital care record
    - Integration engine that will enable IT inter-operability (we are now at the point of commissioning this facility)
    - Person-held record

- Public and patient participation with a focus on overcoming barriers to access, co-production of care plans, and feedback informing commissioning.
- Launch of Community Education Provider Network in April. See case study: [Developing the workforce](#).
- New ways of commissioning for outcomes using value-based commissioning as a model – leading for North Central London to develop value-based commissioning approaches for diabetes and mental health.

13.4.6 Communicating with our partners and the public

A communications strategy with a weekly bulletin, an animation and public facing posters: (https://www.youtube.com/watch?v=M5-6d87ykhQ&feature=youtu.be)

13.5 What has been the most exciting aspect?

Being chosen as an integration pioneer site has generated a huge amount of energy among our partners and clinical leads. Senior-level interest has been instrumental in developing system leadership and partnership, moving us from a small "community of interest" to what we hope will be a movement for change. It has been great to see GPs and hospitals around the table.

13.6 What has been the most challenging aspect?

- Alignment of priorities across the system – financial challenge for some organisations has an impact on driving change
- Good quality local data – for example we have not yet been able to bring social care data into our risk stratification tool and find it difficult to understand impact across the whole system
- Governance – being clear what decisions can be made by the board, how financial and investment decisions are made and the extent to which the programme is driven equally by partners.
- Commissioning arrangements and provider models –supporting the development of primary care so that we build capacity for delivery is an iterative process and one which requires commissioner as well as provider leadership.
- Contract form – moving from traditional payment by results contracts to supporting integrated models
- Scaling up our locality offer – moving from test and learn to universal coverage.
- Cross border flows – work is beginning with other boroughs to understand the cross border flows, particularly in relation to our registered and non registered populations.

13.7 What are you planning to do next year?

- We will continue to build on the work of 2014/15 in order to develop a full locality offer. This will include:
  - A clear focus on prevention
  - Services that are person centred and support self-management
  - Community health and care wrapped around primary care

- o Proactive, rapid responses, with interface between hospitals and the community
  - o Developing a single point of access across health and care
- We have started the procurement for an integration digital care record
- We will develop workforce plans under the Community Education Provider Network
- We will be running a shadow year for our value based commissioning. We will build learning into the development of a commissioning framework for the locality

13.8 What is your advice for areas starting on their own integration journey?

Whole-system transformational change will only occur if we have the right leadership in place. We have found it invaluable to have mentoring/coaching support for the senior leadership team. Understanding financial issues is one area where the group will need to come together to explore implications in an open and honest way.

Through the pioneer programme we have had an experienced programme enabler who brings board members together to reflect, share and challenge – we know that if we want to shift the workforce to a new ethos and culture, we need to start at the top.

Clear communications – have a communications plan with different communication channels so that you are in constant touch with stakeholders and can keep up the energy for integration.

Co-produce with staff and patients/users – systems leaders have given the mandate for change, but change will only happen if it is co-produced with staff and users/patients.

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14 Case study: Islington – Developing the workforce through a community education provider network

In early 2014, Health Education North Central East London invited local areas to develop proposals to establish community education provider networks (CEPNs) – groups of primary and community care organisations that come together with partner organisations to collaborate with regard to workforce, education and training. The Islington CEPN was established in April 2014 for 12 months to pilot the concept to:

- Develop multi-professional education
- Streamline educational governance and commissioning arrangements
- Have a better understanding of primary and community workforce data
- Ensure that the education and training available is more closely tailored to the needs of local communities and aligned to service commissioners

Islington CEPN is led by Whittington Health as an integrated care organisation providing hospital, community and social care services. The membership includes the CCG, GP practices, Islington Council, community pharmacies, community service providers, acute providers, higher education institutions and the voluntary and community sector.

Since its establishment the CEPN's practical delivery has involved wider engagement from care homes, education institutes and voluntary sector service providers. Further work needs to be done to include community dentistry and community optometry within the network.

Delivery of person-centred care and integrated services requires a person-centred whole-system staff culture that cuts across organisational boundaries. Ensuring that staff from different services and organisations know about each other's roles and receive training that is aligned to local priorities is crucial to achieve this whole-system approach. CEPN workstreams include:

Islington workforce assessment modelling programme Thematic workshops have brought together health and social care staff to develop integrated workforce plans, training needs analysis and new roles/ways of working in relation to long-term conditions, children and families and mental health.

Care certificate A pilot training programme for healthcare assistants and social care support workers began in November 2014 and has been oversubscribed – this includes participants from nursing homes as well as community and other services.

Undergraduate nurse placements We are piloting undergraduate nurse placements in GP surgeries with the eventual aim of increasing the number of nurses entering General Practice on qualification – this is meeting some challenges, however, as primary care is struggling to free up capacity to provide mentoring.

Super hub for community nursing This involves plans to increase library access for all nursing staff and to update and improve the quality of clinical supervision and mentoring opportunities. It will also explore how apprenticeships can be used to

develop new career pathways across health and care. This will be particularly important in support of the work of the local Islington Employment Commission that reported in 2014.

These workstreams are being evaluated independently. Experience thus far indicates that the network has been a catalyst for change and has had a wider impact on the system than initially imagined, in developing an integrated approach to workforce development.

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15 Case study: Islington – N19: bringing together social care and community health services

The N19 pilot team was an innovative integrated care team combining health and social care in the N19 postcode area of Islington. The team was set up to test how some of the council's adult social care services and some of the Whittington Hospital NHS Trust's community services could work more innovatively together, to provide a better and more coordinated service for Islington residents. The team was tasked with finding a new approach to solving the problems of an uncoordinated and complex health and social care system.

Co-located in one building, the team carried out joint visits and joint assessments, guided by patient-led goals. Members of the team included social workers, support workers, district nurses, occupational therapists, a physiotherapist, a rehabilitation assistant, a mental health nurse and an administrator. Their key links included local GPs, access to intermediate care beds, pharmacists, voluntary sector organisations, housing support and hospital staff.

Patient Story – Mrs T

Mrs T is a 98 year old woman who was recently admitted into Whittington Hospital. A support advisor in the pilot team visited Mrs T in hospital and completed a social care eligibility assessment with her. The same support advisor supported Mrs T's return to her home, coordinated her reablement service once she was discharged and consulted with different professionals in the pilot team including the occupational therapist to ensure that Mrs T was receiving the support she required.

The support advisor brought in a physiotherapist and a rehab assistant to carry out therapy with Mrs T and completed a sheltered housing application to address her housing needs.

The support advisor said that "This way of working has worked really well as Mrs T has seen me throughout her journey. She did not have to repeat her story and I have been able to track her progress as I know what her function was like in hospital and now at home. I was able to identify and respond to her needs quicker than normal, bringing in colleagues as necessary, and the whole process has been much more coordinated and joined up. I know exactly who is involved, what they are doing for Mrs T and where she is at in her recovery."

The evaluation report for N19 found evidence that this way of working reduced the number of "handoffs" in the system and led to improved patient/user and staff satisfaction. During the year-long period, 909 people were seen by the team. Learning from this has informed the development of joint approaches between social care and community services provided by Whittington Health.

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16 Case study: Islington – Locality model of integrated health and care

In October 2014, a number of 'test and learn' sites were launched as part of the area's development of a locality model of integrated health and care services. This involves eight GP practices in two aligned pilots in Islington, one in the north locality, the other in the south west. In the south, the pilot is working with University College Hospital to find ways to improve the primary/secondary interface. The pilots build on multi-disciplinary work that has already been established through teleconferencing. The new face-to-face locality model recognises that the teleconferencing approach was not reaching as many patients as would be needed to make a significant impact on care.

The purpose of the pilots is to provide the opportunity for core teams including GP's, social workers, community matrons and mental health professionals to test new ways of working together. The integrated teams are intended to bring about improvements in the following areas:

- Rapid response
- Long-term case management/proactive care
- Supporting people to self-manage
- A health and social care offer to the whole population

The model based on integrated teams is designed to improve patient experience by:

- Providing care co-ordination with a shared care plan
- Providing a named professional who is the main point of contact for health and care needs
- Supporting skills, knowledge and confidence amongst patients through collaborative conversations
- Supporting patient-identified outcomes to deliver an asset-based approach
- Delivering care that is seamless, co-ordinated and proactive

During the pilot, impact is being evaluated through a framework that includes surveys to test soft measures as well as measuring outputs and outcomes. The NHS Energy Index has been used with staff to assess the level at which they are developing as a team as well as their "energy for change". The patient questionnaire has been developed by the Picker Institute. Reductions in admission to hospital and improvements in long-term care will be used as measures of success.

Early learning includes the value of having strong links with acute hospitals – in the south west of the borough the primary/secondary interface with University College Hospital is a focus for the work with proactive in-reach now being planned.

The role of the locality navigator has been brought into the core team and is providing benefit to both patients and staff in being able to make links with local voluntary and community services as well as offering opportunities for peer support The next stage of the programme will be to scale up and roll out the locality offer so that, "everyone providing care to the people in a locality of Islington will work

together to ensure we deliver what people want and need, with a strong focus on prevention and supported self-care". This will involve supporting the integrated health and care teams with additional function such as:

- A streamlined rapid response service
- An expansion of the offer from the integrated community ageing team so that older people living in their own homes can receive a comprehensive geriatric assessment and full care plan
- An enhanced offer into primary care from mental health clinicians, currently being piloted in the north locality
- Medicines optimisation for older people with the addition of two community pharmacists from January 2015
- Further enhancement of the locality navigator service expanding from the current two to a minimum of four navigators

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17 Kent Pioneer Programme – Profile

17.1 What is your area like?

Kent is a large county with a 1.5m population. The health of people living in Kent is generally better than the England average. Life expectancy is above average; rates of early death from heart disease and stroke and from cancer are below average and continue to improve. There are health inequalities within Kent. Swale and Thanet have the highest proportions of people living in deprived neighbourhoods. Swale has a lower life expectancy for women and Thanet for both men and women when compared to the England average.

Overall, the population of Kent is predicted to grow by 8.4% over the next seven years, representing an extra 123,000 people. The biggest increases are to be expected in the older age groups. This makes the work within Kent's Integrated Care Pioneer Programme and delivery of the Better Care Fund a key priority in ensuring a sustainable health and social care system.

Kent has seven clinical commissioning groups (CCGs), four acute trusts spread over seven hospital sites, one countywide community healthcare trust, one mental health and social care partnership trust and many third sector and voluntary organisations, including four hospices.

17.2 What are you aiming to achieve?

Health and social care integration in Kent is about improving outcomes for our population by transforming services locally so that they support independent lives, empower people and place a greater emphasis on the role played by citizens and their communities in managing care. We support the vision of the patient's/service user's perspective outlined in *Integrated Care and Support, Our Shared Commitment* May 2013:

> "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

Specifically, we aim to deliver:

By 2015:

- Fully integrated health and social care teams
- Proactive models of 24/7 community-based care wrapped around the GP as co-ordinator of care
- Access for patients to a shared care plan

By 2016:

- Access to services through local referral units
- Crisis and rapid response teams
- 'Hospitals without walls' in the community

- A continued focus on enablement, admission avoidance and crisis intervention

By 2018 we want to achieve an integrated system that is sustainable for the future and crosses the boundaries between primary, community, hospital and social care with services working together, along with voluntary and private sector organisations. There will be improved outcomes for our population, drawing on the 'Kent Pound' across the entire health and social care economy.

17.3 What have been the highlights of your first year?

- Developing a programme of proactive care
- Setting up an integrated rapid response service
- Setting up an integrated discharge team
- Extending the working hours and co-location at the weekends of our health and social care co-ordination team
- Intergenerational work towards dementia-friendly communities
- A shadow tariff and capitation budget
- Leadership development to support local leaders
- Developing a methodology for self care

17.4 Details of the year

In South Kent Coast we had set up a programme of proactive care for people with long-term conditions supported by a multi-disciplinary team (MDT) which has achieved reductions in A&E attendance and admissions, patient-reported improvements and savings of over £224,000. See case study: Embedding proactive reablement care.

An integrated enhanced rapid response service for West Kent began in November 2013 to avoid unnecessary hospital admissions and support people on discharge from hospital. The service is already achieving results. See case study: Developing an enhanced integrated rapid response service.

Since October 2013, a multi-disciplinary integrated discharge team has been up and running in North Kent. The team aims to reduce admissions, ensure patients' needs are proactively managed to reduce their length of stay and to enable patients whose medical conditions are stable to leave hospital in a timely manner. There is evidence that the team's work is reducing emergency admissions, A&E waiting times, improving access to mental health assessments and avoiding permanent care for people supported. See case study: Operating an integrated discharge team.

Health and social care co-ordinators are based in Canterbury and West Kent CCGs. They help co-ordinate activity around MDTs and between GPs and community services. In Canterbury the current service has had over 3,363 contacts, with 1,920 A&E attendances avoided and 1,443 admissions avoided over the year January 2014 – January 2015. The cost saving to the local health economy has been identified as over £200k. From April 2014 the service moved to extended working hours, included co-locating at the local acute site at weekends.

We have continued our work to build dementia-friendly communities – including work with local communities through intergenerational activity between schools and care homes with people living with dementia. This includes the creation of dementia diaries, connecting people through iPads and training workshops for paramedics.

As an early implementer of the Year of Care approach to funding, Kent has outlined what could be achieved through delivering whole-system transformation. We have established a shadow tariff and annual risk-adjusted capitation budget, based on people's levels of health care need (as opposed to what specific diseases they have) Year two of the pilot started at the end of the first quarter of 2013. Work has continued with the group of patients who had been identified in the first audit phase, to build up a longer-term picture of their care.

The Kent Innovation Hub was launched in December 2013 as a means of connecting stakeholders across Kent on the issues of integration: www.kent.gov.uk/pioneer.

In relation to information governance, we are mapping data sources for shared system-wide intelligence and will be continuing the development of shared data for commissioning

We have been working on ensuring that our workforce is fit for purpose in taking forward our integration work – this includes the innovative development of 'leadership of place', supporting local leaders within services, teams and on the front line.

> *"Since I have been part of the Health and Social Care Integrated Programme pathways work over the last year, I now take a different approach by thinking through the options and alternatives to hospital care – when in the past we sometimes took people to hospital when they didn't need to go."*
> **West Kent paramedic**

17.5 What has been the most exciting aspect?

Kent's approach to integration is about local delivery and, as it is a very large county, we are proud of having brought and kept all the stakeholders together in our Integration Pioneer Steering Group and having developed shared aims and objectives. We believe we have kept the momentum going for change focused on real outcomes for patients and services users because of the commitment of the very senior steering group members and because of regular communication with all those involved in the work programme.

We are aware that other areas may have found it challenging to engage with GPs, ensuring they are involved in developing the vision and plans for new models of care. We are very fortunate, therefore, that our steering group is chaired by a GP who is really focused on the vision, is passionate about it and is a strong advocate with other GPs.

17.6 What has been the most challenging aspect?

Bringing everyone together – it's challenging as well as exciting! We have had to work hard at building relationships between multiple partners.

As with other areas, it has been challenging to sort out information governance arrangements and we are hoping for some assistance nationally with this issue.

We have also requested support with arranging insurance for nurses; if a nurse is not working in a setting that is covered by crown indemnity or a traditional GP practice working under vicarious liability, they are very expensive to insure. The greater the level of independent working and decision-making, the higher the cost. This is a 'block' for going forward if we are to successfully implement more community based services.

17.7 What are you planning to do next year?

- Integration Pioneer Steering Group will be doing further work around leadership and developing work in relation to the models of care in the NHS Five Year Forward View
- Our Better Care Fund work will be very much about embedding local implementation – establishing different models of neighbourhood care teams etc
- Looking at evaluation, furthering our connections with European partners benefiting from the experience with similar issues across Europe: bringing the best practices and lessons learned to Kent through our (CASA) Consortium for Assistive Solutions Adoption Programme
- Kent Innovation Hub is at the forefront of the collaboration between Kent and its European partners to improve:
  - o Synergies between social and healthcare services towards integrated commissioning and provision
  - o Business modelling and proper monitoring by engaging industry and business
  - o Raising the awareness of the European institutions and stakeholders of Kent's successes and identifying opportunities for replication
- The Innovation Hub has the capacity to develop a number of policy instruments and measures bringing together synergies between public/private partnerships, research and development and knowledge transfer, venture capital funding, care providers and the business sector in the county and across Europe
- Implementing our shared care plan model
- The CCGs will be developing contracting and payment models, building on the work we have already done towards capitated budgets

17.8 What is your advice for areas starting on their own integration journey?

- Build in good communication; talk to each other regularly and ensure that you are all sharing the same objectives
- Keep focused on what this is about – improved outcomes for people
- Involve users and carers in the design and development of services or change

In developing our Innovation Hub to support integrated working, we used a number of motivational statements. We have found the following to be a genuine reflection of the reality of bringing together individuals and organisations to collaborate in transforming services:

"Innovations do not just happen – they are a team effort. Most successful innovation occurs at the boundaries of organisations and industries where the problems and needs of users and the potential of technologies are linked together in a creative and collaborative process that challenges both."

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18 Case study: Kent – Developing an enhanced integrated rapid response service

This service was launched in West Kent in November 2013 and has seen 4,000 patients in its first year. It involves support from a multi-disciplinary team (MDT) working with the ambulance service to ensure that people are not unnecessarily admitted to hospital and are supported on discharge from hospital. Key to the success of the service is the collaborative working between health, social care and ambulance services providing a fast response to patients. The MDT includes mental health and social care staff.

The service particularly targets people aged 75 and over and includes clinical treatment, rehabilitation and support, linking with reablement programmes. It focuses on enabling a person to stabilise and regain their independence and by helping them to remain safely at home. Case reviews have demonstrated that the scheme is enabling people with more complex conditions to remain at home, due to enhanced decision-making involving the full MDT.

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19 Case study: Kent – Embedding proactive reablement care

Proactive Care started in April 2012 in South Kent Coast Clinical Commissioning Group (CCG) locality. Each patient on the programme receives a holistic package of care aimed at improving the management of their long-term condition, including improving their confidence to self-manage after the programme. Patients are supported by a multi-disciplinary team (MDT) including GP, community matron, healthcare assistant, physiotherapist, occupational therapist, pharmacist, health trainer, care manager and mental health professional.

Evaluation from the first cohort of 134 patients demonstrated:

- 15% reduction in A&E attendances
- 55% reduction in non-elective admissions
- 37% of the cohort has reduced admission risk score
- Total saving to date £225,938
- EQ5D assessments completed to date show 75% patients reporting improvement in functional quality
- 86% of patients say they are no longer anxious about their condition from baseline of 46%

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20 Case study: Kent – Operating an integrated discharge team

Since October 2013, a multi-disciplinary integrated discharge team has been up and running in North Kent. The team aims to reduce admissions, ensure patients' needs are proactively managed to reduce their length of stay and to enable patients whose medical conditions are stable to leave hospital in a timely manner.

The IDT multidisciplinary team consists of:

Operational clinical lead Post leads the operational team, supports the planning process, improves integrated care and monitors results informing future strategy and operational activity.

Integrated Therapists and Falls Service Physiotherapists and occupational therapists working together in an integrated therapy team.

Specialist nursing services Proactively supporting patient reviews and joint assessments with the specialist teams in Darent Valley Hospital, both on the wards and within A&E.

Discharge coordinators (nurses) The nursing team work in the A&E assessing and treating patients and enabling same-day discharge where possible, in addition to supporting timely discharge from the wards.

Pharmacists All patients who need medical admission are seen by a team of doctors on the post-take ward round (PTWR). The presence of a pharmacist on the PTWR means that pharmacist interventions can occur at the time of prescribing. This also informs the pharmacist of patients' care plans and predicted discharge dates, facilitating prompt supply of medication at the point of discharge. This part of the service has been shown to be effective in supporting discharge and it has been agreed that the pharmacist will also work at front-end of the A&E, five days per week, supporting admission avoidance and timely discharge

Acute/community geriatrician The aim of this post is to work across acute and community settings, working in the A&E with the IDT, focusing on geriatric admission avoidance by carrying out a comprehensive geriatric assessment, providing prompt intervention and tailored support and discharge the same day.

GPs They work at the front end of the A&E identifying those patients who can be seen by primary care and discharged safely to primary care.

Case management Additional social care practitioners have been recruited to work in the integrated discharge team.

Additional psychiatric liaison A specialist mental health assessment service out of hours and weekends, based at Darent Valley Hospital, to reduce delays in treatment for people with mental health problems.

Achievements within the team to date include

- Multi-organisational work and multi-disciplinary work are much improved with a combined sense of purpose, better communications, sharing of information and data and a greater 'can do' attitude
- Anticipatory care plans are being developed for patients with long-term conditions, dementia and repeat presentations at A&E. These are now available on IBIS and accessible by SECAMB (South East Coast Ambulance Service)
- Dementia management support is much improved. The IDT now works with Alzheimer's and Dementia Support Services (ADSS), as well as other agencies, to provide integrated support for these patients, thus avoiding admission. ADSS provide support up to a month after discharge
- There is some indication that the length of stay for people over 65 and admissions following a fall are reducing, but this needs to be monitored as it may be a seasonal impact
- There is early indication that referral for long term placement is reducing
- Goal setting is improving with 95% of in-patients having an estimated date of discharge
- There is early indication that referral for long term placement is reducing.

20.1 Patient story – 1

A patient has had multiple admissions due to chest pain, with 15 attendances at A&E in one month. He was seen by an IDT nurse in A&E, and was assessed and referred to an IDT community cardiac specialist nurse who met the patient in hospital and explained the support that would be provided to him. This included access to specialist nurses, coping strategies, a medicine management plan and support to self-manage. The specialist nurses play a key role in educating and enabling patients about their condition. With this particular patient, that is what has made the difference to him remaining well in the community. He has been maintained in the community for seven weeks now without presenting back to A&E.

The idea going forward is to reduce the number of patients who present to A&E in the first place. A register detailing all patients known to have long-term conditions will be held by the IDT. They will all have anticipatory care plans which will facilitate an integrated approach to the management of each patient.

There have been many similar examples since the implementation of the IDT. Of 59 referrals received by the specialist nurses in March 2014, 20 were referred on to community matrons or were already known to them. All other patients were contacted by the specialist nurses and received varying levels in intervention/input. Three of these people are now using telehealth to support them and their clinician.

