Integration pioneers leading the way for health and care reform

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Care Minister announces details of fourteen areas leading the way in delivering better joined up care.

Fourteen pioneering initiatives are transforming the way health and care is being delivered to patients by bringing services closer together than ever before.

The pioneers are showcasing innovative ways of creating change in the health service, which the Government and national partners want to see spread across the country, Care and Support Minister Norman Lamb announced today.

The fourteen ambitious initiatives are blazing a trail for change by pioneering new ways of delivering coordinated care. The pioneers have been selected by a renowned panel of experts, including international experts drawing together global expertise and experience of how good joined up care works in practice.

The aim is to make health and social care services work together to provide better support at home and earlier treatment in the community to prevent people needing emergency care in hospital or care homes.

Results from these approaches in the pioneer areas include:

- 2,000 fewer patient admissions over a two and a half year period, achieved through teams of nurses, social workers, occupational therapists and physiotherapists working together to prevent crises
- Reducing waiting times from eight weeks to 48 hours at physiotherapy services by making professionals work closer together
- Setting up a crisis house where people who suffer mental health problems can get intensive support

With the number of people with more than one long term condition such as diabetes, asthma or dementia set to rise from 1.9 million in 2008 to 2.9 million in 2018 and increasing pressures on A&E departments, the need to deliver better joined-up care and a more sustainable NHS has never been more urgent.
Norman Lamb, Care and Support Minister, said:

Too often care is uncoordinated, leaving too many people needlessly entering the revolving door of their local A&E again and again, because somewhere in the system their care has broken down.

We have heard people talk about integration before, but it has never truly taken hold across the NHS. These pioneers are a starting gun for the NHS and social care to achieve a common goal – to get local health and care services working together, not separately, in the interests of the people that they all serve.

However, this is just the start – we want to make integrated care the norm across the country and planning has already begun in order to invest £3.8bn into integrated health and care services in 2015/16.

We need to preserve the NHS, and through an integrated approach we can achieve better results for patients and make the money go further, whilst making necessary savings. These fourteen pioneers will test new ways of working for everyone to learn from, and drive forward genuine change for the future.

The Deputy Prime Minister Nick Clegg commented:

I want to build a fairer society and that means providing better care to people in our hospitals, care homes and their own homes. We need to join up care around people’s lives, not force them to fit their lives around the care they need. The pioneers will champion this joined up approach, sharing their good ideas with doctors and nurses across the country so that we get better care in every area.

In Greenwich, one of the areas named today as a pioneer, over 2000 patient admissions were avoided due to the work of a team made up of nurses, social workers, occupational therapists and physiotherapists. The team responds to emergencies they are alerted to within the community. In many cases they are able to avoid a hospital admission for the patient by treating them at home or through short term residential care.

In South Devon and Torbay, having integrated health and social care teams has meant patients having faster access to services. Previously getting in touch with a social worker, district nurse, physiotherapist and occupational therapist required multiple phone calls, but now all of these services can be accessed through a single call. In May 2013, the Department of Health and national partners launched a programme to break down barriers to integrated care and support and deliver better joined up care for people.

It is intended that learning from this process will be shared nationally, with the aim of making integrated care and support the norm and to end disjointed care. The ambition is to help all areas across the country deliver integrated care and support. This will improve experiences and outcomes for people who use care and support services.

Jane Cummings, Chief Nursing Officer at NHS England, said:
We need a health and social care system that is truly seamless so that people receive the right care and support at the right time, in the right place.

At the same time, services are under intense and growing pressure and to succeed, we need radical transformation. We need to embrace and develop innovative solutions and truly integrated multi-agency working so that local health and social care systems work as a whole to respond to and meet the needs of people who use health and care services.

Today’s announcement is an important catalyst for this change and a real opportunity to help improve the lives of some of the most vulnerable people in our society.

Notes to editors

For further press information, please contact the Department of Health press office on 020 7210 5435

Details of the fourteen pioneering areas are below:

**Barnsley**

The aim of the Stronger Barnsley Together initiative is to make sure that the health and care needs of local people are met in the face of an increasingly difficult climate. Population changes, public sector cuts and welfare reforms, have had an impact on how Barnsley delivers these services, and they cannot afford to continue with the existing system as it is. A new centralised monitoring centre has been set up. When the centre is alerted about an emergency case, it is assessed within one of three categories (individual, families, and communities) and the right kind of help is delivered. This will help ensure that the right help is dispatched quickly to the relevant patient.

