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Integrated Care Pioneers

February 2015

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Integrated care pioneers as ‘exemplars’

The ‘pioneers’ scheme was announced in *Our Shared Commitment* (May 2014).

Local areas will act as exemplars, demonstrating the use of ambitious and innovative approaches to efficiently deliver person-centred and co-ordinated care across the whole of their local health, public health and care and support system for the benefit of patients and service users.

Over a hundred bids were received and all the national partners worked to shortlist and select the final pioneers.
Care and Support Minister, Norman Lamb announced:
-14 pioneer localities in November 2013 (Wave 1); and
-11 pioneer localities in January 2015 (Wave 2).

Criteria
1. Clear vision, including use of the Narrative
2. Plan for *whole system* integration
3. Stakeholder commitment, incl. users and HWBs
4. Capability and expertise to deliver *at scale and pace*
5. Commit to sharing lessons
6. Demonstrate evidence base

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25 integrated care pioneers to show use of ambitious and innovative approaches to efficiently deliver integrated care

Wave 1
• Barnsley • Cheshire * • Cornwall & the Isles of Scilly • Greenwich • Islington • Kent * • Leeds * • NW London • South Devon & Torbay • South Tyneside • Southend • Stoke and North Staffordshire • Waltham Forest, East London & City * • Worcestershire

Wave 2
• Airedale, Wharfedale & Craven * • Camden • Fylde Coast * • Greater Manchester * • Nottingham (City) * • Nottinghamshire * • Sheffield • South Somerset * • Wakefield * • West Norfolk • Vale of York

* Indicates where pioneer sites are also in a locality with Forward View New Models of Care Vanguards

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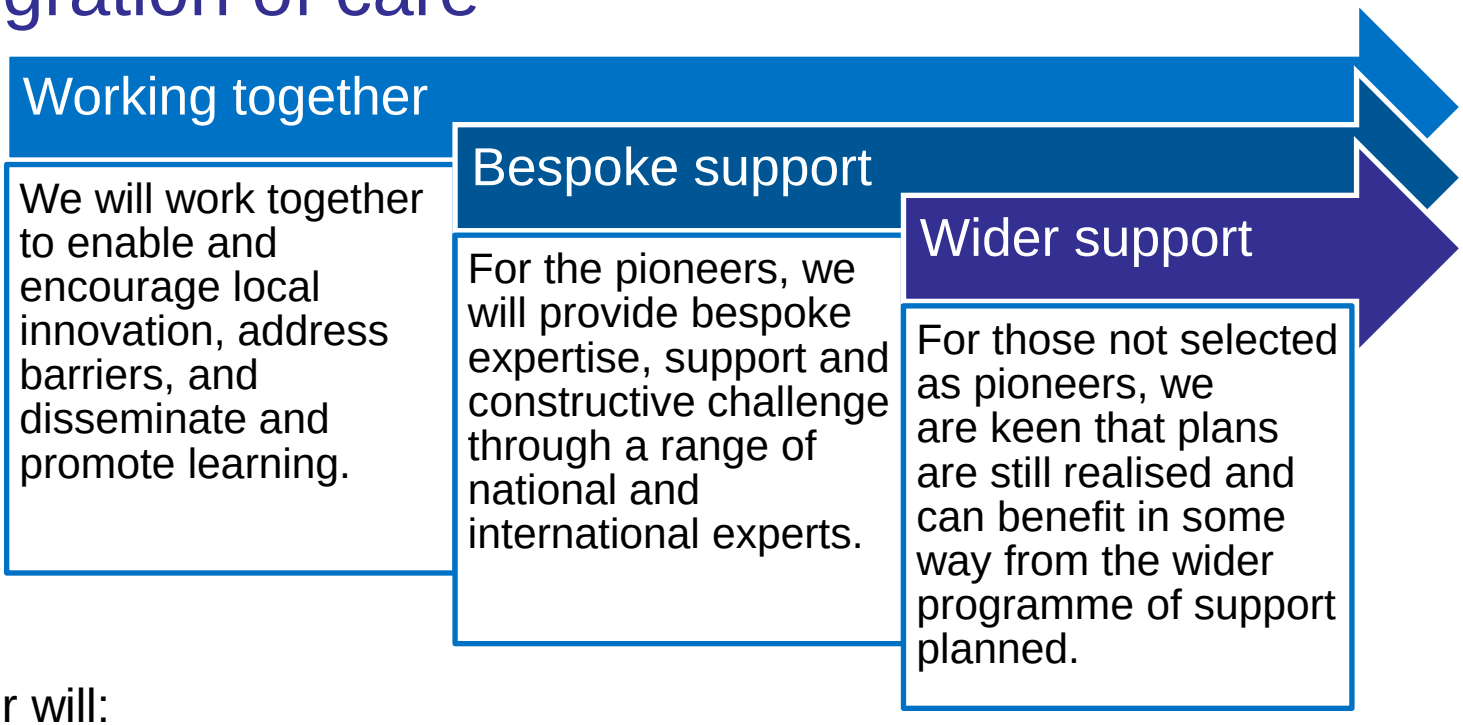
The national partners will provide support for the integration of care