20.2 Patient story – 2

A patient with dementia was brought into hospital after being found trying to climb down scaffolding outside his flat. The IDT arranged for him to be medically assessed immediately and then to be seen by mental health / social care in A&E. The family

felt that they wanted to try supporting the patient at home as he had been in several placements.

The patient's mental capacity was assessed by the IDT and the assessment was agreed by the consultant psychiatrist. A best interest meeting was arranged (with family, consultant psychiatrist, social care and the IDT) to discuss the best outcome for the patient. It was agreed that social care needed to identify a residential home that would meet the needs of the patient.

Had the IDT not have been closely involved from the time the patient arrived in A&E, he would have been admitted purely for social reasons, due to the complexity of the situation, even though there was nothing acutely wrong with him that required a hospital admission. Work is ongoing on trying to prevent patients such as this gentleman from coming to A&E.

In summary, the IDT is beginning to work effectively across acute and community settings. Effective patient management decisions are being made either through face-to-face discussion or by telephone to expedite effective patient management. Integrated working is starting to show the benefit in relation to facilitated discharges both in all assessment areas, including A&E, and on the wards.

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21 Leeds Pioneer Programme – Profile

21.1 What is your area like?

Leeds is a city of innovation, drive and ambition which aims to be recognised as the best city in the UK by 2030. It is a large, modern and diverse city with a population of 800,000. Black, Asian and minority ethnic groups make up 18% of the population. General health and deprivation are worse than the national average with 150,000 people living in the most deprived neighbourhoods and with large gaps in life expectancy for both men and women. Obesity and smoking-related deaths in the city are also worse than the national average. Leeds is a city with demographic pressures at the youngest and eldest end of the spectrum, and a vibrant, transient and large student population, which brings further challenges for health and care.

Leeds has a distinctive health and social care ecosystem, bringing together local and national stakeholders from many sectors into a coherent strategic voice to improve health and wellbeing. The partners involved in the pioneer programme include three NHS trusts, one of which is Leeds Teaching Hospitals NHS trust the largest of its kind in the UK, three clinical commissioning groups (CCGs), two universities, the Leeds Institute for Quality Healthcare, private sector providers such as EMIS and TPP who provide the GP record system, and Leeds City Council.

21.2 What are you aiming to achieve?

Our vision is for Leeds to be a healthy and caring city for all ages. For that to happen, responsive person-centred integrated care must become the norm so that Leeds citizens experience high-quality and seamless care as opposed to the fragmented care many currently receive.

Our vision builds on the National Voices' work and local patient voices of all ages. It is focused on wellbeing, prevention and early intervention for all age groups. We recognise we need to address long-term public health issues to shift and change people's behaviours about their health and their relationship with local health and care services in order to deliver longer term transformational change as well as impact on the more immediate pressures on hospital and long term nursing home and residential care provision.

Our five asks of the national pioneer programme are designed to support the above, specifically:

- Freedoms and flexibilities: Leeds uses one 'currency' flow for money and data across all systems and sectors
- Health economics and analysis: Leeds' commissioners and providers are confident that current and new models of care deliver fully integrated services improving health outcomes and people's experiences of care, and benefitting the local health economy
- Risk underwriting: Leeds is an innovative city, leading the way in new models of commissioning and person-centred service delivery for integrated care which ensure the wider system shares in the benefits and risks of transformation and public sector reform

- Workforce: A highly skilled, flexible and committed integrated health and social care workforce delivering a quality experience for the people of Leeds
- Social marketing: Co-creating a narrative with the people of Leeds to understand the changing nature of services and service usage. This includes understanding what we want to achieve together, why it is relevant, and – most importantly – how it will improve the quality of experience for individuals, families and carers

21.3 What have been the highlights of your first year?

- Rolling out the Leeds integrated care record and developing 'citizen-driven health'. One important aspect of this is making health and care records digital. Leeds is a leader in this area of work. Currently around 87% of GP surgeries have access to the Leeds integrated care record, along with the hospital, including A&E. In time, this will be extended to local NHS and social care services and ultimately to individual patients
- Development of integrated neighbourhood teams across the city
- Launching the Leeds Innovation Health Hub and potential for the Leeds Intelligence Hub to develop innovative solutions and enable system change
- Leeds Assistive Living Hub is the new one-stop centre that houses a range of specialist services to support people with physical, learning and care needs to live safely and independently. The centre provides one place to find information and advice on what type of equipment and other assistive technology is available in Leeds. Leeds City Council is running the scheme in partnership with the NHS

21.4 Details of the year

21.4.1 Priorities for the transformation and pioneer programme

The following diagram sets out priorities for the five-year pioneer programme, which is discussed in more detail below.
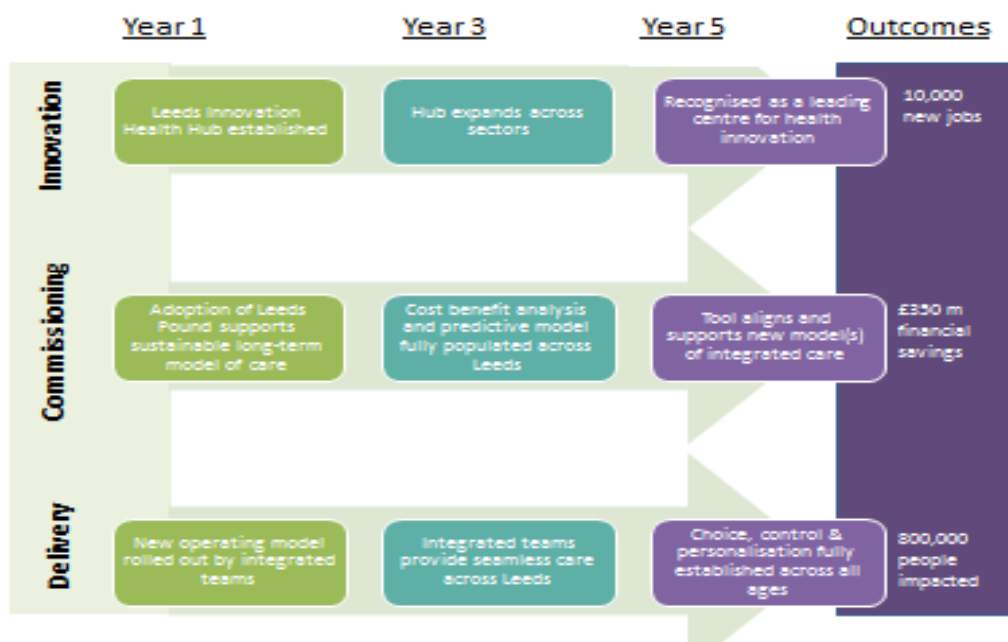
21.4.2 Innovation: Leeds Innovation health hub

The Leeds Innovation Health Hub was recently established to identify and drive innovation across all public and private partners and sectors, to support the transformation of frontline services. Leeds is working to become a 'Smart City' which maximises the potential of all its assets and resources to contribute to better lives and economic prosperity. This includes improving health, care and wellbeing outcomes by developing innovative technology based solutions.

An example of innovation is our push towards 'citizen-driven health' which seeks to use technology more innovatively to help people maximise their health and independence. See case study: testing models for 'citizen-driven health'. As part of the pioneer programme, we have also taken a leading role in a number of national informatics developments including:

- Leeds has volunteered to lead the informatics pioneer network and programme on behalf of the pioneer community, formed to identify barriers and drive improvements both locally and nationally. This network brings together local informatics leads and those from national NHS and other organisations including NHS England, Health and Social Care Information Centre, SOCITM, Local CIO Council, ADASS Informatics Network, and NHS IQ to collaborate on the innovative use of technology to improve outcomes and enable greater integration of health and social care. The pioneer informatics programme includes eight projects that all pioneers are collaborating on delivering to work as one with national health organisations to remove barriers to integration and develop simplified and shared solutions to be used by all and the learning from which disseminated to all areas of the country
- Representing the pioneers as a member of the National Informatics Board, ensuring a link between local pioneer work and national policy and strategy development
- Leeds is a pilot for the Care.Data programme
- Leeds has worked closely with Monitor to publish a guide to creating linked data sets

21.4.3 Commissioning: The Leeds Pound

To bring a sense of common purpose and to underpin partnership working, we have developed over recent years the concept of the 'Leeds Pound'. This is a move away from historic practices where each organisation works in isolation on how they spend their individual budget towards thinking of these budgets as the collective budget of the city and how this can collectively be directed to meet the needs of the people of Leeds. This work builds on a strong recent history of successfully delivering shared outcomes through pooled budgets within the Leeds health and care system.

As part of this, we are working to enhance our health economics to better understand the needs of Leeds citizens now and in the future, and how we can most effectively address them as a whole system. We are continuing to work closely with NHS England, Monitor and the Leeds Early Implementer for Year of Care pilot to

further develop and test our capability and capacity to analyse and model the current and future financial and economic needs of our local health economy.

21.4.4 Delivery: Building high-quality, easily accessible community provision

Called 'Better Lives through Integration', this adult social care led programme recognises the need to wrap community services around individuals, their families and carers, to provide a seamless quality experience. This programme is part of a whole systems approach which includes high-quality integrated health and care services. These include Leeds neighbourhood networks which are community based, locally led schemes that enable older people to live independently, and proactively participate within their own communities by providing services that reduce social isolation, provide opportunities for volunteering, act as a gateway to advice, information and services to promote health and wellbeing, and thus improve the quality of life for the individual. See case study: [Developing an integrated community health and social care service](#).

We have also continued to invest in community based provision to support a shift away from hospital and emergency care. One recent highlight has been the opening of the South Leeds Independence Centre in April 2013 by Leeds City Council, Leeds South East CCG and Leeds Community Health Trust respectively. It is a jointly commissioned and provided intermediate care centre in a community setting designed to provide reablement and rehabilitation to enable people to spend less time in hospital. Our ambition over the next five years, through continuous evaluation and learning from elsewhere, is that the people of Leeds will be able to access further community facilities of this nature.

21.5 What has been the most exciting aspect?

Leeds is proud of the work it has undertaken within the pioneer programme and nationally to chair the informatics and information governance agenda. We are delighted to build on the work of the Leeds care record by leading on the integrated digital care record project across the pioneers that will collaboratively develop shared requirements, approaches and standards for all care record solutions across the country.

21.6 What has been the most challenging aspect?

Leeds was excited and delighted about being awarded pioneer status. In its first year performance against these has been mixed, in part because the national pioneer support offer took longer than anticipated to mobilise and demonstrate a full understanding of our needs. The offer is now under review. For example it has recently proved valuable to have a manager seconded from the Department of Health to bridge local and national perspectives.

Some issues remain, however, particularly on information sharing, but we will continue to influence this agenda through active participation in the pioneer support group.

21.7 What are you planning to do next year?

- Re-examine the role of the pioneer programme in order to more closely align it with the Year of Care pilot and the Forward View implementation and new models of care
- Roll out our new approaches to informatics and reinforce Leeds' reputation as a digital city
- Further develop our work on the 'Leeds Pound' with NHS England and local universities
- Develop further our integrated neighbourhood teams' capacity across the city. See case study: Developing an integrated community health and social care services – development and evaluation
- Through the Year of Care pilot establish models of care and payment systems for 2016/17 and beyond
- Develop a city-wide health and wellbeing communications and engagement framework. This will involve work to better understand the levers for behaviour change such as people appropriately accessing A&E, and to communicate major reforms such as new care models
- Develop our proposals for devolution seeking a more resilient, sustainable local economy that is better able to meet the long-term health and other needs of Leeds citizens

21.8 What is your advice for areas starting on their own integration journey?

Our top tip is transformation and reform require long-term solutions and relationships and success will not happen overnight, even if you are a pioneer site. The expectations of the Leeds pioneer programme and nationally have been very high, and at times this has been a challenge for Leeds and national partners. We continue to remain optimistic. For 2015/16, we have recognised the benefits the first year of the pioneer programme has generated for Leeds and are refreshing our ambitions for 2015-2020, with all key partners.

We recognise that there is much learning to be gained from working closely with other sites. We are seeking to build on an informal partnership that has existed between Leeds, Greater Manchester and North West London since 2013. We are now looking to establish this as a formal learning network sponsored by the pioneer programme, and it is anticipated that the first meeting will commence in February 2015, with input from the King's Fund where possible.

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Web link:
http://www.leeds.gov.uk/residents/Pages/Health-and-social-care-integration.aspx

22 Case study: Leeds – Developing an integrated community health and social care service

Leeds started developing its integrated community health and social care service in 2012. The service aims to provide high-quality, person-centred, co-ordinated care for people with long-term conditions, older people and carers. It works in partnership with individuals to promote health, independence and wellbeing.

Key elements in the service are:

- Single point of access – the service is accessed through a gateway which provides triage to ensure people go straight to the right place
- Integrated neighbourhood teams – 13 teams work alongside GP practices to support practice populations. These bring together previously separate services to provide integrated case management, community nursing and community therapy; each team also has community geriatrician input
- Integrated independent living team – providing step-up and step-down reablement and rehabilitation to reduce the need for hospital admissions and care home placements, and help people return home from hospital safely
- Access to digital, shared information – Leeds Digital Care Record is in place across much of Leeds NHS, and is set to be rolled out to social care

Case management is a crucial element of the model. An appropriate professional from the neighbourhood team is identified to proactively co-ordinate care and support identified through working with the individual and their family. Case managers, working with other professionals, ensure that personal plans and goals are set on the basis of needs, preference and individual choice. To date over 1,000 service users have been supported successfully through case management.

It was recognised early in the integration process that much more needed to be done than 'lifting and shifting' previously separate teams and professions and expecting them to work seamlessly together. A programme of support was instigated to establish a 'one team' approach and to develop the model over time, based on learning. This programme included:

- Workforce redesign and development
- A baseline survey of staff, service user and carer perceptions of integrated services, undertaken by Birmingham University and the Social Care Institute for Excellence
- Setting up a case management outcomes framework

Ensuring that people who use services and carers are at the heart of service delivery is vital. Building on the baseline survey, Leeds University National Institute for Health Research has worked with Leeds to develop a way of capturing how service users and carers experience integrated neighbourhood teams, so their views can be used to drive improvements.

The Service User Feedback Framework for Improving Integrated Care – SUFFICE – has been produced. Key features include:

- National Voices methodology – using 'I' statements, from the perspective of the service user
- A simple schedule for interviewing service users
- Training for people undertaking the interviews (in the trial, 15 people were recruited from Leeds' older people's networks)
- A mechanism for producing composite stories from the data
- A protocol to enable teams to listen to a composite story, understand their contribution to the story, select areas for service improvement, and develop a service improvement plan

When trialling the framework, Leeds University found that the process helped teams to focus both on the things they did well and on areas in which they could improve. Sometimes, however, teams moved away from the service user story and began to focus on organisational and professional issues.

The SUFFICE project report highlights a number of observations and recommendations about implementing the framework and was shared with other Pioneer sites at a learning event. It can be found at the following link: http://medhealth.leeds.ac.uk/info/555/research/746/integrated_health_and_social_care_teams_designing_a_developmental_evaluation_framework

Health and social care partners across Leeds are currently working together on how best to use the SUFFICE framework so that it compliments integrated care and its ongoing development.

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23 Case study: Leeds – Testing models for 'citizen-driven health'

Leeds is working to become a 'Smart City' which maximises the potential of all its assets, including devices and technology, to contribute to better lives and economic prosperity. This includes improving health, care and wellbeing outcomes by sharing information and developing technology.

One important aspect of this is making health and care records digital. Leeds is a leader in this area of work. Currently around 87% of GP surgeries have access to Leeds Digital Care Record, along with the hospital, including A&E. This will be extended across the NHS, to social care when their new IT system is installed, and ultimately to individual patients.

Another important approach that Leeds is developing is 'citizen-driven health'. This uses the potential of new technology and shared information to support integrated working and self-care for people with long-term conditions. Citizen-driven health will allow individuals, carers, support networks, and workers from all sectors to work more seamlessly together.

The citizen-driven health approach is likely to result in better individual outcomes; it could also result in cost savings, through a shift in resources from acute care to support in the community. It is, however, a relatively new and untested field, so Leeds is running three pilots, testing out the approach with different cohorts and different types of device, commissioned from the independent sector. The cohorts are:

1. Older people who are infirm
2. People who are isolated and lonely
3. A long-term condition, possibly diabetes as a major factor in poor health

In the first pilot, people have been issued with simple tablet devices with the following functions:

- Recording professional input, such as a support worker recording their visit
- Remote access – allowing, for example, a relative to see if the district nurse has attended
- Condition-related information such as a reminder to take medication
- 'Circle of care' – a Facebook-style function allowing the individual to communicate with their support network

Most people have been able to use the devices, following training, and where people are unable to do so, relatives or support workers provide help.

Baseline data (such as unplanned hospital admissions and GP attendances) have been collected and Leeds University is currently working on an evaluation framework which will test outcomes for individuals and costs to the system to see whether the models provide a high quality, cost-effective alternative to more intensive care. The first two trials are expected to report mid-2015, the third later in the year.

A fundamental feature of citizen-driven health is that it is not about imposing top-down technical solutions on service users and professionals; instead it is about talking to people about their lives and goals, and developing technologies that will support them. The experiences of those involved in the pilots will be an important element in their evaluation, and shaping the future.

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24 North West London Pioneer Programme – Profile

24.1 What is your area like?

The area covered by the North West London (NWL) pioneer partnership incorporates eight London boroughs, containing very diverse areas of high deprivation as well as affluence. It therefore has a high level of health inequalities and includes almost every ethnic group represented in Britain. The NWL Whole Systems Integrated Care pioneer programme covers two million people and more than 30 organisations.

24.2 What are you aiming to achieve?

Based on what people in North West London have told us is most important to them, our vision for whole-system integrated care is to: "Improve the quality of care for individuals, carers and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their communities."

In working together to achieve this vision, we have made three key commitments.

- People and their carers and families will be empowered to exercise choice and control, to manage their own health and wellbeing and to receive the care they need in their own homes or in their local community
- GPs will be at the centre of organising and coordinating people's care
- Our systems will enable and not hinder the provision of integrated care

24.3 What have been the highlights of your first year?

- Establishing a model of co-design that involves partner organisations, frontline professionals, people using services and carers to develop a shared approach to tackling common challenges to joined-up, personalised care. This process resulted in the development of the North West London Integrated Care Toolkit, bringing together recommended solutions for population segmentation, outcomes and models of integrated care, governance, contracting and payment models.
- 'Early Adopter' projects are now being taken forward within each of our eight boroughs, to implement the framework co-designed and set out in the toolkit with plans to effect real change for patients and service users from April 2015.

24.4 Details of the year

The collaboration between North West London partners has operated at three levels:

- At local level, supporting planning within each borough in accordance with local context and local priorities
- Coordinating across North West London to pool collective experience, expertise and learning
- Beyond North West London, learning from other local places and national partners and contributing to the national pioneer programme

In the first phase of the whole systems programme from September 2013 to February 2014, over 200 professionals and lay partners from across North West London came together to generate common solutions for achieving our shared vision for joined-up, personalised care.

Absolutely central has been our process of co-design with patients and users of services. The term 'lay partners' was created by this group who felt that it signalled a commitment to parity of esteem between commissioners, providers and patients and service users in our programme. See case study: Working in co-design with lay partners.

An important part of our preparatory work was the development of an agreed methodology for segmenting our population into 10 groups based on need to enable new models of care designed for each group matched by a capitated budget. See case study: Profiling the population according to need.

At the beginning of 2014, partner organisations across North West London were invited to work together as 'early adopters' of whole systems integrated care, building on the approach set out in the toolkit and initially focusing on one or more population segment. New models of care would provide for the total needs of that population group, including their social care and wellbeing needs. As we learn by experience and from each other, it is intended that the models of care taken forward by early adopters will be refined and extended to other population groups and geographical localities. See case study: Supporting early adopter projects through an expert panel.

Aligning with and maximising the opportunities presented by other related national and local initiatives has been an essential part of the pioneer programme. This means ensuring that our three to five year vision for whole systems integrated care builds on the Better Care Fund plans agreed by each borough for 2015/16.

At the core of the North West London Whole Systems Integrated Care programme is the principle that GPs should be at the centre of organising and coordinating joined-up, personalised and proactive care – supported by wider networks of health and social care providers. Every practice in North West London is now part of a network for peer review purposes, and some networks are already coming together to deliver services.

Primary care co-commissioning is likely to be a key enabler for delivering the benefits we envisage for our service users and communities. It will also support improvements to primary care estates required for delivery of new and enhanced services.

Progress towards seven-day working will also be an integral part of movement towards integration, as the model is designed to meet people's needs at all times, not just on a 9-to-5, five-days-a-week basis.

Bringing together leaders from across local health and care systems, health and wellbeing boards for each borough will have a crucial role to play as we move to implementation in 2015/16.

24.5 What has been the most exciting aspect?

Working together at scale has provided a unique opportunity to bring together the progress and learning to date derived from a strong history of integrated working across NWL. The whole systems pioneer programme has enabled us to bring together hundreds of people, many of whom had not met before, and to use our people and resources to far greater effect. Early adopters working in each of the boroughs are learning from each other and provide an exciting opportunity to scale up what works so that benefits can be realised as widely and quickly as possible.

The whole systems integrated care programme has marked a fundamental shift in the way we have worked together based on equal partnership and a shared commitment to change. The journey towards co-production has had its challenges and has required trust, honesty and ongoing learning as patients and professionals adapt to working differently. It has led, however, to better solutions and caused us to challenge ourselves to new levels of ambitions for our NWL population.

Going forward, this principle of equal partnership should continue to underpin local implementation, with lay partners continuing to be involved at every stage as guardians and advocates for our person-centred vision.