Patients will receive tailored care to suit their requirements, whether this is day to day support to enable people to stay safe, secure and independent, or the dispatch of a mobile response unit for further investigation. This is vitally important to ensure that patients are seen swiftly and receive the care and information they need – whether this is avoiding a return to A&E, getting extra care support for a child’s care needs, or even work to improve the information available explaining how to access to council services.

**Rachel King**

01226 774586 rachelking@barnsley.gov.uk

**Cheshire**

Connecting Care across Cheshire will join up local health and social care services around the needs of local people and take away the organisational boundaries that can get in the way of good care.
Local people will only have to tell their story once – rather than facing repetition, duplication and confusion. Also the programme will tackle issues at an earlier stage before they escalate to more costly crisis services.

There will be a particular focus on older people with long-term conditions and families with complex needs.

**Laurence Ainsworth**

01244 977 147 Laurence.Ainsworth@Cheshirewestandchester.gov.uk

**Cornwall and Isles of Scilly**

Fifteen organisations from across health and social care, including local councils, charities, GPs, social workers and community service will come together to transform the way health, social care and the voluntary and community sector work together. This is about relieving pressures on the system and making sure patients are treated in the right place. Teams will come together to prevent people from falling through the gaps between organisations.

Instead of waiting for people to fall into ill-health and a cycle of dependency, the pioneer team will work proactively to support people to improve their health and wellbeing. The pioneer will measure success by asking patients about their experiences of care and measuring falls and injuries in the over 65s.

**Zoë Howard**

01726 627892/07919 995189 Zoe.Howard@kernowccg.nhs.uk

**Greenwich**

Teams of nurses, social workers, occupational therapists and physiotherapists work together to provide a multidisciplinary response to emergencies arising within the community which require a response within 24 hours. The team responds to emergencies they are alerted to within the community at care homes, A&E and through GP surgeries, and handle those of which could be dealt with through treatment at home or through short term residential care.

Over 2,000 patient admissions were avoided due to immediate intervention from the Joint Emergency Team (JET). There were no delayed discharges for patients over 65 and over £1m has been saved from the social care budget.

**Andrew Stern**

020 8921 5043 andrew.stern@royalgreenwich.gov.uk

**Islington**

Islington Clinical Commissioning Group and Islington Council are working together to ensure local patients benefit from better health outcomes. They are working with people to develop individual care plans, looking at their goals and wishes around care and
incorporating this into how they receive care. They have already established an integrated care organisation at Whittingdon Health better aligning acute and community provision.

Patients will benefit from having a single point of contact rather than dealing with different contacts, providing different services. Patients will feel better supported and listened to.

**Kathleen Kelly**

020 3688 1217 Kathleen.kelly@nelcsu.nhs.uk

**Leeds**

Leeds is all about aiming to go ‘further and faster’ to ensure that adults and children in Leeds experience high quality and seamless care.

Twelve health and social care teams now work in Leeds to coordinate the care for older people and those with long-term conditions.

The NHS and local authority have opened a new joint recovery centre offering rehabilitative care – to prevent hospital admission, facilitate earlier discharge and promote independence. In its first month of operation, it saw a 50% reduction in length of stay at hospital.

Leeds has set up a programme to integrate health visiting and children’s centres into a new Early Start Service across 25 local teams in the city. Children and families now experience one service, supporting their health, social care and early educational needs, championing the importance of early intervention. Since the service has been in operation, the increase in face-to-face antenatal contacts has risen from 46% to 94% and the number of looked after children has dropped from 443 to 414.

Patients will also benefit from an innovative approach which will enable people to access their information online.

**Stuart Robinson**

0113 224 3937 stuart.robinson@leeds.gov.uk

**Kent**

In Kent, the focus will be around creating an integrated health and social care system which aims to help people live as independent a life as possible, based on their needs and circumstances. By bringing together CCGs, Kent County Council, District Councils, acute services and the voluntary sector, the aim will be to move to care provision that will promote greater independence for patients, whilst reducing care home admissions. In addition, a new workforce with the skills to deliver integrated care will be recruited.