Monitor will:

- proactively provide pioneer sites with:
  - support on rules that we enforce that may affect your plans;
  - help on areas of knowledge (such as the payment system, procurement, patient choice and competition rules, strategic planning advice for trusts etc.) as necessary; and
  - tools, guidance, masterclasses, webinars, Monitor cross-departmental meetings with pioneer sites, bespoke workshops on Monitor's areas of expertise.

- We will collect and share the knowledge generated, which will also inform future work on enabling integrated care and other new models of care.

Do check out our integrated care webpages, including our dedicated online Integrated Care FAQs.

Wave 1 Integrated Care Pioneers

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Barnsley - *Stronger Together Barnsley* has a greater focus on prevention, early intervention and reciprocity

- Focus on better information, advice and guidance, using new technology and signposting to alternative services
- Scaling up preventative services, providing early help, reablement and more self-management of LTCs
- Asset-based approach to individuals and families in need, supporting them to manage their own health and care
- Creating integrated pathways and flexible, user-centred services
- Aligning resources and programmes across agencies
- Reducing costs and personalising budgets
  - Inverting the triangle – shift from passive recipient of services to active agent, from a professionalised model to a community and citizenship model
  - Joining the dots/programmes – increased transparency, quality conversations and coordination
  - Fast track enablers – catalysts at individual, family and community level

Who's involved?

- Barnsley Hospital NHS FT
- SW Yorks Partnership NHS FT
- Barnsley CCG
- Barnsley Council
- Healthwatch Barnsley
- Local police

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Cheshire - *Connecting Care across Cheshire* by joining up local health and social care around local peoples' needs, irrespective of organisational boundaries

- Focus on 1,100 families with complex needs – c.£83.3million cost annually. Early and integrated support services covering mental health, physical health, public health, social care, housing and other key agencies.
  - **Integrated communities**: Live healthier and happier lives in their communities with minimal support; tackle social isolation; extend personalisation and assistive technology; address disadvantage.
  - **Integrated case management:** Access services through a single point, with benefit of a care co-ordinator, single assessment and care plan and multi-disciplinary working.
  - **Integrated commissioning**: Access to services with a track record of reducing the need for longer-term care, e.g. intermediate care, reablement, drug and alcohol support etc.
  - **Integrated enablers**: Joint approach to information sharing, a new funding and contracting model that shifts resources from acute and residential care to community based support, a joint performance framework and joint approach to workforce development.

Who's involved?

- Countess of Chester NHS FT
- Mid Cheshire NHS FT
- Mid Cheshire NHS FT
- Cheshire West and Chester Council
- Cheshire East Council
- NHS Eastern Cheshire CCG
- South Cheshire CCG
- Vale Royal CCG
- West Cheshire CCG
- East Cheshire NHS Trust

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Cornwall & the Isles of Scilly - Shaping services around people's needs by offering a holistic range of care

- 'Newquay Pathfinder' - rolling out a programme that has worked in a small area
- Focus on older people at high risk of a hospital admission or dependency on formal care
- Integrated team approach led by the voluntary sector (12 volunteers embedded in the district nursing team)
- Already shown improvements in people's reported quality of life and a reduction in cost to the system
  - Make it personal – focus on what a person actually wants rather than assumption of what they need
  - Shared belief - strategic sign up/leadership commitment and then translated to frontline staff; shared management plans
  - Robust frameworks for information-sharing and performance management - information-sharing agreement across all organisations; focus on key metrics
- Anticipating delivering cashable net savings across the whole system (e.g. cost of acute admissions, community admissions, cost of mental health services per user)

Who's involved?