24.6 What has been the most challenging aspect?

We know we need to work together to address four fundamental challenges to achieving the outcomes intended through whole systems integrated care:

- Enabling the significant cultural shift and changes to frontline ways of working required to take forward new models of integrated care with patients and service users who have been supported to develop their own new ways of relating to services
- Developing a new kind of leadership – one that sponsors joint working and collaboration across the health and care system, other public services and the voluntary and community sector
- Implementing a new integrated care record and data warehouse to make best use of data for direct patient care and planning services

24.7 What are you planning to do next year?

- By March we aim to secure consensus on the capitation model to be used in shadow form across the system in 2015/16. The ability to share health and care data appropriately across the system will be key
- From April next year, early adopters will begin to implement new models of care, with providers agreeing new ways of working together as accountable care partnerships
- NWL partners will work together to agree the person-centred outcomes to be achieved by accountable care partnerships and the metrics by which we can monitor progress in terms of improved outcomes, patient experience and system efficiency
- Some early adopters will begin to look at alignment of incentives across health and social care to start the shift towards an accountable care

approach. This will be critical to the delivery of the NWL person-centred outcomes

- We will continue to ensure effective governance, collaboration and shared learning within and beyond NWL

24.8 What is your advice for areas starting on their own integration journey?

- Co-design integration and new models of care, working with patients and service users so they are actively involved in shaping proposals from the beginning
- It's really valuable to facilitate time and space for people to come together with others across the system to think beyond their busy day jobs and beyond the current system barriers about how care could be delivered differently
- Acquire the ability to understand population need and to design new models of care in response, to track outcomes and support continuous quality improvement – these all rely on availability of accurate, timely data. Ability to share information is key. Population segmentation provides the foundations on which to build whole systems, focusing on need and outcomes, not on individual budgets and services
- The long-term journey towards integration requires resilience and trust between partners and actively nurturing of relationships and commitment to our person-centred vision

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25 Case study: North West London – Supporting early adopter projects through an expert panel

In North West London (NWL), there are 10 local projects in eight boroughs working to develop new integrated care services.

Joined by a single vision for how patients, carers and their families should experience care, each project has developed its own response to the challenges and opportunities it faces locally.

The scale and complexity of the integrated care transformation in North West London is almost unprecedented in the history of health and social care in England. Alongside the population size, high numbers of partner organisations and the geography, the NWL integration programme is a key component of the Shaping a Healthier Future transformation.

Achieving a degree of consistency in principles and approaches to whole systems local solutions is essential for co-ordination of the improvements to services taking place right across North West London.

In addition to continual engagement with projects and the development of tools to support implementation, an innovative event was held in June 2014 to offer local projects insights from local, national and global experts alongside lay partners from different boroughs.

At the two-day expert panel session, leading professionals from the US joined with NHS and local government leaders, colleagues from Monitor and NHS England to help develop the future direction of whole systems integrated care.

It offered the local teams working on transforming their health and social care services an opportunity to share their plans and gain invaluable feedback and support from some of the top professionals in the field.

All 10 of the early adopters gave presentations as part of a process of preparing detailed planning and implementation for the current phase of the programme. The presenters met with panel members to explain what had already been done to achieve the vision of whole systems integrated care and how the next steps would be undertaken to make integration a reality in local communities.

In Westminster, the project is working on delivering integrated services for adults with one or more long- term condition and for people over 65 years who are generally in good health. It is a partnership of Westminster City Council, the local clinical commissioning group (CCG), hospital trusts, GP networks, Age Concern and community health organisations.

Matthew Bazeley, Managing Director of Central London CCG, says: "We were particularly keen to use this as an opportunity to learn about some of the main challenges to making our model operational, including around the commissioning model and also the information required to support a different way of working. It was

a lively and productive conversation and so, for us, a very useful exercise which has helped us take our planning and thinking forward."

In Kensington, Chelsea and Westminster, older people who are usually in good health and those with one or more long-term condition are the focus of the project for whole systems integrated care. The project combines local hospital trusts, clinical commissioning groups, community health services, the ambulance service, three local authorities and voluntary sector organisations.

Louise Proctor, Managing Director of West London CCG, said: "Preparing for the panel and then having the opportunity to learn from a wide range of lay people and professionals has influenced our next steps in developing our ideas. The scale of our initial project may be small but we are testing out a model of care for all patients in the future."

Varsha Dodhia, a lay partner from Harrow, was one of the people on the panel to give a patient's perspective on the plans. She says: "A lot of people from across North West London, nationally and internationally came together and made a strong statement that we can do this. We face some large challenges in making the changes we want while maintaining a safe healthcare system. But there was a lot of energy at these sessions and a very positive outlook on the challenges we face together."

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26 Case study: North West London – Working in co-design with lay partners

From September 2013 to January 2014, more than 200 people from across the North West London health and care system came together in regular working groups to discuss the challenging design questions that needed to be answered sequentially in order to achieve the partners' vision of integrated, person-centred care.

This co-design process was central to the process of testing ideas and generating an agreed set of options for North West London. For the partnership, co-design has meant an inclusive and collaborative process bringing together patients and service users, clinicians and care professionals, commissioners and providers to contribute to the future of integrated care. A key principle has been the need to incorporate the holistic lived experiences of people using health and care services with the professional expertise of clinicians and care professionals. Partners wanted to move beyond the traditional boundaries of "consultation" or "patient engagement" to achieve genuine co-production at every stage of the process from design to delivery. They believe that equal 'lay partner' involvement throughout a person-centred process is essential to ensuring successful and sustainable integrated care across North West London.

All of the module working groups had equal lay partner representation (some lay partners have acted as working group co-chairs) and in addition lay partners have been involved at every level of programme governance. A lay partners advisory group has met on a bimonthly basis to consider programme-wide issues and provide advice and challenge. Involving lay partners in this way has not only facilitated consensus around solutions going forward but has also led to more creative and effective ideas for the future of the system.

Michael Morton became co-chair of the group alongside Professor Lis Paice after gaining experience representing patient views as an active member of the integrated care pilot which preceded whole systems.

He cites the development of North West London's policy and principles of co-design and co-production together with the toolkit as the lay partners' biggest achievements to date. He says: "We've all felt like highly respected members of the team. We are very well received from the professionals we have worked with. We've found that the patient perspective can often help bring about shared understanding where professionals with different opinions may have disagreed. In some cases we acted as arbitrators of these different viewpoints and that contribution was much appreciated. So, all in all, we feel we've made a very valuable contribution in bringing the patients' perspective and concerns to the development and progress of integrated care in North West London."

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27 Case study: North West London – Profiling the population according to need

People's needs do not always fit neatly into different services or along organisational boundaries, yet it is left to them to navigate their way around a disjointed and duplicatory system. A key tenet of the approach to integrated care co-designed by North West London (NWL) partners is the importance of organising care on the basis of a person's needs, rather than fragmented across different services, budgets and disease pathways.

Over several months in late 2013, a working group bringing together commissioners, providers, professionals and service users considered options for grouping the NWL population in a way that could incentivise a more personalised, holistic response to the needs and circumstances of each individual. This work drew on patient and professional judgment, evidence and research about models used elsewhere, and detailed analytical work using an integrated dataset from Hammersmith and Fulham. It resulted in a co-designed model to segment the population into 10 distinct groups based on common health and care needs. Within each group, support to every individual will be tailored to their personal needs, aspirations, circumstances and capacity for self-care and self-directed support.

Nicola Burbidge, GP Chair of Hounslow CCG, was one of the system leaders behind the population segmentation initiative. She says: "When we started it was a completely novel concept. It was new to everyone involved – lay partners, the boroughs, commissioners and providers. What was remarkable was that a group of people using post it notes and discussing how to group the local population came to conclusions that were 90% the same as the results from in-depth statistical analysis. That made it feel like it was the right way to go about how we treat people and, therefore, how we commission services for them."

Early adopter partnerships in each of NWL's eight boroughs have been designing and developing new models of integrated care, focusing on one or more of the 10 population groups. As early adopters implement and learn about what works best, the whole systems approach can be extended to other population groups.

As well as informing the design of new models of care, the NWL population segmentation model will also form the basis of a new capitated payment approach. Groups of providers (accountable care partnerships) will assume joint accountability for the health and care needs of a population group, to be met by a global capitated payment allocated for that group (ie a payment based on an average cost of care for a member of the group multiplied by the number in the group), and will share the associated financials savings and risk. Capitation encourages coordinated, preventative care and a focus across the whole care pathway, giving providers the flexibility to innovate to achieve an agreed set of outcomes for the target population group. Moving to a capitated system is complex and challenging and NWL partners have been undertaking focused work to develop and refine their approach. This includes work in collaboration with other local places and national bodies, in particular Monitor through its integrated care payment forum and work on profit/loss sharing mechanisms.

Population segmentation is vital to NWL's plans for implementation of whole systems integrated care and provides the potential to look beyond health to include outcomes for people's overall wellbeing.

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28 South Devon and Torbay Pioneer Programme – Profile

28.1 What is your area like?

The area served by South Devon and Torbay Clinical Commissioning Group (CCG) stretches from the south Devon coastline to Dartmoor, covering 286,000 people with 35 GP practices. Southern Devon is a rural area four times the size of Torbay and is made up of small towns, villages and hamlets; Torbay is more urban.

About 25% of the population of South Devon and Torbay is aged over 65. Today, in England, 2.2% of the population is 85 or over. Torbay reached this level 31 years ago. By 2021, the rate for England will be 2.9%, but 4.9% in Torbay. South Devon's population is ageing, too, at a much faster rate than the national average. Inequalities in life expectancy result in a seven-year life expectancy gap and 17 years more for some of expected ill-health. In South Devon and Torbay this could represent a cost to our system of £150m-plus per year. Our pioneer and integrated work also addresses inequalities at the other end of the life course including numbers of children on protection plans or in looked after care, which in Torbay are among the highest in the country.

On Dartmoor we see rural isolation, with poor transport links and more difficult access to services. Suicide rates are falling in Torbay but those of self-harm are not. Housing problems for many are acute. There is much to do to reduce alcohol misuse. In the moorland area of south Devon we see higher than average rates of fuel poverty.

28.2 What are you aiming to achieve?

As a joined-up health and care community, South Devon and Torbay has left behind the disease-based and reactive model, with an agreed vision to focus on wellbeing, prevention, self-care and reablement, always striving for maximum independence – so that over their life course the people of South Devon and Torbay can start well, develop well, live and work well, age well and die well.

We foresee a reformed and vibrant primary care model integrated with the community in the widest sense – with the whole spectrum of health and care but also with the voluntary and community sector offering support for self-care and peer support. At the centre is a smaller acute hospital offering leading-edge, highly specialist care – not when all else fails, but only when all else could never have succeeded.

For some years before the integration pioneers' programme started, we had been working towards integrated care and we are beginning to see results.

- The number of residents supported by Torbay Local Authority in residential care placements as on 31 March of the year reduced from 739 in 2011 to 663 in 2014
- The number of residents supported by Torbay Local Authority in nursing care placements as on 31 March of the year reduced from 90 in 2011 to 74 in 2014

- The number of Torbay Local Authority supported permanent admissions to residential and nursing care in the 18-64 age group reduced from 49 admissions in 2010/11 to 29 in 2013/14
- The number of hospital admissions from care homes in South Devon and Torbay has reduced to 769 admissions so far in 2014/15 from 849 admissions in the same period in 2012/1313 – a reduction of 9.42%

The graph below, from Devon County Council, shows the reduction in long-term care home placements since the introduction of joined up intermediate care in southern Devon (includes western area):

Southern Res/Nurs monitoring
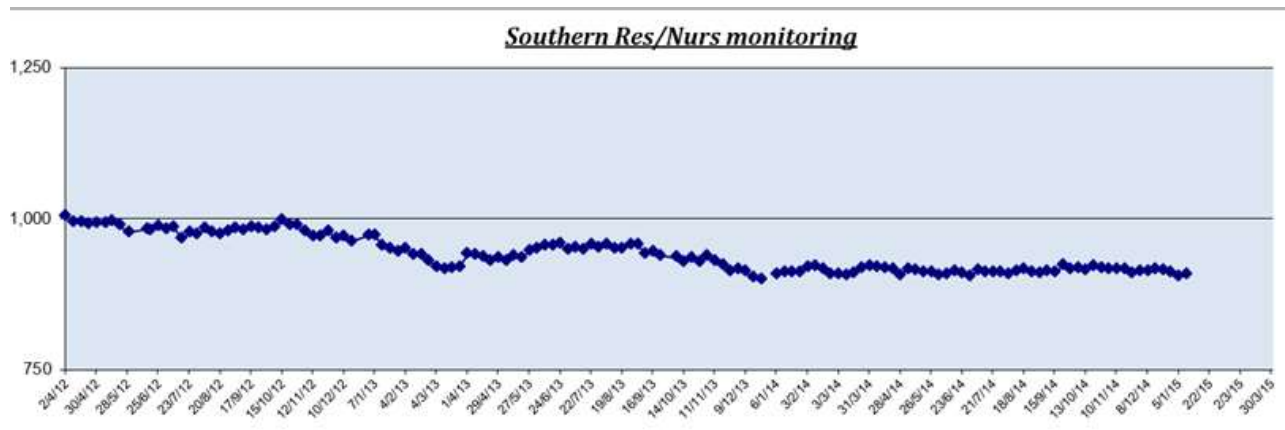
The above is a snapshot indicating that the care being delivered to our imaginary representative, 'Mrs Smith', is changing.

More widely, we are proud of our progress so far, but we now need to tackle the rapid, whole-system transformation required to make our vision a reality for all our residents. Our current challenge is to extend our integrated health and social care for adults across the whole community. We want to offer everyone the same seamless, multi-disciplinary working, strong relationships, culture of holistic care and care co-ordinators across two local authorities.

28.3 What have been the highlights of your first year?

Shared values are the starting point for integrated working. In January 2012, leaders of the whole health and care community formed the JoinedUp Health and Care Cabinet, with the agreed commitment to deliver 'high-quality, reliable and joined-up health and care which puts people first'. The cabinet includes a voice for people who use services. We have established a JoinedUp programme board to take forward and oversee the implementation of ideas from the JoinedUp Cabinet; and we have recruited a programme lead for delivering transformed services.

Our plan for the first year of the pioneers programme had four elements:

- Establishing a children's hub, for children and their families
- Setting up a Newton Abbot frailty hub
- Taking action to make mental health integral and mainstream within our integration programme

- Building the resilience of the community and voluntary sector

28.4 Details of the year

28.4.1 The Newton Abbot Frailty Hub

The hub provides services for the top 2% of high-risk patients (around 1,000), identified by means of a predictive model, building on our well-established virtual wards. The aim is to support people to live and age well, with multi-agency wrap-around support. The hub will be working next year with the community and voluntary sector to identify and support 'pre-frail' patients as well. See case study: Newton Abbot Frailty Hub.

28.4.2 Mainstreaming mental health

The medical director of our mental health trust is a member of the JoinedUp Board. Progress to date includes:

- Introducing GP link workers between GP surgeries and community mental health teams (CMHTs) and closer relations between mental health consultants and GP practices
- All in-hours referrals now come through a single point via the Devon Referral Service and work is under way to ensure a single point of access for out of hours referrals.
- A multi-agency integrated psychological therapies group with representation from people with experience of using psychological therapies meets monthly to design improved access to and patient experience of, psychological therapies
- A series of engagement events with people and carers who use adult mental health services in response to which the following services were commissioned:
  - A crisis house providing short-term intensive support. See case study: Corner Retreat Crisis Service
  - Step-down beds
  - A court liaison and diversion service
  - A street triage pilot working with the police
  - A perinatal mental health service
  - An integrated dementia care pathway

28.4.3 The children and families hub

The hub focuses on a number of deprived neighbourhoods in the locality. It has clear governance arrangements developed through the community-led Health and Neighbourhood Development (HAND) Group. There are three workstreams:

- **Single point of access** This brings existing resources together with a single access point for information and advice, a call centre drawing on a shared directory of services, an e-hub gateway and a shared website with App functionality. A 'social prescribing' model started on 12 January 2015 targeting overweight and obese children in the 5-11 years range. See Case Study: Developing Social Prescribing.

- **Building community capacity** Funding has been secured to create a neighbourhood development plan focusing on reducing social isolation and improving the health and wellbeing of children and families living in poverty. A 'Timebank' scheme with members of the community sharing their skills and experience as buddies and peer supporters has been launched.

- **Workforce** Plans to co-locate public health nursing and the lifestyles service (commissioned by public health to support self-care and management of conditions) with peer support in surgeries, community centres and schools are in development. A successful funding bid allows us to train community voluntary sector staff in guided conversations and we have submitted a further funding bid for non-professional care co-ordinators.

  To support primary care, we are developing the physician's associate model with Plymouth University and exploring the use of pharmacists to support patients with long-term conditions. Working closely with Health Education England South West, we've achieved significant funding to transform the workforce. For example: accelerated learning to consider strategic reform, and local funding to develop 'care coaches' to guide local people towards community wellbeing assets.

28.5 What has been the most exciting aspect?

Cross-organisational leadership is a hallmark and significant strength for South Devon and Torbay integration plans. Building on the success of our strategic, 'blue-sky' Clinical Cabinet (a unique group existing since 2011), we formed the Pioneer Board (known as the JoinedUp Board). The board includes chief executives, medical directors and their equivalents across the public and voluntary sectors of the patch and they are absolutely focused on delivery of the pioneer (JoinedUp).

We now have two major lead groups for the pioneer. The cabinet retains a strategic and innovative approach and includes a very wide range of clinical and non-clinical people from across our system, and the JoinedUp Board takes lead accountability for areas of work, and for connecting with other organisations, such as housing, the Department for Work and Pensions and criminal justice. We used the pioneer systems leadership funding grant to offer specific strategic development to the JoinedUp Board in 2014, and this has significantly contributed to the shared vision and drive for Pioneer in South Devon and Torbay.

We are also pleased that the commitment to collaboration has resulted in a risk sharing agreement between the CCG, Torbay Council, the hospital trust and the community health and care trust. With the CCG taking delegated responsibility for commissioning the South Devon aspect of social care for Devon County Council. We believe that this will facilitate the development of integrated health and social care across South Devon and Torbay and the improvement of services by aligning financial incentives with our overall objectives

Working with people in the community has been very rewarding. We are working with Torbay Community Development Agency on their Ageing Better Big Lottery

programme which will reduce loneliness and isolation by building on the strengths of our communities to support each other through guided conversations and time banks. Patients and service users are involved in co-production and design of services and their evaluation through groups such as Torbay Voice, Experts by Experience (South Devon and Torbay group of patients and service users), carers' services and Teignbridge CVS.

28.6 What has been the most challenging aspect?

While the development of an integrated care organisation is a building block to our pioneer programme plans, there is little doubt that the cost of integration may prove a challenge to investment in other areas, at least in the first two years. This relates not only to the project costs of set-up, but also to the cost of managing integrated services until such time as transformation really does release savings.

We have found it very difficult, in the context of financial pressures, to keep 'business as usual' going while introducing new ways of working and delivering services. We would like to have seen more allowance in the pioneer programme made for double running of services.

Seven-day working is a central tenet of our pioneer aims. This will be difficult to achieve without national resolution of changes to the consultant contract, which is key to local change. Similarly, we find that some national workforce policies (for example community placements for F2 doctors) do not well support seven-day working. We would welcome national support to ensure that future workforce planning and policy is more joined up.

Being a pioneer has however, helped us to work at a national level on overcoming IT and information governance. Locally there is an IT sub group of the JoinedUp Board. This group makes recommendations on an integrated approach to IT and information and oversees an information sharing group and implementation of a work plan which drives the development of an integrated IT system.

Following an extremely successful information sharing event, a cross-organisation information sharing toolkit will be launched in February. Data sharing agreements are already in place to support the Newton Abbot Frailty hub, flu clinics and Devon Doctors to work effectively and have the information they require when they need it.

28.7 What are you planning to do next year?

- Prioritising prevention and promoting independence, for example by rolling out our frailty service to all localities
- Developing our whole model of care towards becoming an integrated care organisation, using the Better Care Fund and pooled budgets to support this work

28.8 What is your advice for areas starting on their own integration journey?

It is absolutely vital to establish joined-up leadership and explicit commitment to integration at the most senior level from the start. In South Devon and Torbay this has been greatly helped by the development of a narrative about what real integration could mean for ordinary people who use services. We have used the longstanding example of an imaginary, representative, elderly Mrs Smith and introduced her carer daughter and troubled teenage grandson Robert to help shape our vision and as a constant reminder of who will benefit from improved and integrated services.

It is very important to have a single programme of work that pulls together all the projects that will lead to integration. Otherwise there is a danger of gaps, duplication and confusion.

We believe our efforts in taking the workforce with us have been well worthwhile. It is important that frontline staff own and 'buy-in' to the JoinedUp programme because without them the programme will not succeed. This includes finding ways to give staff permission to innovate and work differently, for example by relaxing the key performance indicators to which they work. We have also worked with specific staff groups, using coaching methodology, to embed the way we want to do business.

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29 Case study: South Devon and Torbay – Corner Retreat Crisis House

Corner Retreat is a newly developed service for people experiencing significant levels of distress where a period of support away from their home environment will prevent the need for acute hospital admission. The service, which opened in November 2013, is delivered in partnership with Devon Partnership Trust CRHT and Community Care Trust.

The house currently provides short-term (up to 7 nights) intensive 24-hour support to people who are assessed by the Torbay and Teignbridge Crisis Teams as needing additional support to avoid an admission to hospital. In collaboration with the crisis teams, the project is able to offer a holistic package of support in a safe, comfortable and supportive environment without the stigmatising effects and restrictions of a hospital admission.

Corner Retreat is a large five-bedroom house in a residential area, without external signs of being associated with mental health services and has the capacity to support 260 people annually. It is staffed 24/7 by a team of seven support time recovery workers and a project manager. The team offers a support package that considers the individual's needs.

The staff team seeks to promote understanding into what may have led to, or contributed to, the person's crisis, then to work alongside the individual to learn strategies aimed at their ongoing recovery, and avoidance of future hospital admissions. The team engages with the individual at a point of significant mental distress and focuses on promoting and maintaining mental wellbeing. Each person is given a welcome pack on arrival, and allocated staff to support setting personal recovery goals. During someone's stay they will have an opportunity daily to spend one-to-one time with the support staff and appropriate access to the crisis team. This is all undertaken in a comfortable, safe environment that promotes the involvement of the person in the recovery of their mental health.

On departure each person is provided with relevant information or signposting to services available to them in their local community.