Patients will have access to 24/7 community based care, ensuring they are looked after well but do not need to go to hospital. A patient held care record will ensure the patient is in control of the information they have to manage their condition in the best way possible. Patients will also have greater flexibility and freedom to source the services they need through a fully integrated personal budget covering health and social care services.
The care of North West London’s 2 million residents is set to improve with a new drive to integrate health and social care across the eight London boroughs. Local people will be supported by GPs who will work with community practitioners, to help residents remain independent. People will be given a single point of contact who will work with them to plan all aspects of their care taking into account all physical, mental and social care needs.

Prevention and early intervention will be central - by bringing together health and social care far more residents will be cared for at or closer to home reducing the number of unplanned emergency admissions to hospitals. The outcomes for patients and their experiences of care are also expected to increase. Financial savings are also expected with the money saved from keeping people out of hospital unnecessarily being ploughed back into community and social care services.

Five of Staffordshire’s Clinical Commissioning Groups (CCGs) are teaming up with Macmillan Cancer Support to transform the way people with cancer or those at the end of their lives are cared for and supported.

The project will look at commissioning services in a new way – so that there would be one principal organisation responsible for the overall provision of cancer care and one for end of life care.

The teams want to ensure that mental health services are every bit as good and easy to get as other health services and coordinate
care so that people only have to tell their story once, whether they need health, social care, GP or mental health services.

Having integrated health and social care teams has meant patients having faster access to services; previously, getting in touch with a social worker, district nurse, physiotherapist and occupational therapist required multiple phone calls, but now all of these services can be accessed through a single call. In addition, patients needing physiotherapy only need to wait 48 hours for an appointment – an improvement from an 8 week waiting time. A joint engagement on mental health is bringing changes and improvements even as the engagement continues – for instance, people wanted an alternative to inpatient admissions so we are piloting a crisis house, where they can get intensive support.

An integrated service for people with severe alcohol problems frequently attending A&E, is offering holistic support. The service might help sort out housing problems rather merely offer detox. 84% report improvements. “The people helping me have been my lifesavers. I shall never, ever forget them.” – Patient, alcohol service.

Sallie Ecroyd
01803 652 480/07515 393 491 sallie.ecroyd@nhs.net

Southend

Southend’s health and social care partners will be making practical, ground level changes that will have a real impact on the lives of local people.

They will improve the way that services are commissioned and contracted to achieve better value for money for local people with a specific focus on support for the frail elderly and those with long term conditions. They will also look to reduce the demand for urgent care at hospitals so that resources can be used much more effectively. Wherever possible they will reduce reliance on institutional care by helping people maintain their much-valued independence.

By 2016 they will have better integrated services which local people will find simpler to access and systems that share information and knowledge between partners far more effectively. There will be a renewed focus on preventing conditions before they become more acute and fostering a local atmosphere of individual responsibility, where people are able to take more control of their health and wellbeing.

Hayley Pearson
01702 215020 hayleypearson@southend.gov.uk

South Tyneside

People in South Tyneside are going to have the opportunity to benefit from a range of support to help them look after themselves more effectively, live more independently and make changes in their lives earlier.
In future GPs and care staff, for example, will have different conversations with their patients and clients, starting with how they can help the person to help themselves and then providing a different range of options including increased family and carer support, voluntary sector support and technical support to help that person self-manage their care.

In order to do this there will be changes in the way partners organise, develop and support their own workforces to deliver this and a greater role for voluntary sector networks.

**Samantha Start**

0191 424 6515 Samantha.Start@southtyneside.gov.uk

**Waltham Forest and East London and City**

The Waltham Forest, East London and City (WELC) Integrated Care Programme is about putting the patient in control of their health and wellbeing. The vision is for people to live well for longer leading more socially active independent lives, reducing admissions to hospital, and enabling access to treatment more quickly.

Older people across Newham, Tower Hamlets and Waltham Forest will be given a single point of contact that will be responsible for co-ordinating their entire healthcare needs. This will mean residents will no longer face the frustration and difficulty of having to explain their health issues repeatedly to different services.

**Savaia Stevenson**

020 3688 1490 Savaia.stevenson@nelcsu.nhs.uk

**Worcestershire**

The Well Connected programme brings together all the local NHS organisations (Worcestershire Acute NHS Trust, Worcestershire Health and Care NHS Trust and the Clinical Commissioning Groups), Worcestershire County Council and key representatives from the voluntary sector. The aim is to better join up and co-ordinate health and care for people and support them to stay healthy, recover quickly from an illness and ensure that care and treatment is received in the most appropriate place. It is hoped this will lead to a reduction in avoidable hospital admissions and the length of time people who are admitted to hospital need to stay there.