- Cornwall Partnership FT
- South Western Ambulance Service NHS FT
- Royal Cornwall Hospitals NHST
- Kernow CCG
- Cornwall Council
- Isles of Scilly Council
- Peninsula Medical School
- Peninsula Community Health
- Healthwatch Cornwall and Isles of Scilly
- local Age UK
- Carers
- Volunteers organisations

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Greenwich - Focus on prevention, early identification and care coordination

- Partnership across mental and physical health, social care and public health, as well as other public services, e.g. education.
- Integrated care system already delivered coordinated services for older people and those with physical disabilities. Phase 2 to target adults and older adults with complex needs across all care groups identified as being at high risk of ill health and hospitalisation ('Test & Learn' site in Eltham for six months from September 2013. Roll out across Greenwich July 2014)
- To rebase health and social care delivery around clusters of GP practices (with core team and named leads), co-ordinating services across acute, primary and community.
- Teams of nurses, social workers, occupational therapists and physiotherapists work together to provide a multi-disciplinary response to emergencies in the community that require a response within 24 hours.
- Programme linked to the Trust Special Administrator change programme.

Who's involved?

- Oxleas NHS FT
- Greenwich LA
- Greenwich CCG
- Lewisham NHST
- Healthwatch Greenwich
- GAVS

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Islington - Creating individual care plans for people to help them take control of their own health and wellbeing

- Specific focus on four population groups - vulnerable older people, people with long term conditions, young people at risk and people with mental health issues within each of the four Islington localities
- Focus on 3 enablers:
  - public and patient participation with a focus on overcoming barriers to access, co-production of care plans, and feedback informing commissioning.
  - mobilising the individuals' own abilities and motivations with a focus on the scale-up of existing pilots across health and social care, addressing inequality and encouraging activation, and personalisation.
  - embedding health and well-being with a focus on mobilisation of community assets and abilities and learning from patient journeys.
- Anticipating improved patient experience and reduction in A&E activity, readmissions following rehab and reablement, development of other co-morbidities, early deaths, inequalities across the population and care home referrals

Who's involved?

- Islington CCG
- Islington Council
- Whittington Health
- UCL Partners
- Islington Health & Wellbeing Board
- Healthwatch Islington

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Kent - Creation of 24/7 community based care models to promote greater independence for patients

- Shared goal to develop integrated commissioning and integrated provision though a 5 year programme (focus initially on adults but acknowledges opportunities in children's services).
- Design of a fully integrated care system that is: financially viable; proactive; integrates budgets; delivered through outcome based contracts; available 24/7 and is community based; provides personalised support for people with LTC; supported by integrated IT; builds wider community well being resources.
- Plans for: a local tariff system based on Year of Care; allocation of risk adjusted budgets that are co-managed and owned by integrated teams and patients; use of more personal health budgets and to adopt a "Kent Card" for individuals to pay for their own care directly.

Who's involved?

- Swale Borough Council
- Kent County Council
- Thanet CCG
- South Kent Coast CCG
- Ashford CCG
- Canterbury and Coastal CCG
- West Kent CCG
- Swale CCG
- Dartford, Gravesham and Swanley CCG
- Kent County Council
- Kent and Medway Commissioning Support Unit
- Kent Community Health NHST
- Kent and Medway NHS and Social Care Partnership Trust
- East Kent Hospitals University NHS FT
- South East Coast Ambulance Service NHS FT

Leeds - Improving local people's experience of services through the effective use of technology

- Builds on a number of integrated care initiatives in place for adults and children, including:
  - Care Trak system used to identify whole system costs, baselines (using a unique identifier for health records across health and social care)
  - Approach to infant mental health
  - Integrated care model (NHS/adult social care/neighbourhood teams). 12 co-located health and social care teams coordinating care for older people and those with long-term conditions
  - Use of information, data sharing & analysis, e.g. Early Start dashboard and interactive Integrated Activity Dashboard (enables tracking of changes in the health & care system over time).
  - Adult integration outcomes framework
  - Joint NHS and local authority recovery centre offering rehab
  - Programme to integrate health visiting and children's centres into a new Early Start Service across 25 local teams
- "Ensure everyone will have the best start in life", "increase the number of people supported to live safely in their own home", "ensure more people recover from ill health", "ensure more people cope better with their conditions" and "ensure people have a positive experience of their care".