29.1 Corner Retreat versus hospital admission

Corner Retreat offers:

- A higher staffing ratio enabling intensive support to be offered
- A homely environment, less stressful for the person and their family
- Individualised support and care planning
- Personal space and privacy (every person is given their own room with key, and an agreed plan around support)
- An open door policy giving everyone the freedom to leave when they choose
- Support to achieve and maintain daily living skills, such as preparing drinks and meals and doing personal laundry
- Signposting to a wider community support service

Since opening its doors in November 2013 Corner Retreat has accepted 15 referrals, and up to 90% of those using the service were successful in avoiding a hospital admission, and were able to return home.

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30 Case study: South Devon and Torbay – Developing social prescribing

Social prescribing is a means of enabling patients with social, emotional or practical needs to be referred to a range of local, non-clinical services, often provided by the voluntary and community sector. Patients will have a guided conversation with a social prescribing co-ordinator to discuss their needs. It is hoped that social prescribing will provide the following benefits to patients:

- Improved health and wellbeing
- Support for a health and lifestyle change
- Improved self-esteem and confidence
- Offer of accompanied visits to services and community activities
- More specialised local knowledge
- Allowing time to be heard

A local pilot started at the beginning of January in Torquay with Chilcote Surgery for children, families and isolated older people living in Hele, Watcombe and Barton. It involves collaboration between GPs, a range of voluntary sector organisations and the public-health commissioned Healthy Lifestyles team.

When patients with low emotional health and wellbeing present to their GP, under the social prescribing scheme they will be referred to a 'social prescribing co-ordinator' who will arrange a guided conversation and the completion of an outcome star (a tool for supporting and measuring change). Individuals and families will then be signposted to a range of voluntary sector organisations, community centres and churches. If more support is needed they will be referred to a buddy service or if a public health need is identified to the Healthy Lifestyles team. If higher-level support is needed, for example if safeguarding issues are identified, a referral will be made to the early help panel, which provides an access rout to statutory children's services. If a health need is identified, they will be referred back to their GP.

After three weeks, the social prescribing co-ordinator will phone the patient to check on progress and see if any other support is needed. A more formal follow-up will take place after six weeks when a second outcome star will be completed.

The evaluation of the Torquay hub will incorporate a longitudinal study over two years and include qualitative interviews and observations with staff and community members running alongside quantitative measures. Measures include:

- Improved ability to self-manage / build resilience among families
- Reduction in smoking in pregnancy
- Increase in breastfeeding rates
- Reduction in childhood obesity
- Improved rates in school readiness
- Reduction in in referrals to CAMHS (in particular for self-harm)
- Number of children on a child protection plan
- Number of children looked after by the local authority
- Emergency contact in relation to alcohol

- Emergency contacts in relation to domestic violence

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31 Case study: South Devon and Torbay – Newton Abbot Frailty Hub

The hub provides services for the top 2% of high risk patients (around 1,000) with the aim of supporting people to live and age well, with multi-agency wraparound support. It integrates the reactive and the proactive (the virtual ward) care of the most frail by building on the already established complex care hub.

There is a single point of contact and a single-assessment document with all members of the multi-disciplinary team (MDT) having access to the patient's records. Joint health and social care co-ordinator posts have been created. Newton Abbot GPs have been providing a seven day service since the end of October 2014. They are fully mobile, have access to every patient's records and are able to print out prescriptions from their cars. A GP with special interest in frailty has been in post since September 2014 and is running daily MDT meetings to discuss complex patients. There is support from a geriatrician and the MDT includes palliative care, social care, mental health and pharmacy. Teign Community Voluntary Services hs located a post in the frailty hub to signpost and support those who do not meet eligibility for statutory services. The outcomes aimed for include:

- Improved experience of care for patients and their carers – using 'I'm Still Me' 'I statements', collected by Senior Voice and Healthwatch
- Reduced avoidable emergency admissions and A&E attendance
- Reduction in permanent admissions to care homes (national indicator)
- Reduction in temporary admissions to care homes (local indicator)
- Primary care contacts for elective admissions
- Mortality measure
- Referrals for elective admission
- Experience of care delivery and contact (service user/carer perspective)
- Activation and self-management (where appropriate)
- Experience of care delivery (staff perspective)
- Organisational checklist to monitor person centred integrated care (PCIC) activities

Initial feedback has been overwhelmingly positive – GPs report that the majority of calls have prevented an admission, and no patients have refused consent for the GP to view their records.

The flow chart below shows the referral process.

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┌─────────────────────────────────────────┐
│ Patient Identified for proactive         │
│ management within the Frailty Service    │
└─────────────────────────────────────────┘
                    │
                    ▼
┌─────────────────────────────────────────┐
│ GP Completes SystmOne Referral Template  │
│ and sends email to Frailty Service       │
│ Co-ordinator                             │
└─────────────────────────────────────────┘
                    │
                    ▼
┌─────────────────────────────────────────┐
│ Responsibility of care becomes shared    │
│ between Frailty Service and GP           │
└─────────────────────────────────────────┘
                    │
                    ▼
┌─────────────────────────────────────────┐
│ Discussed at next MDT meeting.           │
│ Comprehensive assessment process         │
│ initiated                                │
└─────────────────────────────────────────┘
                    │
                    ▼
┌─────────────────────────────────────────┐
│ Agreement reached regarding appropriate  │
│ professionals to assess patient.         │
│ Agreed date for next MDT review          │
└─────────────────────────────────────────┘
                    │
                    ▼
┌─────────────────────────────────────────┐
│ Patient visited (joint visits           │
│ encouraged where appropriate)            │
└─────────────────────────────────────────┘
                    │
                    ▼
┌────────────────────┐        ┌──────────────────────┐
│ MDT review as      │ ─────▶ │ Patient stabilised,  │
│ planned            │        │ optimisid and        │
└────────────────────┘        │ interventions        │
       │        ▲             │ complete             │
       ▼        │             └──────────────────────┘
┌────────────────────┐                   │
│ Interventions      │                   ▼
│ instigated         │        ┌──────────────────────┐
│                    │        │ Patient discharged   │
│ Specialist input   │        │ back to GP           │
│ as needed          │        └──────────────────────┘
└────────────────────┘
              ┌──────────────────────┐
              │ Interventions        │
              │ instigated           │
              │                      │
              │ Specialist input     │
              │ as needed            │
              └──────────────────────┘
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The hub model will be rapidly rolled out to each locality following initial evaluation. Plans for the hub have been developed alongside integrated care organisation plans for a frailty specialist unit at Newton Abbot Hospital so that services complement each other.

Phase 2 of the hub will be working next year with the community and voluntary sector to identify and support 'pre-frail' patients as well. It will focus on prevention and the wider determinants of well-being.

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32 South Tyneside Pioneer Programme – Profile

32.1 What is your area like?

South Tyneside is a compact area with a population of 150,000. It has high levels of income deprivation and social isolation in older people, and a high percentage of people living with long-term conditions, cancer and cardiovascular disease. Many people do not actively seek support and are dependent on statutory services at times of crisis. Many engage in multiple 'unhealthy behaviours' such as smoking, poor diet and no exercise. Communities in South Tyneside, however, are strong and supportive, and have many assets which can be built on to improve health and wellbeing.

Local demographics are as follows:

- 26,853 older people (18% of population – above average and growing)
- 9,973 older people live alone in South Tyneside (37.1% of the total)
- 50% increase in dementia across all ages by 2030
- 23% of older people have long term conditions or disabilities that limit day-to-day life
- 10,132 older people are living in deprivation (29th out of 326)
- Increasing numbers of under-65s with learning difficulties or disabilities

Partners involved in our integration programme include the council, clinical commissioning group (CCG), acute hospital trust, mental health trust and the third sector. As in similar areas, the local authority and the NHS are facing severe financial constraints, but local partners have a long and successful track record of working closely together.

32.2 What are you aiming to achieve?

We want more local people to live longer, healthier and more fulfilling lives. We think better-coordinated health and social care services can make a real difference here, but only if we make radical improvements in how people are encouraged and supported to take better care of themselves.

Our integration board leads our work on health and social integration and by working with patient groups and frontline staff developed this vision:

> *"I can promote my own health and wellbeing by planning my care & support with people who work together to understand me and my carers, allow me control and bring together services to achieve the outcomes important to me"*

Integration Principles

We will impose a person perspective throughout our work	We will manage the organisational consequences of being person-centred	Our staff will not automatically reach for traditional solutions	We will develop our staff jointly, not separately

Building on these principles, 'Integrated South Tyneside' is our plan to join up local health and care services so that people receive a single, seamless service based on personalisation, prevention and self-care.

There are five workstreams; the first four involve structural integration:

- Integrated community teams – integrating and streamlining health and social care services around clusters of GP practices across the whole borough.
- Integrated care services hub – a £30m partnership between the council and foundation trust to house all dementia services in one new facility
- Urgent care hub – streamlining and consolidating A&E and urgent care into one place with accessible support services
- Change4Life wellbeing model – integration of various health improvement programmes into one accessible package of support

The fifth strand, and the focus of the pioneer programme, is a medium to long term programme of fundamental cultural and behaviour change for staff and residents, based on the concept of self-care.

This will mean:

- Staff have the motivation, capability and opportunities to have different conversations with people – promoting self-care
- People of South Tyneside will have the motivation, capability and opportunities to manage their own health and care

While it is in the planning and testing stage, self-care is being viewed as a separate workstream. It will be embedded in all services across South Tyneside. Over time, staff in integrated community teams, the integrated care services hub, the urgent care hub and the Change4Life wellbeing model will all be proficient in promoting self-care and supporting those who do so, as will relevant services in the other health, social and voluntary care sectors.

The self-care programme and integration work as a whole will be supported by an integrated digital care portal (subject to final funding approval), which will help to make our services more joined up and promote self-care through access to personal digital records.

Once implemented, self-care should result in less demand on all statutory health and care services, and is seen as contributing to objectives in the Better Care Fund. Self-care will underpin any new model of care, identified in the Five Year Forward View. Fundamentally, we think the best measures of success will be patient's positive experiences of care and their ability to manage their own conditions, and self-reported wellbeing.

Alongside this we believe that over the short to medium term better coordination of services and the promotion of self-care skills will have a major impact on a range of important indicators, including:

- Reduced A&E attendances
- Reduced admissions to hospital
- Reduced admissions to residential and nursing care homes
- Reduced re-admissions to hospital within 30 days of discharge
- For those in receipt of reablement, percentage reduction in hours support require
- Increase percentage of people feeling supported to manage their conditions
- Reducing depression and isolation
- Closing the life expectancy and inequality gaps that exist in the borough

32.3 What have been the highlights of your first year?

This has been a year of intensive preparation, which has included setting up governance arrangements, creating teams, testing ideas and approaches and working with local people on what better health outcomes means to them.

2014 saw the launch of our programme of NHS IQ-facilitated workshops with a broad cross-section of staff from across the partnership. Kicked off by the chief executives from all the participating agencies, including the council, CCG, foundation trust, mental health trust and HealthWatch, this has seen us take a bottom-up, staff-led approach to service redesign, developing a model which is now in place in Hebburn.

As the winner of this year's LGC Public Health Award for our work to embed 'Every Contact a Health Improvement Contact' across the whole council workforce, we have a strong track record in innovative workforce development. So alongside the restructure of our teams our 'Changing Conversations' programme has been rolled out across the partnership so that over 300 professionals on the front line have now

been equipped with the right skills and knowledge to promote self-care. We were able to showcase this work to Simon Stevens who visited us in the spring, and we have hosted a string of ministers and senior civil servants too.

An example of self-care in action includes one pioneer operating group discussing evidence that 80% of people use their inhalers wrongly. Following this, the group's clinical lead – a GP – saw two of his patients with asthma and asked them to show him their inhaler technique. This turned out to be incorrect, so he was able to correct their technique and give them other advice. Little changes can bring positive impacts.

32.4 Details of the year

A programme of massive cultural change is a subtle and complex thing to achieve, and has to be developed in a way which is both focused and flexible. The key stages so far are as follows.

32.4.1 Leadership and governance

Clear governance The integration board, which reports to the health and wellbeing board, is responsible for overseeing implementation across all workstreams. A pioneer operating group manages the pioneer programme, co-chaired by the director of public health as lead director, and a clinical director and GP.

Top-level support In meetings and workshops with staff, senior leaders have consistently reinforced the message of self-care and empowering bottom-up solutions.

Dedicated support A team able to provide dedicated support to the integration programme was set up, and grew as the programme required more capacity.

Training in large-scale change Staff involved in delivering the programme attended a pioneer workshop on how to implement large-scale change, and have used many of the theories in practice.

Project approach Project plans and risk mitigation logs were used to keep on track and report progress or problems.

32.4.2 Evaluation

We have developed an evaluation framework to assess the impact of the project on service users, residents and local services. This includes quantitative, process and qualitative measures. We are establishing baseline data through 11,000 postcards to residents of South Tyneside and through a staff survey. See case study: An evaluation framework for the self-care programme.

32.4.3 Establishing a prototype

The programme builds on our successful 'every contact a health improvement contact' work. Initially we tried a simple approach by asking a group of staff to ask three questions aimed at promoting self-care to their conversations with service

users. They told us this did not work, so we developed a more sophisticated approach based on their feedback and self-care methodology.

A third sector organisation was commissioned to run workshops for staff and residents together to explore self-care and why it is important, the benefits it provides to individuals, and to start to learn the skills to put this into practice. Workshops are followed by more detailed training. Feedback from the sessions indicates that they are successfully improving staff and public attitudes towards the importance of self-care.

We have also kept a register of attendance which will build into a borough-wide picture of which professional groups, teams and organisations have been involved so far.

32.4.4 Testing our prototype

Initially we had intended to use risk stratification to pilot self-care with particular conditions or demographic groups. We engaged national pioneer support, and were challenged about why we wanted to narrow our focus. We realised that risk stratification was not the way to go initially, and that self-care was for everyone in South Tyneside. The best way forward was to identify a locality to test and learn about implementing self-care. The locality of Hebburn was chosen; Hebburn has a number of socio-economic and health challenges, however the community has a vast range of physical, social, health and environmental assets which we need to utilise more effectively.

Action we have taken in Hebburn so far includes:

- An asset map to identify all the potential for health, wellbeing and care in Hebburn. We are looking at how this can be used to help the environment support our residents
- Building in-depth knowledge about the economic, health and care needs of the area so we understand its challenges
- A schedule of engagement activity to reach the widest range of people, e.g. through liaising with Healthwatch and linking to local events and campaigns
- Provision of workshops, attended by Hebburn residents and staff who work in a health and care setting in Hebburn
- Collection of baseline data to feed into our evaluation framework

All these actions will also help the work of the integrated community teams by developing a greater understanding of their patch.

32.5 What has been the most exciting aspect?

The workshops, attended by 450 people so far, have been a highlight. Bringing together the public, patients, service users and carers with professionals including GPs and care workers has produced massive energy and enthusiasm. See case study: Engaging with the local community to 'change the conversation'.

It is not easy to establish a framework which captures both hard and soft information about cultural change and its impact; we struggled for two months and involved

further support to help us. We are pleased that we have been able to co-produce such a framework (see case study).

32.6 What has been the most challenging aspect?

As well as being very useful, the workshops have also brought challenges. We did not always have ways of channelling peoples' enthusiasm quickly. To address this we are looking at options such as setting up action learning sets and workplace sessions, such as in GP practices or integrated community teams.

Another issue is that many staff think they are using a self-care approach already, when it has become clear from the workshops that this is not generally the case. We will tackle differences in perception through training.

The area we have struggled with most has been communicating and marketing the programme. There was some scepticism about self-care in organisations and communities, and we needed clear, simple messages to explain what we were doing and why. Because this was a developing process we were not able to be sufficiently clear at first. We have now tendered for support in this area, and the successful provider will help us develop and deliver our message to accelerate the programme.

32.7 What are you planning to do next year?

- Raise awareness of the programme and what it will mean for people by developing and implement the marketing and communication strategy
- Deepen joint work with the third sector, through co-designing a five-year joint plan, requested by the sector
- Build on work in Hebburn, identifying professionals and service users who have attended the workshops and involving them in the development of self-care interventions. An event will be held in February to consider the evidence-base for various interventions and what could be trialled in South Tyneside; this could include, for example, self-monitoring, educational groups etc
- Modify and extend self-care to children and young people
- Evaluate all work which will have taken place in Hebburn (workshops, engagement with residents, marketing and communications, self-care interventions) to support wider roll-out across the borough
- Looking at involving FUSE, a collaboration of five north east universities, to help us with independent evaluation

32.8 What is your advice for areas starting on their own integration journey?

We believe achieving a shared purpose and clear vision has been key to getting so many people involved so many sectors. Achieving this has taken time with many iterations of the vision and challenges of "we do this already" and "it will never work" but the time invested in this has led to a greater clarity and commitment.

We believe that the thorough way we approached planning at the beginning is now starting to result in benefits. Because our programme was an iterative process based

on testing things and learning from them, without a sold framework we would have struggled to keep on track.

Also important are bringing together a mix of professionals with a range of backgrounds and expertise, with input from patients, service users and carers to keep things real.

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33 Case study: South Tyneside – Engaging the local community to 'change the conversation'

Self-care: the conversation starts it; the environment supports it.

South Tyneside is undertaking a programme of fundamental cultural and behaviour change for staff and residents, based on promoting self-care through all health, care and community services. Central to this is the 'Changing Conversations' approach.

Changing Conversations has two aims:

- Health and social care staff and volunteers in all sectors have conversations that enable people to be active members of their 'care team'
- The environment of South Tyneside supports people's contribution to their health and wellbeing

Changing conversations involves staff shifting from "How can I help you?" to "How can I help you to help yourself?".

The programme is being trialled in the Hebburn area of South Tyneside, and a range of methods are being used to test and gather views about how people see self-care, and what they see as the barriers to this.

33.1 Engaging with communities

Methods used to gather views include:

- Street surveys
- Facilitated discussions
- Focus groups (with incentives to attend e.g. Supermarket vouchers)
- Link with public events and local forums
- A staff survey
- A large data collection exercise involving a simple online survey and postcards to 11,000 Hebburn households

33.2 What residents said – postcards

Some 11,000 simple postcards were issued on 14 October and 1,018 were returned (example postcard at end of case study). Results showed a very high level of agreement about the importance of personal responsibility. For example:

- "Taking an active role in my own health and social care is the most important thing that affects my health" – 91% agreed
- "When all is said and done I am the person who is responsible for taking care of my health" – 93.2% agreed

On the question about one thing they would like to change, themes include: shorter waiting times for GP and hospital appointments; better out of hours services in

primary and dental care; and better availability of support for people with a disability and older people.

33.3 What staff said

203 staff returned a simple survey. Results showed that staff were committed to helping people take control over their own care, and to motivate them to do so. For example:

- "I encourage individuals to take responsibility for changing their own behaviour" – 91% agreed

A significant minority however, over 30%, were sceptical as to whether what they did would make a difference to people's behaviour.

33.4 Feedback from street surveys and focus groups: barriers to self-care

Feedback from street interviews and focus groups (nearly 600 respondents in total) identified barriers to self-care such as lack of confidence, lack of information, financial worries, fear of crime on the streets, and isolation. Assets included free bus pass, community groups and affordable activities.

33.5 Next steps

Information from the resident and staff surveys forms a baseline for perceptions about self-care which will be tracked over time to identify any impact from the programme. See case study: An evaluation framework for the self-care programme.

Views are being fed into the development of the self-care model.

An asset-based approach has been used to look at the collective resources which individuals and communities have – internally, externally and collectively – which help protect against poor health and support the development of health and wellbeing. A draft community asset map of Hebburn has been produced covering people, communities, environment and physical assets. The map will be used by staff promoting self-care to identify the range of support and opportunities in the area.

Staff and residents who have expressed an interest in self-care are encouraged to become involved in the 'Scene Setting' and 'Skills' training workshops taking place in Hebburn.

Postcard to residents of Hebburn

South Tyneside Partnership

Please take a few moments to complete this postcard or alternatively go to www.surveymonkey.com/s/5KMKPGW and complete online.

Please rate how strongly you agree or disagree with the following statements:

1. Taking an active role in my own health and social care is the most important thing that affects my health.
   Strongly disagree 1 2 3 4 5 6 7 8 9 10 Strongly agree

2. When all is said and done, I am the person who is responsible for taking care of my health.
   Strongly disagree 1 2 3 4 5 6 7 8 9 10 Strongly agree

Can you tell us one thing that you would like to change so that services work better together and support you to live independently and get on with your life: _____

_____

South Tyneside Partnership

Organisations in South Tyneside are working together to improve services for you. Your views are very important to us.

Gender: Male ☐ Female ☐ **Age:** _____

Ethnicity: White ☐ Black/Black British ☐ Asian ☐ Asian British ☐
Mixed ☐ Other ethnic group ☐ I do not wish to disclose ☐

Postcode: (first 3/4 characters) ☐ ☐ ☐ ☐

Thank you for taking the time to fill in this card. Please return by **16th November 2014** by using the envelope provided (no stamp needed) and send it FREEPOST to:

FREEPOST RLSH-KHYU-YREH
NHS (NECSU) Pioneer Programme,
Riverside House, Newburn,
Newcastle upon Tyne, NE15 9NY

healthwatch South Tyneside

South Tyneside Council

NHS

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34 Case study: South Tyneside – An evaluation framework for the self-care programme

South Tyneside is undertaking a programme of fundamental cultural and behaviour change for staff and residents, based on promoting self-care through all health, care and community services. Central to this is the 'Changing Conversations' approach, shifting conversations from "How can I help you?" to "How can I help you to help yourself?" The overall aim is that people will have improved health and wellbeing, and less reliance on costly statutory services.

The pioneer operating group (POG), the oversight body for the programme, developed a local framework to evaluate this work. The framework is intended to complement, and respond to, the forthcoming national pioneer evaluation, to be undertaken by the Policy Innovation Research Unit (PIRU). It will also support evaluations of South Tyneside health and wellbeing board's 'plan on a page', the Better Care Fund (BCF) plans and the programme itself.

The framework will include both quantitative and qualitative measures which will allow the POG to:

- Measure, monitor and evaluate whether the programme is achieving the desired outcomes
- Measure, monitor and evaluate whether the programme is achieving its objectives
- Facilitate discussions with stakeholders
- Facilitate a shared plan for action

34.1 Highlights from the programme

The full evaluation framework is available. Below are some of the key elements.