A more connected and joined up approach has reduced unnecessary hospital admissions for patients.

**Gary Morgan**

01905 733632 Gary.morgan@hacw.nhs.uk

Annexe of full national partner quotes:

**Toby Lambert, Director of Strategy and Policy at Monitor, said**:
We look forward to helping the pioneers provide people with innovative and coordinated health and social care that meets their needs. Our support will help pioneers improve the quality of care they deliver while making the best use of their financial and organisational resources. We will ensure that our regulatory framework supports the pioneers to deliver integrated services.

**Don Redding, Director of Policy at National Voices, said:**

Since 2011 National Voices has been saying that joining up care around the needs of the individual is the biggest step forward in quality that people who use services want to see. We have helped provide all local areas with a ‘narrative’ of what this would mean for people’s management of their lives and conditions. Now we are looking to these pioneers, with their exciting visions of person centred care, to demonstrate what is possible.

**Sally Warren, Director of Programmes at Public Health England, said:**

Successful integration can support people to stay well and independent, and can ensure that if they are unwell they have services shaped around their needs. Public Health England are committed to supporting the pioneers in leading the way in integrating health and care, along with other services that can have a huge impact on people’s health and wellbeing such as housing, transport and preventative services, such as smoking cessation or nutrition advice.

**Lord Michael Bichard, Executive Chair, Social Care Institute for Excellence said:**

There is broad consensus from people who use, provide and commission services that more integrated care is better and more cost effective. The challenge now is how to do it well. The Social Care Institute for Excellence welcomes the opportunity to support and learn from the integration pioneers. In particular, we will share our knowledge about how to tackle the barriers to integration through our new online tool – Integration: step by step.

**Sandie Keene, President of ADASS said:**

Today’s announcement of the Integration Pioneers is a landmark day which will be remembered as one which heralds a new social and health care services journey leading to far more seamless services for all people within their localities. It will bring better delivery, better satisfaction and better value than ever before.

Overall nearly 100 authorities bid for Pioneer status,” she said, “but of those not chosen many will have been deemed to have been too far down the road already; and others will only narrowly have missed out on what was a wide range of very exacting criteria indeed. Lessons from all those authorities will still make vital contributions to our growing knowledge and understanding of the complexities of integration.
Richard Jeavons, Interim Managing Director at NHS Improving Quality (NHSIQ), said:

The NHS is committed to providing patients with the very best care, making sure that services are joined up and focused around patients’ needs. The pioneer sites have a key role to play in making integrated care a reality, by developing innovative new approaches that others can learn from. NHS Improving Quality will provide expertise to support the sites, and will challenge them in their quest to deliver rapid improvements that will respond to the needs of patients now and in the future.

Cllr. Katie Hall, Chair of the LGA’s Health and Wellbeing Board, said:

We welcome the Government’s endorsement of 14 new Pioneer sites across the country as a great opportunity to deliver integrated health and care services in those local areas.

The quality and quantity of bids bodes well for a future of better, more coordinated care and support for people in England.

It is really important that we share the learning from the Pioneer areas, with those areas not selected, to ensure that all areas benefit from the wider programme of support planned, recognising too that non-Pioneer areas will also have a great deal to offer.

The LGA is contributing to the support provided through the development of a comprehensive evidence base and toolkit, as well as sharing learning from the system leadership and Health and Wellbeing Board programmes.

Professor Ian Cumming, Chief Executive, Health Education England:

HEE welcomes the role of the pioneers. We are committed to supporting localities in workforce training and organisational development, working with relevant Local Education and Training Boards (LETBs), to stimulate working cultures that actively encourage integrated care and support.

The education and training of healthcare staff is vital in the widespread adoption of integrated care across the NHS, public health and social care systems. We will work with the pioneers and health and care partners to build on existing work such as skills passports and national minimum training standards, in order to develop common standards and portable qualifications to make it easier for staff to work and move between settings. Through this focus, can we ensure that the workforce has the right skills, values and behaviours, in the right numbers, at the right time and in the right place to deliver integrated care.
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