34.1.1 Measuring public perceptions about self-care

This will allow the programme to see whether people's views about self-care change over time and whether messages are getting through. A simple postcard has been designed, and has been issued through a mail-out, on the street, through focus groups, GP practices and other centres, and online. The initial focus is on the area of Hebburn where the self-care programme is being trialled. By identifying an initial population, a 'control' comparison group will be available, as data can be compared to the whole of South Tyneside. A baseline has been produced and the exercise will be repeated at six monthly intervals to track any changes in public perception. See case study: Engaging the local community to 'change the conversation'.

34.1.2 Measuring staff perceptions about self-care

A similar, simple survey is being used to track staff perceptions in Hebburn, and beyond, to see whether communication about self-care and training is having an impact on how staff operate.

34.1.3 Key performance metrics

Four key performance metrics, taken from national outcomes frameworks, have been selected to provide a focus for measuring the impact of the self-care programme (and are part of a much larger set of metrics in the BCF):

- Proportion of people who use services who have control over their daily life
- Proportion of people feeling supported to manage their condition
- Proportion of pregnant woman smoking at time of delivery
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions – broken down by condition

34.2 Process evaluation

This element evaluates the programme as it progresses and allows continuous quality improvement. A number of strategies will be used including:

- Reflective diaries
- Case studies reflecting user and staff experience
- Publications and reports – summaries of views before and after training programmes

34.3 Future plans

As the programme is embedded, it will be important to extend the framework to include collective information on staff ability to promote and support self-care and users' ability to self-care to inform future planning.

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35 Southend on Sea Pioneer Programme – Profile

35.1 What is your area like?

Southend is best known as a seaside resort and is located on the north side of the Thames estuary, 40 miles east of central London. With 174,000 residents, it's one of the UK's more densely populated areas and there are two aspects of the borough's demographics which pose challenges to the local health system. We have a higher than average number of frail older people over 80 (9.8% of the population against a regional average of 7%). We also have a high level of deprivation which, again, is higher than average. About 7,900 children are living in poverty and overall life expectancy is around nine years lower in the most deprived areas when compared with the least deprived areas.

While there are challenges, Southend has a number of factors in its favour as a pioneer site; we are a single unitary authority, a single clinical commissioning group (CCG) and a significant amount of our attention is focused on the performance of acute care, and the community care that supports it. We also have a system culture of innovation and making things happen.

35.2 What are you aiming to achieve?

We want Southend to have a truly integrated health and social care system, where information is shared between professionals enabling them to create a single, comprehensive care package encapsulating all of a patient's needs. By working in a more joined-up fashion, and promoting the prevention agenda, we can reduce unnecessary hospital admissions and keep patients independent in their own home for longer. We also aim to increase community resilience, helping people take more responsibility for their own health and wellbeing.

35.3 What have been the highlights of your first year?

Our focus has been on finding innovative ways to overcome local barriers which have historically prevented truly integrated health and social care in Southend.

The key features of our work have been on developing an integrated commissioning model, Better Care Fund planning for 15/16 and beyond and information sharing. We are developing innovative solutions which will change the way we work within our area, benefit Southend's residents and patients and provide leadership for other pioneer areas.

35.4 Details of the year

In the first year of our programme there have been a number of significant developments:

- **Building relationships** We brought together the collective resources of Southend's statutory, voluntary and third sector organisations. This has allowed key relationships to be developed at the senior, system and

operational level. These relationships have proved to be an enabler to the planning and implementation of integration.

- **Agreement to integrate commissioning** We have developed a number of joint initiatives to transform services. This has included the signing of a memorandum of understanding through which we will design and deliver an integrated commissioning function spanning Southend Council and Southend CCG. See case study: Developing an integrated commissioning service.

- **Developing a single point of referral** See case study: Developing a single point of referral (SPoR).

- **Promotion and prevention agenda** We have developed a project plan for social prescribing that engages the voluntary sector and has begun to engage with primary care providers. We have commissioned the voluntary sector to deliver a 'Talking Health' project that engages communities and encourages prevention and independence. Talking Health has engaged over 1,600 households since mid-November 2014.

- **Government approval to share data** In December 2014 we made progress with our application to the Confidentiality Advisory Group to share data across social care and health enabling risk stratification and predictive modelling. Our plan was provisionally approved with conditions, which is a step forward and we are now reviewing those conditions in order to take this project to the next stage.

- **Opened a two-way conversation** Our communications workstream has opened a two-way conversation with those who design and commission services as well as those who use them.

35.5 What has been the most exciting aspect?

In Southend, we have worked on several aspects of the pioneer programme where successful outcomes will help all pioneer areas. We have led on the application to the Confidentiality Advisory Group where the development of an innovative solution to data share will deliver major benefits to all pioneers. The development and successful implementation of our integrated commissioning model will also provide a valuable model of best practice.

35.6 What has been the most challenging aspect?

We are resourcing a number of large projects simultaneously. We did initially find it a challenge to deliver work relating to the pioneer programme in parallel with other work, such as the Better Care Fund (BCF). However, by working on the BCF we were able to speed up our planning and decision-making for our integration work, as it forced us to make a number of necessary and realistic decisions in a very short period of time.

35.7 What are you planning to do next year?

For 2015, we are planning to implement huge changes to the way we commission and deliver integrated services in Southend. These are:

- **Fully integrated commissioning function** Under the memorandum of understanding we plan to address issues about new accountabilities, sovereignty and resource sharing, leading to a formal agreement about how to implement a fully integrated commissioning service. The agreement will specify those service and budget areas to be included in pooled arrangements.

- **Primary care hub** To develop the target model we plan to implement a pilot primary care hub which will integrate health, social care and voluntary services at community level.

- **Promote prevention and independent living** Through our prevention and engagement workstream we will be rolling out a number of projects that support residents and address issues that impact negatively on their own health and wellbeing, for example social prescribing, patient activation measures and a 'Talking Health' project.

- **Risk stratification and predictive care pathway modelling** Following the government's conditional approval for data sharing, we plan to work with our private sector partners to further develop our understanding of our residents' needs which will enable us to create and model innovative care pathways.

35.8 What is your advice for areas starting on their own integration journey?

In Southend, we got the right people round the table from the start and ensured all organisations involved in the delivery of health and social care had a voice through the pioneer programme. We made sure system leaders were engaged and that we had a firm idea of the direction we needed to go from the start. Ensuring buy-in from all partners and involving them in the journey is essential.

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36 Case study: Southend on Sea – Developing a single point of referral

The Southend single point of referral (SPoR) approach provides a single entry point and process through which any health or social care professional can access rapid, integrated community care. Ultimately this approach will reduce care needs that have recently increased, either by preventing decline or admission or by supporting recovery and independence.

The service is accessed through a single contact number which leads to an assessment and home visit within two hours. The services SPoR refers into are predominantly time limited, such as intermediate care and reablement as well as short term and goal based. Support can be provided for up to six weeks and is aimed at optimising an individual's independence in the community.

Although this is a professional referral service without direct contact with patients, SPoR commissioners are aware of the well-documented evidence that 'right care, right time and right place' is beneficial to patients. The SPoR enables this by supporting people to remain at home where possible.

Since the SPoR became operational, Southend has seen a continued improvement in the outcomes of those people who undergo reablement services. The SPoR is already being widely used by health and social care professionals in Southend-on-Sea.

As of November 2014, 62% of our GPs (200+) use the services provided by the SPoR. For the period April – September 2014 referrals into the SPoR from both the discharge team and GPs have grown by 132%.

Operations in the SPoR are currently being reviewed with a view to commissioning the integration of similar services within the council. The integration partners believe the opportunity will provide real benefits for the residents of Southend, support the planned reduction of total emergency admissions and deliver efficiency savings.

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37 Case study: Southend on Sea – Developing an integrated commissioning service

There is a willingness to commission health and social care services differently in Southend, and within an integrated model. Developing an approach to integration has provided the opportunity to rethink desired outcomes and combine resources and the partners are working towards the implementation of an integrated commissioning function for Southend's residents.

As a result, Southend Clinical Commissioning Group (CCG) and Southend Council have a signed memorandum of understanding that agrees a set of principles and approaches. It defines the work programme for 2014/15 and 2015/16. The aim is to design and deliver an integrated commissioning function that spans both the council and the CCG. The services specifically targeted include mental health, frail elderly and children's commissioning.

To achieve fully integrated commissioning teams the existing teams have been brought together, a head of integrated commissioning has been appointed (a role jointly funded) and a work plan has been agreed for the commissioning of services for the next two financial years.

It has been agreed that a fully integrated team will be in place by 1 April 2016.

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38 Stoke and North Staffordshire Pioneer Programme – Profile

38.1 What is your area like?

The areas of Stafford and Stoke-on-Trent covered by the programme have a combined population of around 771,500 people. Overall, the health of the population is improving; however there are many health challenges and significant health inequalities. Currently around 22,000 people live with cancer, projected to rise by 68% to 36,600 by 2025. Around 8,500 people die locally each year, but only 0.2% are on an end of life care register, indicating significant under-identification of needs. By 2021 it is estimated that the number of people over 75 will increase by 38%, compared with 27% for England.

The local NHS is facing significant financial challenges, as well as reorganisation following the Mid Staffordshire NHS Trust Inquiry.

38.2 What are you aiming to achieve?

We are seeking to make a paradigm shift in commissioning cancer and end of life care services. We want to move from a focus on the needs of care providers to putting the needs of patient as service users at the heart of service delivery. To achieve this we have launched an ambitious programme of transformation in which delivery of care will move from being a series of disparate treatment episodes to integrated pathways built around improving outcomes for patients.

North Staffordshire, Stoke-on-Trent, Stafford & Surrounds and Cannock Chase Clinical Commissioning Groups (CCGs), and NHS England are the five commissioning partners; we are working with Macmillan Cancer Support, Staffordshire County Council, Stoke-on-Trent City Council and Public Health England to deliver the Transforming Cancer and End of Life Care Programme.

We know that the system that supports both cancer and end of life care patients has a number of limitations, in relation to:

- Delivery models
- Barriers to integrated care
- How services are commissioned and the range of different commissioning agencies
- Funding gap
- Consistent and equitable patient experience

In addition, we have poor cancer outcomes – one-year survival rates in all four CCGs are below the national average of 68%, less than satisfactory cancer waiting times, poor patient and carer experience, and too few people dying in their preferred place. There is also a lack of clear accountability for the whole patient journey with 34 providers delivering end of life care and 26 delivering cancer services.

The current spend on cancer and end of life care is around £100m a year across the commissioners.

The programme has been developed to provide a sustainable solution to these issues, as well as the growing incidence of cancer and escalating costs. It will also address significant variations in clinical outcomes, expenditure and patient/carer experiences, and a lack of clear accountability for the whole patient journey.

The aim of the programme is to appoint an accountable body, responsible for ensuring that services are person-centred and integrated. To achieve this, two major procurement exercises are being undertaken:

- End of life care – for all long term conditions
- Cancer services – from prevention through treatment to survivorship

At the end of the procurement, two 'service integrators' will be appointed – one for cancer, one for end of life care.

Because of the need to maintain quality and stability during a time of great change, the contract will be implemented in two phases over ten years.

38.2.1 Phase one 2015-17: Redesign and integration

In years one and two, the service integrators will be responsible for working with local partners, including current providers, clinicians, service users and carers to redesign all aspects of the services. For example, removing barriers such as red tape, poor communication and data gaps. The service integrators will then coordinate the planning of new models of care.

38.2.2 Phase two 2018-25 – Accountable delivery

In years three to ten, the service integrators will work with commissioners and providers to implement integrated pathways and will be responsible for ensuring integrated delivery of all the services across the patient journey; they will be answerable to the CCGs for overall performance.

38.3 What have been the highlights of your first year?

- Extensive involvement of people with experience of service in co-designing the transformation programme
- Two major procurement exercises involving local and national partners launched
- The development of an outcomes based framework, new contracting model and payment mechanism
- Independent evaluation to provide ongoing learning for the programme

38.4 Details of the year

38.4.1 Partnership and governance

We have built and maintained a tight partnership between the six NHS commissioners (including NHS England and Public Health England for the cancer pathway), Macmillan Cancer Support as the strategic partner, and working with two local authorities. As well as the robust governance structure there are a number of mechanisms in place to provide independent advice and oversight, including:

- An external national expert advisory group has been set up with colleagues from NHS England, academia, providers and national patient groups to provide independent advice and act as a critical friend
- The Office for Public Management was commissioned to run alongside the programme to undertake action based learning

38.4.2 Co-design with service users

We have been talking to the public, communities, patients and carers about the programme since 2012. In 2013 work took place to recruit three people with experience of services to the programme board with responsibility for increasing engagement. Fifty champions were recruited and now form a champions' network. See case study: Patient champions' stories.

A small group of patient champions have been trained and actively involved in the procurement process to appoint the service integrators. Specifically they are involved in framing questions for procurement purposes, evaluating bids, involved in dialogue with bidders. See case study: Co-design of programme with people who have experience of services.

38.4.3 Preparing for procurement

Memoranda of information and pre-qualification questionnaires (PQQs) were published, setting out the direction for the transformation of cancer services and end of life care. A 10-year outcomes framework describing the outcomes that service integrators must meet, and how these are linked to a payment mechanism which rewards performance has been developed for cancer services, and is currently in progress for end of life care. A new contracting mechanism has also been developed to sit alongside the outcomes framework. This work has involved extensive stakeholder input, both nationally and locally.

38.4.4 Commencing procurement

The procurement process started in May and June 2014 with notification through the Official Journal of the European Union (OJEU). It will take a year to complete, running until the autumn 2015. PQQs were issued and returned, and were subject to rigorous scrutiny and evaluation before final consideration and approval by the programme board. Across cancer and end of life care, seven organisations were successful at PQQ stage – two local provider trusts, two private sector consultants/management firms, and three private sector healthcare providers.

Service integrators will need a range of skills, and organisations which have succeeded at PQQ may wish to form alliances and consortia. The eventual service integrators will still engage with local care providers to deliver care in the future.

38.5 What has been the most exciting aspect?

Having the patient voice at the heart of the programme, and ensuring that every decision that is being made in the programme has a patient involved within that. This has often meant stretching and changing the way that we work and pushing our own boundaries to enable this to consistently happen.

The innovative approach that we are taking to the work and what has been achieved so far, namely an outcomes based contract, population based commissioning, new payment mechanism, and the approach to be taken to dialoguing with bidders.

The partnership with the voluntary sector: Macmillan Cancer Support is an important partner in the programme and a catalyst for change. It is a member of the programme board, and brings fresh skills and perspectives, particularly in engaging with patients and communities. Macmillan funds the local programme team to allow a dedicated resource to work on designing new models of care. Staffordshire is part of Macmillan's national Redesigning the System programme which supports organisations to make large-scale change, based on principles devised by Macmillan from many years working in cancer and end of life care.

Through the RTS programme, Macmillan is working with partners to change the cancer system to ensure all cancer services – in hospital and the community, providing medical, practical emotional and financial support – are joined up. The aim is that learning from Staffordshire can be rolled out to improve cancer and end of life care nationally. Macmillan is not bidding to provide either of the contracts. See case study: [National voluntary organisation as strategic partner for change](#).

38.6 What has been the most challenging aspect?

Only a handful of large-scale NHS procurement exercises have taken place so far, and while we are learning from what has gone before, an ambitious, innovative programme brings a number of challenges.

The programme involves both local and national NHS commissioners. The programme commenced during a state of flux post NHS reforms, and there has been a period of bedding down when it was being developed, with further changes in key contacts during the first year. Reforms such as health and wellbeing boards are proving helpful, and additional assurance for the programme is positive. We, however, believe that a period of stability for the NHS and its partners would be beneficial for all ambitious integration programmes.

There has been some opposition to the programme locally, with probably the main concern being that it would result in cancer services being taken over by a private healthcare provider. Some of the concerns may have been exacerbated because initially we used the language of 'prime provider/prime contractor' rather than the more accurate 'service integrator'. While the service integrator could be from the NHS or the independent sector (or a combination), service delivery is likely to remain a mixed economy.

38.7 What are you planning to do next year?

- Progress the next stage of procurement, ensuring the process is rigorous, cost effective and aligned with NHS Five Year Forward View
- Issue Invitation to Submit Outline Solutions; bidders will discuss ideas and solutions with a panel in a process of competitive dialogue
- Refresh approach to engagement building on work of non-executive board members and champions to ensure continued involvement in co-design and contact monitoring
- Progress plans for commissioning a longitudinal impact evaluation

38.8 What is your advice for areas starting on their own integration journey?

A shared vision and commitment A clear vision among all the partners, with clarity as to roles and expectations, both organisationally and individually, is essential, especially when partners may have differing priorities. A memorandum of understanding is a useful way to do this. Having strong relationships in place among partner organisations will help when challenges present.

Partnership working Work with the community from the outset to design the approaches for getting the 'public voice' into the process. There is no one set way for doing this and it is important that a clear process with feedback mechanism is developed.

Ongoing evaluation Integration takes time to achieve. Building in an evaluation approach helps capture the learning along the way and reflect on achievements to date. The Office for Public Management has been commissioned to undertake action based learning.

We have also been working with NHS England and the King's Fund to share our learning to date. For further information on our approach to commissioning see the case study in the King's Fund's publication Commissioning and contracting integrated care.

Transparency in procurement One of the tensions in a procurement process is between commercial confidentiality and being open with stakeholders. We have learned that it is important to push the boundaries to ensure as much transparency as possible, because it is vital that all stakeholders are well informed. A strong communications and engagement strategy and plan is key to this. Throughout 2015 we will continue to engage with those with an interest in the programme including clinicians, local medical committees, communities, MPs, Unison, lobbying groups, and patients.

Website: Details of the programme and procurement so far are on our website: www.staffordshirecancerandeol.com

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39 Case study: Staffordshire – Co-design of programme with people who have experience of services

Service users and carers are at the heart of all aspects of the transformation programme for cancer and end of life care services, from governance, through preparing for procurement, to evaluating applications. Work from extensive engagement with patients and clinicians during 2013 and 2014 has been used to inform the procurement process and the underpinning documentation, such as the outcomes framework.

A programme board is responsible for overseeing procurement. Three non-executive members with experience of services have been recruited to the board, and are each paid for one day a week to increase engagement in the programme. Fifty champions who want to be involved in specific aspects of the programme have been recruited and form a champions' network.

Champions contribute to the design of the procurement documentation. Specific examples of their suggestions include:

- Outcomes framework – advising that patient experience should be monitored across the entire pathway not just acute care
- PQQ – a question about organisations' experience of co-design with patients and the public

Five of the champions have received training, alongside other members of the evaluation panel, to be involved in application evaluation, and interviewing prospective applicants.

The area is keen to involve all those interested in the programme, including those that have concerns, and the local organisation Cancer not for Profit has agreed to work with the programme.

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40 Case study: Staffordshire – Patient champions' stories

40.1 "The Most Devastating Words You Can Hear…"

Jen Richards' description of the moment she was told she had cancer will ring true for many patients undergoing treatment.

"They are the most devastating words you can hear," she says. "You think you understand what it must be like, but until you are that person you have no idea."

Jen describes herself as a strong person and the demands of her 29 years' service and role as a police inspector in the West Midlands means she has tackled many challenges. But everything changed when Jen, who lives near Stafford, was diagnosed with breast cancer and she began to undergo treatment.

It is Jen's experiences and frustrations that led to her joining the Transforming Cancer and End of Life Care programme as a patient champion. She says the consultants, nurses and others who treated her were brilliant but what she describes as 'red tape' and 'bureaucracy' caused complications.

"Systems are not joined-up. The systems don't seem to talk to each other and information is not always properly transferred from one hospital to another."

Jen was concerned the cancer would return and decided she wanted to have her other breast removed but she was transferred back to her GP, although she was already undergoing treatment. She agrees patients often become frustrated having to repeat their circumstances to different healthcare professionals again and again.

"It was an awful time of worry I had to go through. It's the frustration of waiting for letters and referrals and it led to depression. We are not statistics, we are individuals. This is all about the experiences of patients."

Jen joined the programme and has worked to publicise her experiences and offer her own unique insight into cancer care in Stoke-on-Trent and Staffordshire. She works closely with GPs, commissioners and other patient champions to evaluate organisations bidding for the cancer contract.

"We've been through or we're going through treatment in Staffordshire so we understand there is great care, but we need to ensure the patient is at the heart of everything we do. We can bring our own experiences to the table and we know what is good, but we also know what needs to change."

Jen has become a regular media commentator for the programme and has recently featured on BBC Radio 4's File on Four, as well as BBC's Sunday Politics and BBC Radio Stoke.

'I'm extremely passionate in my support for the programme and driven by the desire to make a harsh journey better for patients.'

40.2 I was given six months to live in 1994 and I'm still fighting for better end of life care

Former actor and teacher Maurice Greenham has been living with HIV for 30 years and is a dedicated and passionate campaigner for better health services for older people.

Maurice's desire for positive change in the NHS is based on his personal experiences with end of life care and treatment, as well as the death of his mother and close friends.

In 1984 Maurice was diagnosed with HIV and a decade later he was diagnosed with AIDS but took the decision to refuse what he describes as a 'highly toxic' drug AZT because reports indicated that it was killing as many people as it was saving, and at the time he felt well.

"In 1994 I developed AIDS and was given six months to live, so I sorted out a power of attorney and arranged my funeral," he says.

In the years since his diagnosis, Maurice has given his support to research, worked as an HIV activist and appeared on numerous occasions on television and radio. He has witnessed the experiences of close friends and family with end of life care.

He was chief carer for his elderly mother and says when she went into hospital his intervention and support made a big difference when staff refused to prescribe morphine and she was prescribed an 'inappropriate drug'. "It was a slog and extremely difficult at times but we have to work to make these changes and persevere. We have to put the patient at the centre of things."

When Maurice and friends visited a friend in hospital they witnessed him behaving in an unusual manner and it was their persistence that led to the discovery of a brain tumour. Unfortunately their friend died in hospital but Maurice and friends organised music and readings in his final hours after convincing staff it was the right thing to do.

"We got him out of the public ward and into his own room. It was a good send-off."

It is Maurice's frustrations and experiences with end of life care that led to him joining the Transforming Cancer and End of Life Care programme as a patient champion. "I was interested in anything that could really make a difference to end of life care," he says. "And I want to give a voice to people who don't feel they're being heard, especially older gay, lesbian, bisexual and transgender people and those living with HIV."

Maurice feels the NHS needs to do better when it comes to caring for older people with HIV. "I want to work to help drive that positive change."

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41 Case study: Staffordshire – National voluntary organisation as strategic partner for change

Macmillan Cancer Support is an important partner in the Staffordshire's transformation programme and a catalyst for change. It is a member of the programme board, and brings fresh skills and perspectives, particularly in engaging with patients and communities. Macmillan funds the local programme team to allow a dedicated resource to work on designing new models of care.

Staffordshire is part of Macmillan's national Redesigning the System programme which supports organisations to make large-scale change. Through the RTS programme, Macmillan is working with partners to change the cancer system to ensure all cancer services – in hospital and the community, providing medical, practical, emotional and financial support – are joined up and designed around individual needs. The aim is that learning from Staffordshire can be rolled out to improve cancer and end of life care nationally.

Staffordshire's service integrator and all providers will be expected to deliver Macmillan's nine outcomes, devised from many years of working in cancer and end of life care.

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42 Waltham Forest, East London and City (WELC) Pioneer Programme – Profile

42.1 What is your area like?

The Waltham Forest, East London and City (WELC) Integrated Care Programme focuses on revolutionising care for almost one million people in an area facing significant health and social challenges:

- Deprivation is twice the national average
- Hospital stays for alcohol and substance misuse are up to 50% higher than average
- Newham and Tower Hamlets have the second and third-highest levels of admissions for psychosis in London
- 22% of patients account for 80% of hospital costs
- The number of people over 65 is projected to increase by 7% by 2016

There is a compelling case for changing the health and social care system across this part of London, which covers the boroughs of Newham, Tower Hamlets and Waltham Forest.

The programme was started in September 2012 by the WELC Care Collaborative, made up of clinical commissioning groups CCGs) and councils from the three boroughs, with Barts' Health NHS Trust (the main acute provider), North East London Foundation Trust, East London Foundation Trust and UCL Partners.

42.2 What are you aiming to achieve?

- To enable as many people as possible to live independently
- To personalise and co-ordinate care around the patient
- To deliver care in the most appropriate setting
- Eventually, to provide targeted services for 20% of people most at risk of hospital admission
- By 2017/18 to have built a holistic model of care for people most at risk

We recognise that we cannot change by doing things the way they have been done.

We want providers of care to work together to:

- Focus on outcomes, not inputs and outputs
- Put user involvement and experience at the heart of what they do
- Co-ordinate services around individuals' needs
- Use one budget for a population so they are collectively responsible for risks and rewards

To achieve our aims we wanted providers and commissioners to plan better together. We wanted to move away from activity-based payments to encourage prevention activity. We wanted to encourage joint decision-making and shared responsibility for gaps that occur in the health and social care system.

We have agreed this core service model:

WELC will provide nine key interventions for its population underpinned by five components and enablers

Areas of interventions		Essential components	Enablers
Self-care	Self-care, behaviour, and expectation management	Information sharing platform	Patient engagement
Care coordination	Care planning	Evidence-based pathways & care packages (e.g. last years of life, diabetes, COPD, CHD, falls, alcohol and substance misuse)	Joint decision making and accountability
	Health and social care naviagation		
	Case management	Joint health & social care assessment	Clinical leadership and culture development
	Specialist input in the community		
Ensuring people are in the most appropriate setting of care	Discharge support for mental health patients from secondary to primary care	Creation of new roles within the workforce: • Case manager • Hybrid health & social worker • Health & social care coordinator • Discharge coordinator based in acute wards	Information sharing and decision support
	Rapid response with short team reablement		
	Mental health liaison (RAID)	Organisation of practices into networks	Aligned incentives and reimbursement models
	Discharge support from acute to community		

(Left vertical band: Joint health, social care and mental health approach)

We have partnered with UCL Partners to support the evaluation of the impact of our programme, embedding a researcher in residence within our team. We will know we have succeeded when we see a measurable impact in the following areas:

- User experience – we are involved in the national integrated care PROM pilot and exploring the use of PAM (patient activation measures) all partners are undertaking more qualitative work with individuals and groups of patients, to explore the impact of joining up services
- Frontline staff experience – the involvement of frontline identified many things they could do differently; we will evaluate the impact of change on working lives
- Health and wellbeing outcomes – WELC Integrated Care expects to reduce emergency admissions by 20-40% (dependent on variable baseline rates)
- Impact on cost – impact on cost is being remodelled each year of the programme. The focus now is less on cash savings for commissioners and more about long-term sustainability of the local health economy and associated provider landscape

We are tracking a core set of metrics by linking GP and acute data as part of the acute provider CQUIN in 2014/15. These are reported monthly for the top 5% of the population at risk of admission:

- Emergency admissions per 1,000 population

- Avoidable emergency admissions per 1,000 population (using the Better Care Fund (BCF) definition)
- Readmissions at 30 days per 1,000 population
- Total bed days per 1,000 population

For 2015/16 we are considering adding BCF outcomes to this list to look at use of residential and nursing care across the system, creating shared responsibility for these outcomes by adding them to all CQUINs (for community health services and mental health) in a stepped approach towards payment on outcomes.

42.3 What have been the highlights of your first year?

- Development of provider collaboratives
- Implementing our service model
- Exploring approaches to self-management See case study: Supporting self-management
- Information sharing
- Creation of new roles within the workforce
- Progress towards commissioning for outcomes and capitated budgets

42.4 Details of the year

Implementation of our service model is almost completed in all three boroughs for the very high risk and by the end of the first quarter of 2015/16 for the high risk group too (the top 5 % at risk of a hospital admission). We are now in a position to measure results across the three boroughs.

We are now able to join up data across acute and GP care for all three boroughs and are using this to track progress. We brought together analysts, clinicians and commissioners in September 2014 to explore this outcomes data and refine approaches to evaluation. We are progressing real-time data sharing in different ways across the three boroughs, working together with providers and local authorities to do this consistently across the patch.

We have created new roles to reinforce relationships between providers, improve patient experience and reduce inefficiencies. The creation of senior case manager posts (for the very high risk group) and care navigator posts (for high and moderate risk groups) is helping to ensure that patients' care needs are better met.

GP practices are starting to work together as federated provider networks. This is important for aligning community services, social care and mental health and helps ensure efficient use of resources and information sharing. We created a specification for an integration function and completed a two-stage assurance process with providers in one borough this year, asking providers to account collectively for how they would work together around outcomes, finances, workforce, information sharing and clinical governance. GPs have reported being better able to identify trends for patient needs at network level, and have been able to 'look up' and see beyond their individual practices.

They key enablers so far have been:

- Patient engagement, using National Voices principles, involving patients in evaluation and having patient representation on our integrated care boards
- Joint decision-making and accountability with a joint steering group bringing together commissioners and providers
- Clinical leadership and culture development – bringing providers into single meetings thereby encouraging collaboration; and facilitating network meetings between GPs, allowing broader consideration of patient trends and risks
- WELC's programme management office facilitates information sharing between partners and disseminates best practice across the boroughs. It also supports the 'do once and share' aspects of the programme, such as developing approaches to contracting and reimbursement, metrics and evaluation and workforce and organisation development

Changing existing pathways of care to implement the WELC service model has been our priority in the first year of the programme. We are now developing with commissioners and providers an approach to capitated budgets and payment for outcomes which will incentivise integrated care for particular population groups with the aim of stimulating further integration. See case study: Developing capitated budgets.

42.5 What has been the most exciting aspect?

We have put much effort into provider development. See case study: Developing the provider landscape. Based on learning from how the GP provider networks developed in one of the boroughs, we have used a similar process of identifying joint tasks to stimulate collaborative working. The two-stage assurance process has stimulated the development of a provider partnership which is now actively working on joining up their services. The providers are working collaboratively on eight workstreams.

42.6 What has been the most challenging aspect?

This is a massive programme to implement across three geographical areas, with hundreds of people involved. The real challenge is not so much managing the programme, but building trust between individuals and organisations and between professional staff and patients. We have had support from the King's Fund Four Communities programme to facilitate local conversations about how to create and maintain collective and distributed leadership across the patch.

42.7 What are you planning to do next year?

The main challenges for 2015/16 will be:

- Fully implementing all aspects of the service model for the top 5% at risk in all three boroughs and then planning which aspects of the model are implemented for the remaining 15%
- Agreeing baseline data for the remaining metrics and identifying a core set of metrics for payment on outcomes

- Creating a model for exploring suitable groups for capitation and working with providers to explore risk and gain share, improving data quality, and system readiness for shadow capitation in 2016/17
- Consolidating the federated GP model in all three boroughs to create a base for extended provider networking
- Realigning incentives and payment to ensure providers take ownership of system-wide outcomes. A new payment model will contract providers as a group to be responsible for key performance indicators
- Adapting the integration function and 'assurance process' in the remaining two process and completion of the process to bring together provider collaboratives

42.8 What is your advice for areas starting on their own integration journey?

Don't strive for perfection in the system. Our mantra has become "you have to start somewhere and just do something". Instead of being paralysed by fear at not being able to reach the perfect holistic health and care system, we think about steps we can take tomorrow and the next day to take us further along the road. Chipping away at small tasks can add up to real achievements.

To get people to work together you need to give them 'something to do' collectively. Our providers were meeting frequently together but were unsure what for, until we gave them a specification and a process to go through to focus their discussions. We have to progress this by moving towards payment on outcomes and capitation, to help us commission collectively. It is very important that both providers and commissioners invest time and resources in provider development.

Information governance was a stumbling block for many areas but we have found ways to join up data by working with our commissioning support unit using data processing contracts.

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43 Case study: WELC – Developing capitated budgets

WELC integrated care partners have concluded that reforms to contracting and reimbursement are necessary to achieve their integrated care programme objectives. They believe that capitated budgets which allocate a fixed amount for a defined scope of care are a proven enabler of integrated care. In the current system, providers are not incentivised to work together to deliver integrated care. As a result, patients' experiences of the health and care system can be confusing and disjointed.

In a capitated budget, each patient's annual care costs across some or all services in different care settings are included in the budget. This budget is used to deliver some or all health and care services for the entire integrated care population. A percentage of the budget will be paid for outcomes that the provider(s) are required to deliver and any savings that providers make by working together more efficiently within the allocated budget they would keep. This materially changes the risk profile of the commissioner/provider relationship and incentivises collaboration, cross-organisation working and integrated care.

WELC is taking a phased approach to moving towards a system of capitated budgets. It has carried out a scoping analysis of activity and spending in Tower Hamlets and Newham and is one of the case study sites for capitation budget development to support Monitor's work on developing tariffs for providing integrated care for different groups. It is also part of the capitation learning collaborative with the integration pioneer programme.

WELC has started to engage providers around system-wide outcomes. Analysts from each CCG, each provider and each local authority are working together to develop a whole population view of spending based on historic activity and cost data. This analysis will be used to develop a 'budget envelope' of how much commissioners are willing to pay providers to deliver integrated care now and in future years. Commissioners and providers will negotiate how much of this budget will be fixed and how much will be dependent on outcomes. Commissioners are exploring how to use a variety of incentive pots like the CQUINs and Better Care Fund performance monies to incentivise joint working in 2015/16 and it is hoped a simulated capitation year will run alongside conventional agreed contracts for that year to support the provider development work.

It is hoped that in 2016/17 a shadow capitation model will be in place it so that it can be tested and refined over the course of the year.

In 2017/18 an integrated budget will be implemented for an agreed population cohort.

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44 Case study: WELC – Developing the provider landscape

For transformative integration to take place the way in which providers in a locality relate to each other needs to change. We were mindful that this would not happen overnight, nor through a purely contractual route. To provide focus to the development of local collaboratives, we developed an integration specification that outlined our vision for joined-up services, outcomes measures and a picture of 'what good would look like'.
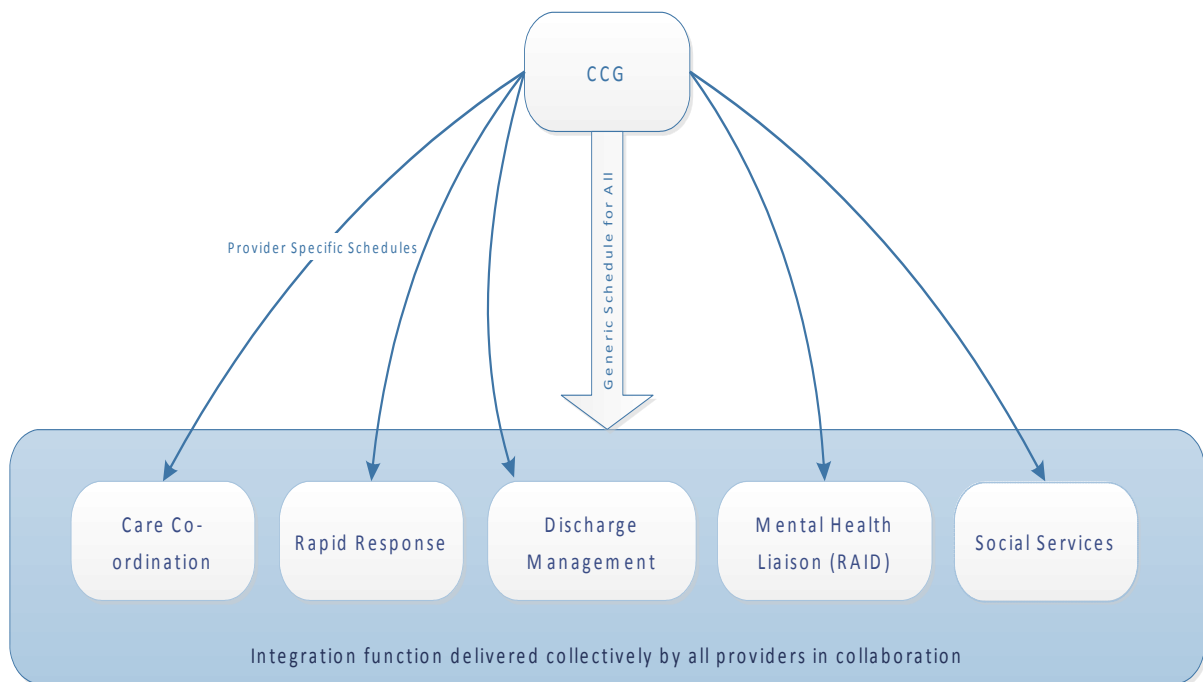
A two-stage assurance process (or non-competitive tender) was developed. This served two purposes:

1. To provide clinical commissioning group board level assurance that local providers will respond collectively to the challenges laid out in the integration specification as well as individually to their individual part of the service model
2. To give providers a joint piece of work, to provide focus and direction to their collaboration discussions

Indicative summary provider development approach to commissioning integrated care services
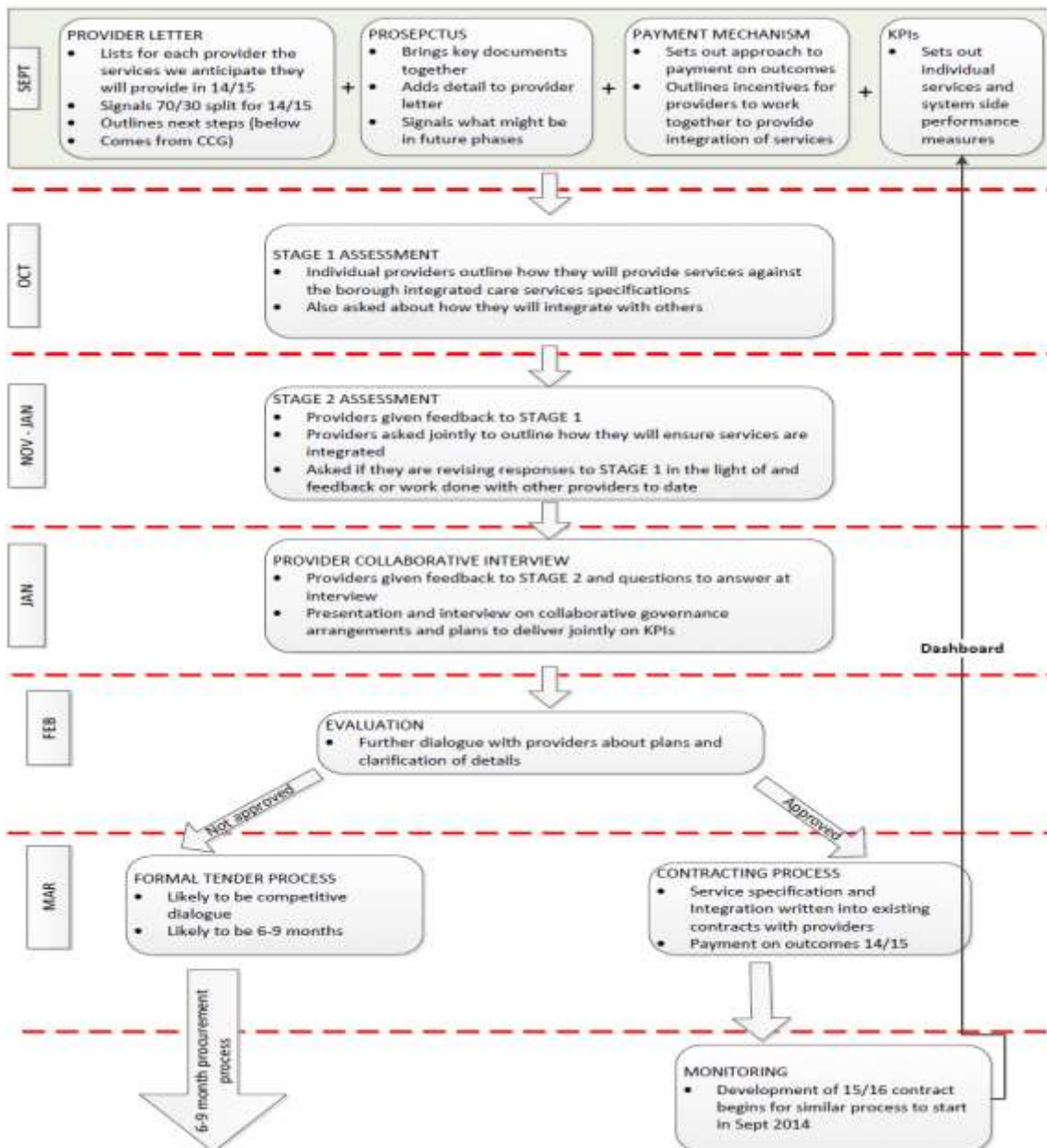
Successful completion of the process in one of the three WELC boroughs in April 2014 led to the development of the Tower Hamlets Integration Provider Partnership. This is a collaboration between the Tower Hamlets GP provider body (covers all 36 practices in Tower Hamlets), the acute trust, the community health services provider, the mental health provider and the local authority.

It is hoped that a process similar to that undertaken in Tower Hamlets but tailored to local circumstances in Newham and Waltham Forest will stimulate similar focused joint working for the providers in these boroughs.

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45 Case study: WELC – Supporting self-management

A fifth of those most at risk of admission to hospital in WELC represent 80% of the cost across the system. Not all those at risk require the more intensive elements of the service model but most would benefit from self-management.

Supporting self-management aims to promote and enhance the quality of life for people with long term conditions. Therefore WELC set up an exploratory initiative to investigate how supporting self-management could contribute to its integrated care programme. The objectives were to:

- Map current provision of self-management interventions
- Identify best practice from literature and research
- Identify gaps in provision
- Develop model of care
- Define operating model to deliver support for self-management
- Provide options for potential services who can deliver a self-management support programme

The target population is:

- Patients who are at moderate risk of an unplanned admission to hospital
- People with two or more of an identified list of long-term conditions

Newham has been actively developing its approach to self-management using the model below and exploring a number of pathways for people to access self-management support.
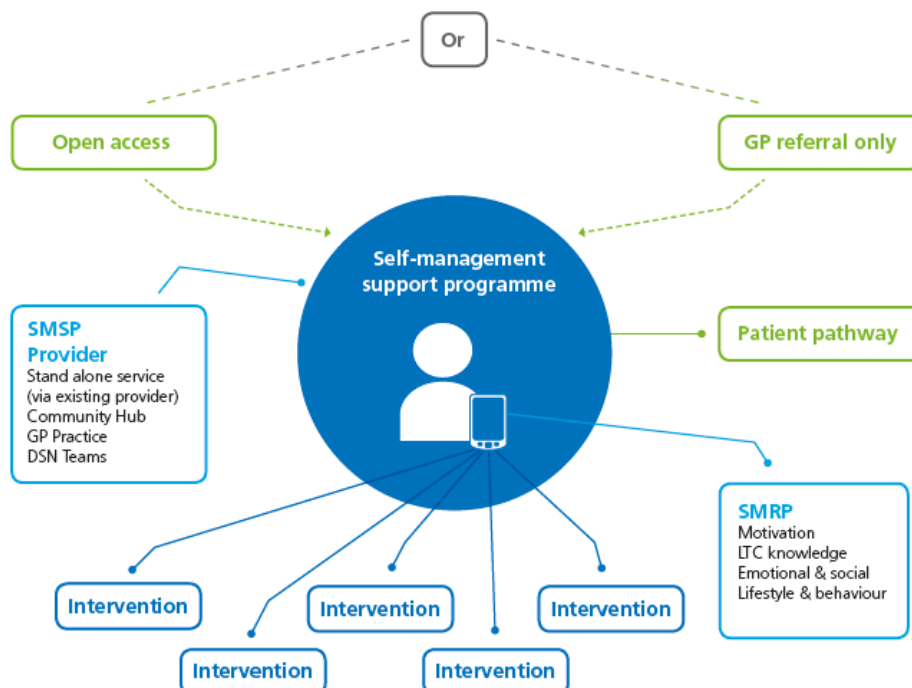
Waltham Forest has embarked on a six-month health coaching pilot for people with diabetes and **chronic obstructive pulmonary disease**.

Results from the pilot scheme will help the clinical commissioning group better understand the needs of patients with long-term conditions as well as educating and empowering patients.

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46 West Norfolk Alliance Pioneer Programme – Profile

46.1 What is your area like?

West Norfolk is a rural area with one of the most rapidly ageing, dispersed populations in England. The population has high prevalence of long-term conditions and obesity and a culture of lifestyle choices that adversely affect morbidity. West Norfolk faces the pressure of a small district general hospital (DGH) in financial distress, with difficulties in low volume activity, recruitment and retention of staff. A Monitor contingency planning team (CPT) is in place and the clinical commissioning group (CCG) is leading a long-term programme of local health and care system sustainability work which commenced six months before the CPT was appointed.

The main element supporting the implementation of our vision for integrated care has been the development of the West Norfolk Alliance. This is a collaborative partnership involving all the main organisations commissioning and delivering health and social care in West Norfolk. Initially it focused on improving and integrating care across three selected clinical pathways: care of frail and elderly people, maternity care and paediatric acute care. This work has widened as joint work with the CPT has developed.

The CCG is taking a proactive leading role in driving the CPT programme, ensuring it builds both on completed clinical pathway work and on West Norfolk Alliance's achievements to date, thereby building a sustainable model of system-wide integration on a strong foundation of existing cross-sector collaboration. We see this as a valuable opportunity to develop solutions for challenged smaller DGHs that can be transferred to other health systems across England.

46.2 What are you aiming to achieve?

Our vision is for 'sustainable coordinated services with patients in control' enabling:

- Independence, choice and quality
- One assessment and one care plan
- No organisational boundaries and shared information and decision-making

We are committed to the delivery of person-centred, coordinated care (the National Voices definition of integration).

We will know we are successful when:

- People are more satisfied with their care
- We have confirmed stakeholder and public support
- Inappropriate admissions to hospital have been reduced (to 2010/11 levels) and to care/nursing homes (by 5% per year)

46.3 What have been the highlights of your first year?

- Establishment of the West Norfolk Alliance

- Development of a multi-agency prevention strategy and delivery of a local web-based system providing information on support
- Six-week reablement services extended to include 'premises reablement' (with plans also to include 'social network' reablement) as well as individual reablement
- A network of senior community matrons with prescribing powers and integrated care coordinator posts.
- A pilot to share summary records across primary and secondary care
- Social work added to multi-disciplinary teams and integrated operational management of community health and social care
- Plan for an integrated hub to provide a single point of access
- A virtual ward model delivered by an integrated team
- Extensive public consultation and stakeholder involvement
- A shared approach between NHS and both tiers of local government to voluntary sector support
- Improved sharing of relevant information
- Reduced duplication of assessments
- Increased uptake of personal health budgets for social and health care

46.4 Details of the year
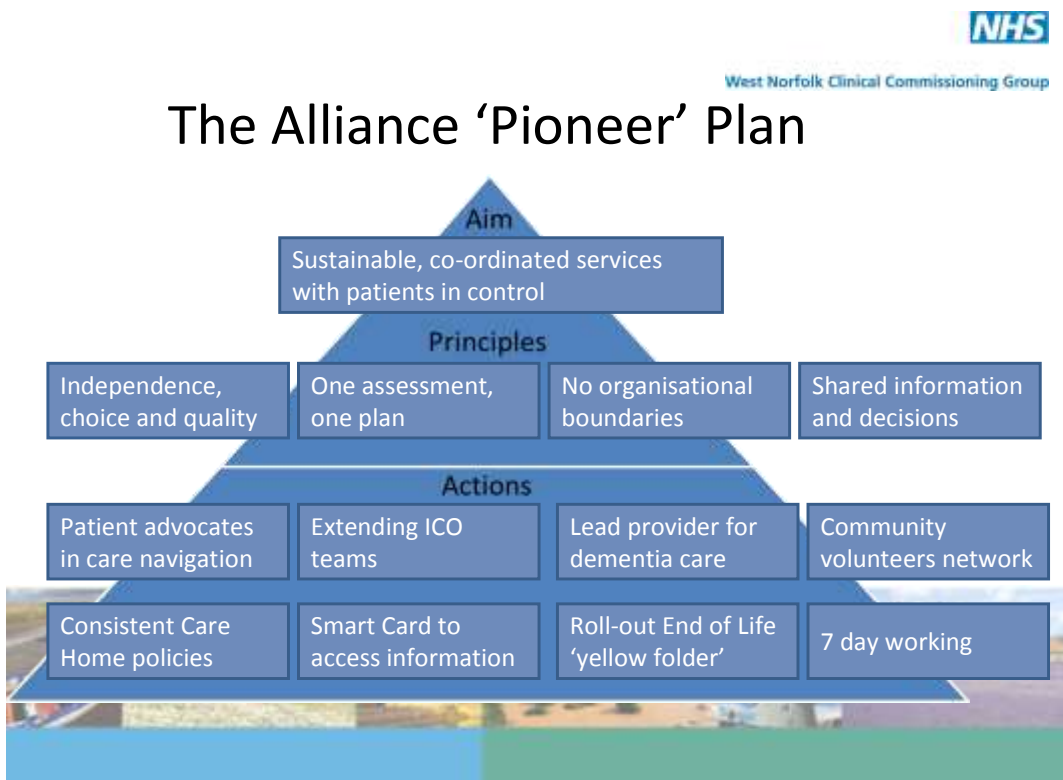
The alliance is redesigning services across health and social care to achieve greater integration and whole-system sustainability. This is likely to involve substantial innovation and reconfiguration. This year, we have made progress on the following:

The development of a multi-agency prevention strategy and the delivery of LILY (Living Independently in later Years); this is a local web-based information system (with call centre back-up) that provides information on support available locally to enable people to remain independent and connected to their communities. See case study: LILY (Living Independently in Later Years).

Highly performing Norfolk County Council six week reablement services are in place. A more holistic approach is being implemented. In addition to reabling the individual, a partnership with the borough council home improvement team allows 'premises reablement' to be included where necessary. The third aspect of reablement is the social network. Research on this area is currently taking place with the support of a local social enterprise.

We have a network of senior community matrons with prescribing powers who manage a stratified caseload of people with complex needs. They work closely with a multi-disciplinary, primary-care focused team using an integrated care coordinator to enable information-gathering and communication across systems and connect with services.

Our 'Eclipse Live' information sharing project has been refreshed and given new impetus through the formation of a new cross-functional project team and a focus on overcoming the human and operational challenges of adopting new technology as part of clinical practice. See case study: Eclipse Live information sharing project. We are designing a technological solution to securely sharing records – a smartcard using primary care data that can be accessed by approved partners with patients' consent, to treat them appropriately in situ, connecting with community resources and avoiding unnecessary journeys to hospital. A pilot is under way to share summary care records with nursing homes and emergency services to establish the principle of data sharing across primary and secondary care.

Social work input has been added into multi-disciplinary teams – a rapid assessment team based in A&E and the virtual ward team. Integrated operational management brings together community health and social care with some co-location. We plan further co-location across community health, social care and community mental health.

Plans are being developed to expand an existing integrated hub to provide a single point of access for a more comprehensive rapid, coordinated response. This will include representatives from community health, mental health, social care and a link to the voluntary sector.

Capacity for seven-day working is being built – a social worker is now present in the acute hospital over the weekend to carry out assessments and coordinate services in order to facilitate discharge.

A review of the long-established integrated care organisation (ICO) model has been completed. This will result in the establishment of a West Norfolk 'best practice' model which will be progressively implemented across all 23 GP practices. This will bring greater process consistency to the multi-disciplinary risk stratification and working, key worker model and the support it receives through the integrated care

co-ordinator posts. It will also add a care navigator role (commissioned from the voluntary sector) to mirror with high-risk patients the integrated care co-ordinator role in respect to professionals.
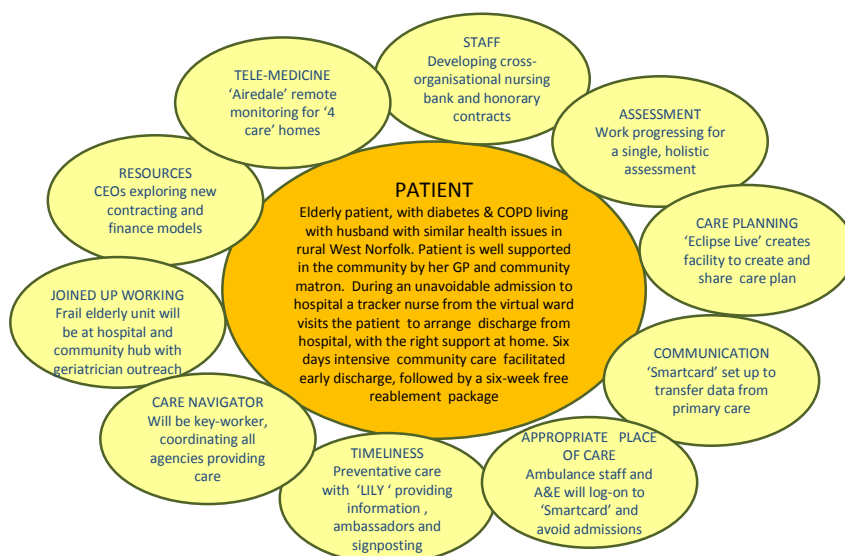
We have enhanced our admission avoidance/early discharge capability through the establishment of a Hospital at Home (virtual ward) model where more intensive clinical support can be delivered in the patient's own home. This service is delivered by an integrated team that includes occupational therapy and social work staff as well as intensive community nursing. See case study: Hospital at Home (virtual ward).

Our whole-system sustainability initiative has been built on public consultation with discussion sessions at many existing local forums (such as the local older persons forum and the local voluntary sector provider forum) and discrete CCG-held public consultation sessions. The area of co-production is also being featured with the active engagement of a wide range of stakeholders in redesigning the local health system to ensure the future financial viability of the local acute hospital. A further example of co-production has been the design of "LILY plus", where a stakeholder group attended a series of six independently facilitated design workshops.

Through the close partnership between commissioners (the district (borough) council, the county council and the CCG), the main providers and the local voluntary sector, the alliance has a shared approach to supporting a sustainable community-based voluntary sector. An example is the piloting of the 'care navigator' model: three temporary posts are being managed by two local voluntary organisations and a local social enterprise where the potential for utilising community assets is at its strongest.

The 'Alliance Sunflower' diagram below shows how we see the different parts of the integration programme working together to provide a holistic person-centred service for an individual.

A case study of care of an individual ... progress so far ...

STAFF
Developing cross-organisational nursing bank and honorary contracts

TELE-MEDICINE
'Airedale' remote monitoring for '4 care' homes

ASSESSMENT
Work progressing for a single, holistic assessment

RESOURCES
CEOs exploring new contracting and finance models

CARE PLANNING
'Eclipse Live' creates facility to create and share care plan

PATIENT
Elderly patient, with diabetes & COPD living with husband with similar health issues in rural West Norfolk. Patient is well supported in the community by her GP and community matron. During an unavoidable admission to hospital a tracker nurse from the virtual ward visits the patient to arrange discharge from hospital, with the right support at home. Six days intensive community care facilitated early discharge, followed by a six-week free reablement package

JOINED UP WORKING
Frail elderly unit will be at hospital and community hub with geriatrician outreach

COMMUNICATION
'Smartcard' set up to transfer data from primary care

CARE NAVIGATOR
Will be key-worker, coordinating all agencies providing care

TIMELINESS
Preventative care with 'LILY' providing information, ambassadors and signposting

APPROPRIATE PLACE OF CARE
Ambulance staff and A&E will log-on to 'Smartcard' and avoid admissions

The whole-system sustainability project is very much a work in progress, but early indications from some of the projects that have established closer integrated working are of increased patient satisfaction.

46.5 What has been the most exciting aspect?

The formation of the West Norfolk Alliance, which has provided the integrated leadership to make the whole project possible. The group of chief executives led by the CCG which make up the alliance have committed their support via a formal memorandum of understanding to tackle the obstacles to implementing more ambitious integration. Despite some senior departures and new arrivals, the resolve of the alliance remains undiminished and is pushing forward the pursuit of greater integration with the commissioning of multi-agency work in the following areas:

- Alignment of it systems
- Co-location of staff
- Recruitment and retention
- Sharing back office services
- Empowering staff

46.6 What has been the most challenging aspect?

Bringing about change across the total alliance workforce. The alliance is committed to the delivery of person-centred, coordinated care across the whole local health and social care system. This requires a move from silo working and the merging of professional cultures and the adopting of a new 'alliance ethos'. The biggest challenge is to achieve this level of changed thinking – to get to the position where every manager owns, promotes and models integrated working and where every frontline worker is empowered to carry it out.

46.7 What are you planning to do next year?

- Planning the implementation recommendations from the system sustainability programme, which at this stage are embryonic, but could involve a radical new 'health campus' approach to integrated care, based on one of the models in the Five Year Forward View
- Developing the existing limited 'hub' model by the community health provider that provides a central point for referrals and the co-location of 24/7 immediate response services (including one small social care service). There are plans in the next year to relocate the hub to enable significant expansion of co-located immediate response services from across community health, social care and community mental health
- Implementing the recommendations from our estates strategy that is currently mapping the estates holdings of each of the members of the alliance with a view to maximising both value for money and the potential for co-location of key functions and staff groups

46.8 What is your advice for areas starting on their own integration journey?

A helpful starting point has been the agreement at an alliance board level to the development of a shared ethos across the workforce – a common way of thinking and behaviour that is recognisable to service recipients as 'the alliance way of working'. This is being developed through our workforce strategy that includes such initiatives as the engagement of staff, a shared recruitment portal, a shared staff bank, and a common induction element. We have a progressive workforce development programme under way to challenge frontline staff, managers and organisational leads to implement an agreed set of actions to promote positive assumptions and overcome obstacle to integrated care.

Public engagement has been extremely helpful in establishing a baseline in local public expectations. This was our starting point and has remained the reference point for the evaluation of progress.

Of course we did not welcome the fact that our local DGH is in special measures with Monitor. A beneficial consequence, however, is that we have all been forced to recognise that the issues affecting the acute hospital are part of the whole system. They must therefore be addressed in a holistic way by changes across the whole system, with collective responsibility across the system for ensuring that those changes are implemented to improve outcomes for patients and service users.

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47 Case study: West Norfolk – Eclipse Live information sharing project

This project deals with sharing data in various forms, including patient identifiable data, and has recently been refreshed as part of the West Norfolk Alliance System Sustainability Programme. A new project team has been formed, led by a cross-functional project manager and supported by specialists in clinical operations and information governance. The project has four distinct work streams whose scope and sequence are shown below.

Scope and Sequence of Eclipse Live Project Deliverables

Data Quality & Information Governance

| Review of supplier contracts | IG review of data sharing arrangements | Updated statutory returns and notices | Integration of data from other sources e.g. SUS | IG assurance for dedicated West Norfolk infrastructure | Ongoing IG audit and governance processes |

System Wide Operational Roll Out

| Eclipse Live alerts available for GPs | CCG level data analysis available | Clinical governance & operational protocols agreed | Eclipse Live roll out & training for QEH, EEAST, Community Matrons & Social Services | Triage piloted and rolled-out | Digital passport roll-out via GPs | Ongoing support & training |

Care Home Integration

| Green Envelope in all care & nursing homes | Eclipse Live roll out & training for care & nursing home staff | Digital passport roll-out across care and nursing homes | Integration with telehealth process e.g. Airedale | Eclipse Live care home module availability |

Infrastructure

| Secure funding for Digital Integrated Care Record | Integration with HSCIC Spine and 15 mins data upload | Design, build and test dedicated West Norfolk Digital Integrated Record infrastructure | Transfer live data to dedicated West Norfolk infrastructure | Ready to enable future projects |

The governance structure follows NHS best practice and centres on a project board which will have full accountability. It is funded by non-recurrent winter monies held by West Norfolk Clinical Commissioning Group.

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48 Case study: West Norfolk – Hospital at Home (virtual ward)

This model provides enhanced clinical and practical support to up to 20 patients in their own home either to facilitate an early discharge from the local acute hospital (75% of referrals are of this kind) or to avoid the need for admission (25% of referrals).

This is proving successful on a number of levels:

- Integrated service – the service is delivered through a partnership between the community health provider (providing the clinical oversight and practical support) and the local authority (providing a dedicated linked social work post and input (where appropriate) from the reablement service)
- Patient satisfaction – the scheme is hugely popular with patients with close to 100% scoring the service as a 1 or 2 on a 5-point scale where '1' = 'excellent' and '5' = 'very poor'. On the Family and Friends scale, close to 90% of patients report that they would be 'extremely likely' to recommend it to family and friends
- Outcomes – bed occupancy is close to 100%, with an average length of stay of five days and an admission/readmission rate to the acute hospital of only around 5%

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49 Case study: West Norfolk – LILY (Living Independently in Later Years)

This is an online directory and associated call-centre option that brings together information about a wide range of local services, activities, advice and guidance aimed at helping older people maintain their independence and remain connected to their communities.

It is hosted by the Borough Council of King's Lynn and West Norfolk with additional funding support from both Norfolk County Council and West Norfolk Clinical Commissioning Group. The total number of 'hits' between the 'soft' launch in March and the end of the calendar year was 64,000. The average monthly hits are now in excess of 5,000**.**

The next development of the strategy – LILY plus – is about to be launched. This includes an extensive marketing drive, remote site access and the recruitment of 'LILY champions' in communities who can both promote the service and assist individuals to access it.

The LILY brand will be developed as the one-stop shop for essential information on local support to remain independent. It is the central plank of the local Prevention First strategy that was drafted by a wider group of local stakeholders, including the voluntary sector.

LILY continues to be developed with increased marketing, new permanent community access points and a pop-up capacity (the ability to take a laptop and supporting material to events etc) and the recruitment of community-level volunteers as LILY champions.

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50 Worcestershire Pioneer Programme – Profile

50.1 What is your area like?

Worcestershire is a large county in the west of England, with a population of 567,000. It has both urban centres of population and also widely scattered rural communities. It has a higher than average elderly population (19.3% over 65), of whom a higher proportion live in rural areas than in urban, adding to the challenge for health and social care services. The health of the people of Worcestershire county is generally better than the England average. The rate of hip fractures, however, in older people is higher than the England average.

Health and wellbeing priorities include older people and management of long-term conditions, mental health and wellbeing, obesity and alcohol.

50.2 What are you aiming to achieve?

Our integration programme is called Well Connected. It is a collaboration of all the health and care partners in Worcestershire and seeks to manage whole-system change in health and care delivery. The collaboration includes three clinical commissioning groups (CCGs), an acute NHS trust, a health and community NHS trust, Worcestershire County Council, NHS England, Local Healthwatch and representation from the voluntary and community sector.

A transformation vision was established between the stakeholders, adopting the National Voices 'I statements' on integrated care. Our vision for improved and integrated care covers all people in Worcestershire with a focus on older people and adults and children with multiple long-term conditions or complex problems. The integrated care programme was rebranded as the Well Connected Programme. A five-year strategy was developed to transform the commissioning and delivery of care.

We will know we have succeeded in our ambition if:

- We can secure additional years of life for people in conditions amenable to healthcare
- All people over 65 and those under 65 with long-term conditions have their own personalised integrated care plan
- Emergency admissions and length of stay are reduced by managing care more proactively in other settings
- There is safe and effective care and the proportion of people having a positive experience of care in all settings increases
- The need for long-term residential and nursing care for all age groups by people being healthy and living independently falls
- There is parity of esteem between people with mental health conditions and those with physical health conditions

50.3 What have been the highlights of your first year?

- Developing and clarifying the health economy vision for health and care and incorporating the Well Connected vision into the Worcestershire five-year health and care strategic plan. This covers five transformation programmes (with a children's and young people's programme overseen by the children's trust board) and the establishment of a number of enabling programmes that support and integrate the transformation programmes
- Profiling the health and care needs of half of Worcestershire's population to enable us to divide the population into segments with the aim of designing new models of care to meet their different needs, delivered by a collaboration of providers through the mechanism of a capitated budget
- Setting up an integrated commissioning unit to build on our previous joint commissioning for mental health and learning disabilities, strengthening its governance and incorporating the necessary capacity for integrated commissioning for older people and to deliver our Better Care Fund proposals

50.4 Details of the year

At the beginning of the programme, we identified a number of integration projects to address, in particular the challenge of a higher-than-average older population. A small team was recruited to manage and take forward the integration projects but it quickly became clear that the individual projects would not meet the scale of change required and that much wider system transformation was required.

All partners worked to identify what transformations in care our populations needed through a series of multi-organisational meetings and visioning events. This process cumulated in the development of a comprehensive five-year strategy defining the direction of changes in health and care in Worcestershire.

The strategy has defined five transformation programmes, including:

- **Future Lives** The major change programme for adult social care, including new models of care for integrated health and social care working
- **Out of hospital care** This project is in an early stage and will be developing new models for primary care at scale and care closer to home, including enhanced services for prevention and early intervention.
- **Urgent Care** This encompasses 14 projects to improve urgent care and manage increasing demand.

In the last year the urgent care programme has included:

- Implementation of a patient flow centre that collects, reviews and acts on all whole-system data related to bed and service capacity and demand. See case study: Patient flow centre and clinical triage.
- Setting up a clinical navigation unit at the front door of Alexandra Hospital A&E and locating GPs in A&E at Worcestershire Royal Hospital
- Developing a new sub-acute model in community hospitals, building on virtual wards
- The further development of enhanced care teams and a care home project utilising advanced nurse practitioners. See case study: Enhancing the quality of care for care home residents.

In spite of the relentless increase in demand and attendance at A&E that most areas are experiencing, we have managed to stem the flow of increasing emergency admissions with numbers holding steady compared to last year. At 31 December 2014 the total number of A&E attendances across Worcestershire was up 7.22% on the previous year. Over the same period emergency admissions stood at 36,366. This is compared to 36,277 in 2013/14 – a decrease of 0.09%.

Although not yet showing the reductions we need, we are hopeful that as current projects embed more fully and new initiatives come on stream, we will start to show an increased reduction in emergency admissions, increase in community provision and better 'flow' through the system that we are planning.

50.4.1 Profiling the needs of our residents

The development of the transformation programmes was underpinned by research which indicated that approximately 5% of our population consumes 40% of the health and care resource and a significant proportion of those individuals were elderly with complex co-morbidities and long-term conditions.

We decided the best way we could achieve a transformation in health and wellbeing was to divide the population into segments and design new models of care to meet their different needs, delivered by a collaboration of providers through the mechanism of a capitated budget.

To date, the initial analysis has been commissioned and undertaken by a commissioning support unit, which has matched records for approximately half the adult population of Worcestershire. The first analysis of the data has been undertaken and this is being further refined by the addition of primary care data. See case study: Profiling the population.

50.4.2 Systems leadership and enabling activity

The programme has had buy-in from all partners in the county, including all the statutory health organisations, the county council, Healthwatch and the voluntary and community sector. The senior leaders from all the organisations meet regularly within a clear governance structure. Even when things have been difficult the commitment to attendance and resolution of problems has been maintained.

The vision and strategy have developed over time through contributions from all the stakeholders – throughout the process the service user and their families and carers have remained at the centre. All stakeholders are committed to an overall principle that the needs of service users are more important than individual organisations – even when at times this is difficult because each organisation has its own duties and responsibilities.

Above all, a commitment to systems leadership has been crucial. Through the pioneer programme, senior leaders have given their support to develop effective leadership in the world of partnership working where no one person or one organisation is 'in charge'. This support has challenged those leading and

implementing the programme, identified barriers and helped stakeholders find solutions to overcoming difficulties between organisations or individuals.

Alongside the systems leadership support, a number of other projects have been developed to enable and integrate the transformation programmes. For example:

- **Finance and governance** Population segmentation to develop capitated budgets, development of the integrated commissioning unit
- **Information technology and information governance** A roadmap developed with support from Health and Social Care Information Centre to implement our vision for sharing service user information through IT. This is supported by a multi-organisational information governance group
- **Workforce** We are starting to develop an integrated workforce strategy across health and care, with an initial focus on urgent care
- **Communications and co-production** Development of a website and newsletter, presentations at many groups about our vision and plans, development of a co-production strategy, supported by Healthwatch

50.5 What has been the most exciting aspect?

We have invested significant energy in developing the framework for integrated care at scale across the health and care economy. This is now beginning to show results with new integrated projects coming online and significant work on designing new ways of working starting early in 2015 with co-production and co-design with service users and carers and frontline staff at the heart of the process.

50.6 What has been the most challenging aspect?

It is hard work laying the foundations of partnership working and maintaining this during challenging periods. Sometimes behaviours do not match the rhetoric of integration – it can be difficult always to put the needs of service users above the needs of organisations.

Like other areas, we have struggled with information governance and this has now put a block on progressing our planned work on capitated budgets until it is resolved at the national level.

In general, there is a lack of resources for the large-scale change needed; for example for 'double running' to invest in community services before down scaling the acute sector. Our work is also influenced by the cuts in the social care budget and the rapidity of changes required to implement the Care Act.

Workforce planning is challenging and new ways of working can have unintended consequences, for example recruiting high-quality staff to the care home project has left workforce gaps elsewhere in the system.

Finding the resources and time to carry out evaluation has been challenging and we are concerned that there are pressures to evaluate too early before being in a position to assess long-term outcomes of our changing models of care.

We believe that our attempts to communicate the vision of integrated care and care out of hospital and closer to home is not helped by national messages about the NHS – these still give the impression that health is all about hospitals.

50.7 What are you planning to do next year?

Specifically, we will be:

- Commissioning and implementing our Better Care Fund plans
- Developing our out-of-hospital model
- Developing our segmentation model and capacitated budget – we plan to have set it up in shadow form by October 2015 and for it to go live in 2016/17
- Implementing our IT roadmap
- Developing our integrated workforce strategy
- Developing GP co-commissioning
- Developing our provider collaboration model
- Implementing a co-production strategy

50.8 What is your advice for areas starting on their own integration journey?

Important steps for us have been:

- That 'integration' and 'co-ordination' have entered the language of our health and care economy, becoming embedded in thinking throughout the partner organisations
- Multi-agency work has become the norm
- The voluntary and community sector is fully engaged with our integration work
- A shift in mindset has taken place towards a person-centred approach
- Supporting and developing the 'softer' skills required for system leadership is difficult but vital

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51 Case study: Worcestershire – Enhancing the quality of care for care home residents

The aim of this project is to enhance the quality of care for care home residents by improving the coordination and management of each resident's care needs. In 2012, five community nurse practitioners (CNPs) were assigned to individual South Worcestershire care homes to deliver the project via the production of clinical management plan (CMP) for each home resident.

Through the production of a CMP, risk was mitigated by ensuring a detailed care plan was agreed in conjunction with the resident, care home staff and GP. The CMP is available for any healthcare clinician treating the patient and includes details of a resident's care needs and preferences in regard to end of life care or avoidance of hospital admission. It remains with the patient at their care home, allowing direct access to ambulance crews and GP out-of-hour's services for rapid support close to home.

As part of the project, the enhanced primary care (local enhanced services) required GPs to have weekly contact with the CMPs to review the management of complex care patients. In addition, pharmacists provided an annual medication review for all residents and dietetic support was available as required.

This was a commissioning-led project embodying integration and the fostering of partnerships, working across community providers, independent sector organisations, and local GP practices to enhance the quality and safety of care for care home residents, facilitating patient choice and putting patients more in control of their health care.

At the end of March 2014 the project resulted in the production of CMPs for 2,100 care home residents in South Worcestershire. In year one evaluation of this project revealed a 26.5% education in all admissions when compared to the same period in the previous year, with a 23.1% reduction in A&E attendances from care homes, with savings in the region of £700.000.

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52 Case study: Worcestershire – Patient flow centre and clinical triage

As part of Worcestershire's Well Connected integration programme an integrated patient flow centre has been set up. The centre is intended to address previous complex discharge processes, fragmented admission avoidance, reliance on manual systems, poor data transparency and other factors leading to reactive rather than proactive multi-agency working.

The centre, which is staffed by members from all the stakeholder organisations, provides a link between Worcestershire Acute Hospitals NHS Trust, Worcestershire Health and Care Trust, and Worcestershire County Council. It supports a systematic process for dealing with capacity and demand issues, patient flow and admission prevention. It provides one single source of real-time admission, transfer and discharge data using electronic whiteboards located in the acute and community hospital wards that every organisation can access and act on. The system of clinical triage facilitates a clinical conversation, taking information about the patient's ongoing need at the first point of contact. Patients are allocated to a discharge pathway depending on whether their likely discharge will be to home, short term care for rehabilitation or long term residential care. The emphasis is on discharge home with appropriate support wherever this is possible.

Processes to facilitate discharge such as transport arrangements have been streamlined and brought forward early in the admission (see diagrams).
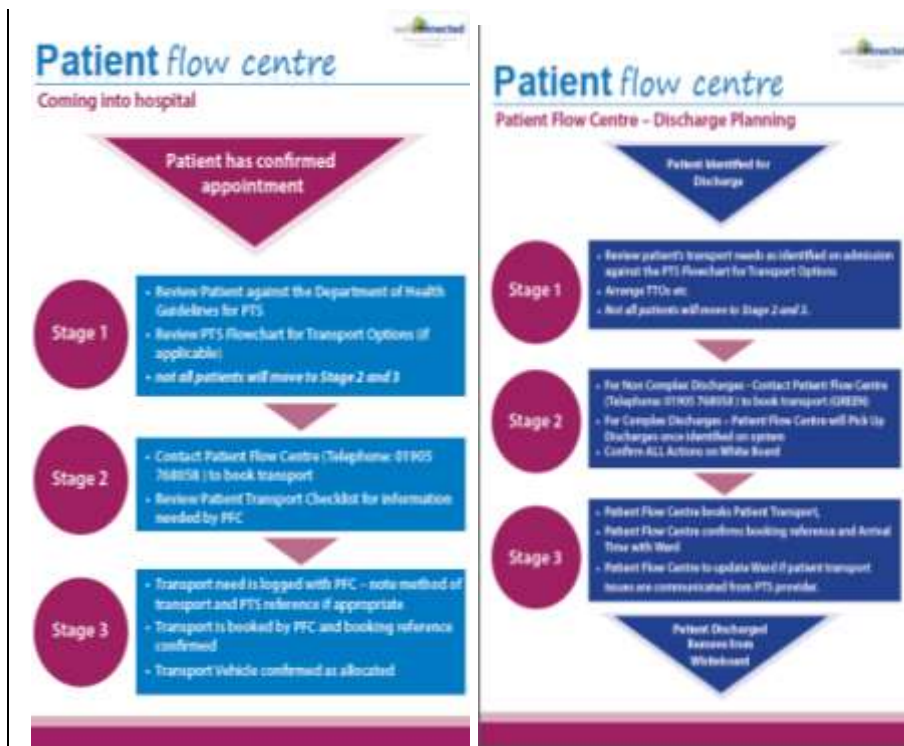
Although up and running for only a few months, the centre is processing increasing numbers of discharges, with discharges home running ahead of target.

The next stage of the transformation included a move to a seven-day service in December 2014, and will include a full review of the IT and the service and full integration of admission prevention services.

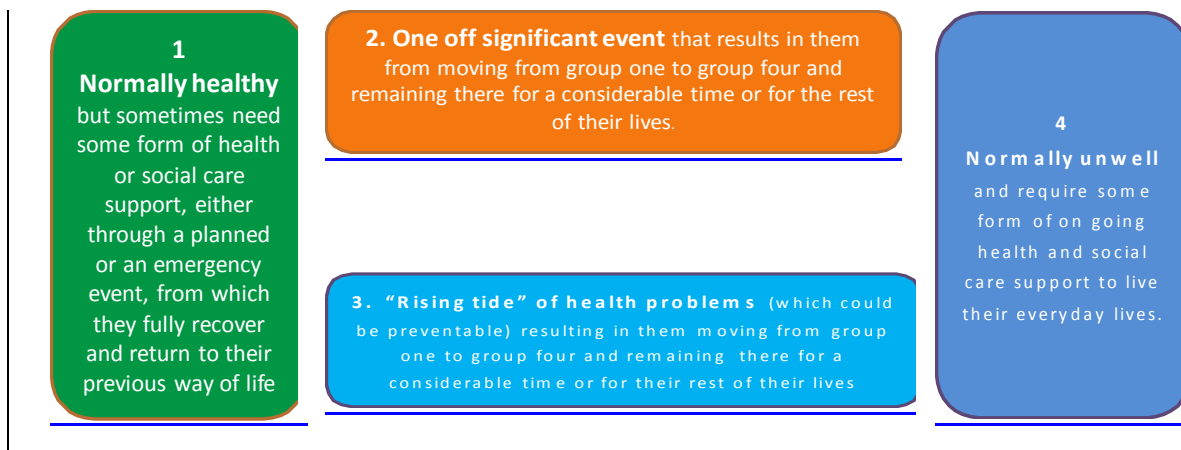Aspirations for achievements over the next stage include:

- Improving patients perceptions/experience of patient flow
- Increasing number of phone calls answered
- Significantly increasing number of discharges each day
- Improving referral to discharge to under one day
- Becoming more accessible
- Pulling patients to the patient flow centre so that it processes increasing numbers of discharges, improving efficient discharge and leaving more time for ward staff

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53 Case study: Worcestershire – Profiling the population

The development of the transformation programmes was underpinned by research which indicated that approximately 5% of the general population consumes 40% of the health and care resource and a significant proportion of those individuals were elderly with complex co-morbidities and long-term conditions. It was decided that the best way Worcestershire could achieve a transformation in health and wellbeing was to divide the population into segments and design new models of care to meet their different needs, delivered by a collaboration of providers through the mechanism of a capitated budget.

1
Normally healthy but sometimes need some form of health or social care support, either through a planned or an emergency event, from which they fully recover and return to their previous way of life

2. One off significant event that results in them from moving from group one to group four and remaining there for a considerable time or for the rest of their lives.

3. "Rising tide" of health problems (which could be preventable) resulting in them moving from group one to group four and remaining there for a considerable time or for their rest of their lives

4
Normally unwell and require some form of on going health and social care support to live their everyday lives.

The initial focus will be on Segment 4 but ultimately on Segment 3.

The analysis has been commissioned and undertaken by Midlands and Lancashire Commissioning Support Unit, which has matched 225,000 records, approximately half the adult population of Worcestershire, using data from acute services, ambulance services, community services, mental health services, social care and those needing continuing care packages. Primary care data is currently being added to the analysis to further refine the data, particularly in regard to long-term conditions. The NHS number has been used as the identifier and the excellent use of the NHS number in adult social care has enabled matching of almost all adult social care users. The data has also been matched to socioeconomic data.

Initial analysis shows that the top 1% of users of health and care services in Worcestershire consume 35% of the total resource. The analysis can be cut in numerous ways to help the integration programme identify the segment that will most benefit from developing a new model of care delivery, such as by looking at age, diseases and numbers of co-morbidities, combinations of services used, costs and socioeconomic data. For example 12,000 users (5% of the population) received both health and care services but this group consumed almost 40% of the total resource.

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54 Case study – Information governance and Southend's s251 application

One of the challenges that most pioneers have been experiencing is the sharing of information to support integration. The Health and Social Care Act resulted in significant changes to the structure of the NHS and also changed the way in which information flows across the health and care system. This built on the vision outlined by Dame Fiona Caldicott in here Caldicott2 Report – *'Information – To Share or Not to Share?'*.

Primary care trusts had become used to working with patient identifiable information as part of their dual commissioner / provider role. As they became commissioning organisations, however, the limitations on their lawful basis to access and use patient data was not quickly compensated for.

Within the Health and Social Care Act 2012, the Health and Social Care Information Centre (HSCIC) was given the power to receive and process patient identifiable information. The vision of the Act was a single safe haven serving the data storage needs of the Health and Care Sectors. Clinical commissioning groups (CCGs) and commissioning support units (CSUs) therefore needed to establish a legal basis to process patient identifiable data.

Systems in April 2013 were not sufficiently developed to enable the operation of key functions without access to patient identifiable information. Some of these functions were core business functions such as invoice validation and others were innovations intended to improve the care of patients, including risk stratification.

In order to start some of the processes, NHS England made a series of applications to the Confidentiality Advisory Group (CAG) on behalf of CCGs in England under regulations enabled by Section 251 of the NHS Act 2006. Section 251 support is always intended to be a temporary arrangement and any application is expected to include an exit strategy.

Southend-on-Sea highlighted early on the implications on sharing information across health and social care in light of these changes. The section 251 applications submitted by NHS England did not cover the flow of social care data.

In January 2014 there was a two-day visit, led by Department of Health to Southend. This confirmed that there was indeed no legal basis to share information for the purposes Southend were seeking. In summary, Southend has been seeking to link social care information (initially, although the intention will be to extend) with primary care (GP) and acute care (SUS) information in a way that also enables re-identification by those in a legitimate relationship with the patient and supports commissioning using pseudonymised data (where there is limited access) and aggregated data.

While there is explicit consent in place for social care, this is not the case for the registered health population. The outcome of the visit has led to a series of section 251 applications to the CAG – the third of which was submitted in December 2014.

Although this application is provisionally approved, support does not come into effect until formal confirmation of the completion of 16 actions. While some of these actions are relatively straightforward to complete, others, including effective management of patient objections across all datasets and the need to communicate with all individuals impacted by the integrated care programme, have synergies with wider activity around care.data and the pathfinder work being taken forward.

Although the application being made by Southend has, in some ways, intended to act as a baseline for other pioneer sites it is evident that there is not an identical focus for all local areas. For instance, North West London has recently made an application to the CAG for the linking of primary care (GP) data with specified health commissioning datasets. North West London has a history of patient engagement and previous work has included communications to individual households. Importantly the emphasis of its application does not include the need to re-identify patients in the same way as Southend and also excludes the linkage of social care data.

This is a complex area and it is disappointing that swifter progress has not been made – for Southend, that a year on, these issues aren't resolved.

In January, pioneers came together with Department of Health, NHS England and Information Governance Alliance to update on progress and also explore options for Pioneers outside of Section 251.

The next steps include:

- Working with Southend to address the 16 actions highlighted including making links with the care.data programme to explore opportunities for communications
- Working with pioneers to further strengthen the understanding of specific barriers / purposes they are seeking to achieve
- Providing practical real-life examples against the options outlined at the event in January
- Supporting pioneers in using options locally or supporting with an interim section 251 application where this may still be required

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55 The CIS Financial Model and its example for integration

55.1 The CIS service: the case for change

As part of the Better Care Fund (BCF) programme, North West London has been currently developing and implementing a Tri-borough Community Independence Service (CIS). The CIS lies at the heart of integrating care across health and social care, as it will deliver more rapid and responsive out of hospital care for people with acute needs which will be provided by health and social care teams working together in a co-ordinated way. It is critical to enable the shift in the care of patients from acute to community settings. The CIS provides a range of functions including rapid response and in-reach services to prevent people going or being admitted into hospital to support them in community settings, and rehabilitation and reablement which enables people to regain their independence and remain in their own homes. The service is currently delivered by a multi-disciplinary team of community nurses, social workers, occupational therapists, GPs, geriatricians, mental health workers, reablement officers and others.

55.2 The CIS financial model: the evidence-based integrated approach to support change

A business case was needed to support the case for change. As part of this process, we developed the CIS financial model in order to inform decision-making and support the case for new investment in the CIS in 2015/16 and beyond (by understanding the viability of the service). The current level of investment (£16.8m p.a.) on CIS is not sufficient to maintain a stable service and meet the need of the local population, as evidenced by the repeated bids for winter pressure funds each year to supplement the existing service. Undue reliance upon non-recurrent funding is not sustainable and limits the ability of the providers to establish a stable workforce plan.

The model estimates the financial costs and benefits of the new CIS service, incorporating links to and impacts on associated services (such as homecare, nursing and residential care home placements). The balance of activities, costs and related risk share across health and social care commissioners has been the subject of a negotiation process as part of the BCF planning process. The financial model has successfully informed and supported the decision-making process all the way through since its inception. The model has been co-designed with senior managers and built with the best possible available and most recent data sources from across health and social care. It has been developed through a structured process involving technical specialists and clinical input to verify the data and assumptions.

Over the first 12 months of operation of the CIS (starting in April 2015), it is predicted that the adult social care home spend will be reduced by approximately £3.3m across the three boroughs, by reducing both admissions and time spent (length of stay) in nursing and residential care settings and by also reducing the levels of care required by patients who will undergo intermediate care reablement services (reducing pressure on homecare budget indirectly). The system is also expected to experience a reduction of 5% over the planned Tri-borough non-elective and A&E

contract spend for 2015/16, which would result in approximately £4.5m of savings. This range of savings will outweigh the new investment needed to match the predicted increase in CIS demand to staff capacity requirements and service adaptations by approximately £3m, the predicted net savings for 2015/16 period.

55.3 The CIS conceptual model: the visual representation of what the model tried to achieve

The savings in CIS are delivered by supporting people in community settings (cost efficient measure) rather than in hospital or in care homes (more expensive). One of the key outputs of the financial modelling is the development of a conceptual model (see Figure 1 below). This explains, in visual terms, how the savings and costs will be generated based on the future flows of individuals across a number of interlinked services. Within the conceptual model, the services within the purple box represent the core components of the CIS service, as explained above. The conceptual model also highlights the existing flows of people that are to be reduced by the CIS service, represented by the black arrows. At a high level, the model shows that the CIS service will result in a reduction in care home placements and acute admissions, which in turn will increase the flow of people into the CIS and homecare as more people are treated in the community. The grey arrows indicate the targeted flows that will result in an increase in activity and costs.
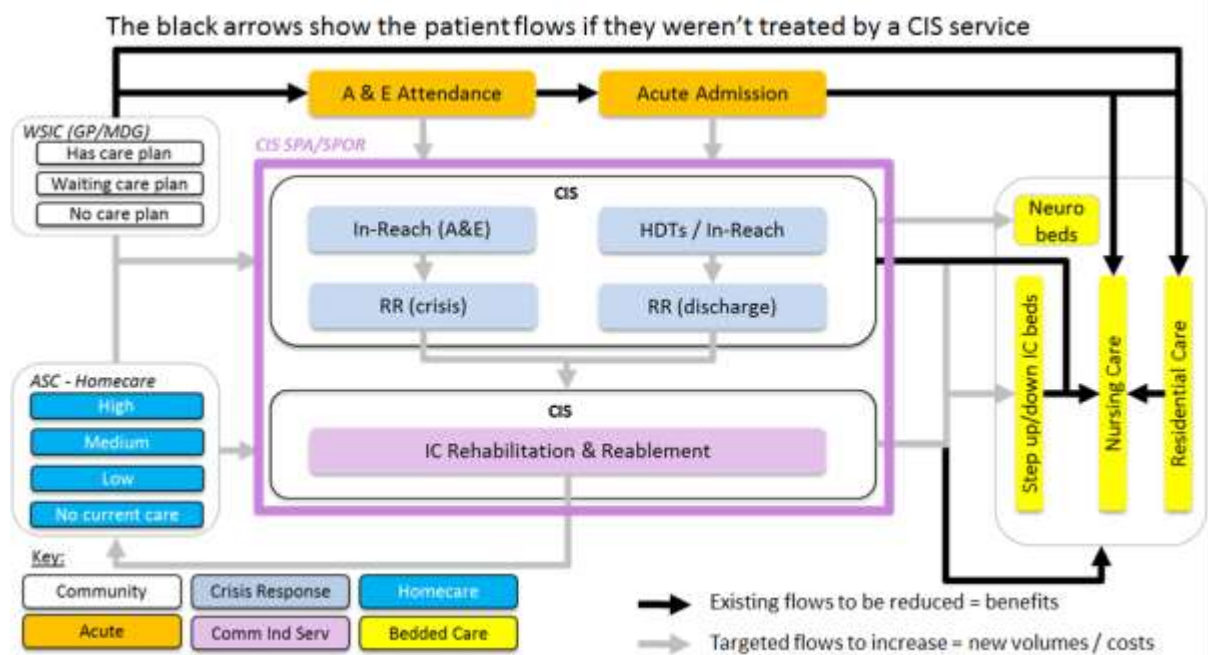

Figure 1: Conceptual Model – flow of people within the CIS system

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