Who's involved?

- Leeds and York Partnership FT
- Leeds City Council
- Leeds North CCG
- Leeds West CCG
- Leeds South & East CCG
- Leeds Community Healthcare Trust
- Leeds Teaching Hospitals Trust
- Local and national third sector partners including Third Sector Leeds and local user groups

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NW London - putting GPs and community practitioners at the heart of a coordinated local health system

- Based on Integrated Care Pilot set up in July 2011
- The 8 NWL localities will retain their own unique approach but will be aligned in:
  i. Empowering people, carers and families to exercise choice and control and to receive the care they need in their own homes or in their local community (with single point of contact working with them to plan all aspects of care needs)
  ii. Putting GPs at the centre of coordinating care, working with others in integrated networks to support people to meet their goals
  iii. Ensuring systems enable integrated care provision
- Risk stratification and financial impact assessment based on collected patient-level dataset for social, health and community care.
- From April 2014, "early adopter" sites trialling whole systems integrated care (shadow capitated budgets in 2014/15 working to full implementation from 2015/16). Ambition for whole systems integrated care to be BAU by 2015.

Who's involved?

- NHS FTs - Chelsea & Westminster Hospital NHS FT; Central & NW London NHS FT; Hillingdon Hospitals NHS FT
- CCGs – Brent; Central London; Ealing, Hammersmith & Fulham; Harrow; Hounslow; West London; Hillingdon
- NHS trusts - Central London Community Healthcare; Ealing; Hounslow & Richmond Community; Imperial; NW London Hospitals; W London MH; W Middlesex
- Councils – Brent; Westminster; Ealing; Hammersmith and Fulham; Hounslow; Kensington & Chelsea; Harrow
- Others - NWL CSU, Imperial College Health Partners, NIHR CLAHRC NWL, Bucks University, Health Education NWL, NHS England

South Devon & Torbay - joined up care across a wide spectrum, including mental health and GP services

- Commitment to delivery high-quality, reliable and joined-up health and care that puts people first
- Shift in emphasis & resources towards young people and families, to help break patterns of lifelong reliance on care
  - Rolling out the Watcombe/Hele project to support the community to better meet its own need
  - Each cluster of GP practices and schools will have a dedicated primary care mental health worker, to seamlessly transition for young people to adult services
  - Plans for an all-age learning disability service in Torbay
  - Further develop health and well-being checks for YP
  - Further integration with end-of-life care
  - Preventative/early intervention model extended to COPD
  - More integrated pathways for medically-unexplained symptoms
  - Integrated service for frequent A&E attenders with severe alcohol problems
  - Combat social isolation
  - Working with Cabinet Office for joined up IT programme for e-prescribing, e-booking etc.
  - Integrate and extend out of hours support (e.g. 7 day working)

Who's involved?

- South Devon Healthcare NHS FT
- South Devon and Torbay CCG
- Torbay and Southern Devon Health and Care NHS Trust
- Torbay Council
- Devon Partnership NHS Trust

Supported by:

- Devon Health and Wellbeing Board
- Torbay Health and Wellbeing Board
- Devon County Council
- Rowcroft Hospice South Devon
- Torbay Strategic Public Involvement Group
- Northern, Eastern and Western Devon CCG

South Tyneside - transform the local care and support system organised around the needs of individuals

- Approach to early help, self-care and integrated support services:
  - Risk stratification to find those people who would benefit from self care
  - Self care 'offer' to educate and promote behaviour change using clinical input and assistive technology (building on the Change4Life behaviour change model and develop a simple navigation system for patients)
  - Joint workforce development to promote consistent messages and reduce duplication (staff to be empowered to work beyond professional boundaries)
  - People to make more effective use of a wider range of local services based on accessible information (delivered out of community settings - and increase 'social prescribing')
  - Support networks to help patients and carers to build their 'self efficacy' to challenge providers (including through the third sector)
  - Implement new commissioning models and pooled budgets to accelerate the integration of local services

Who's involved?

- Northumberland Tyne and Wear NHS FT
- Local Health and Wellbeing Board
- Joint Social Care and Health Executive Team (comprising CEOs of South Tyneside Council, South Tyneside CCG and South Tyneside FT)

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Southend - Provision of seamless services for local people

- Builds on integration work already taken place:
- Further simplification of access and establishing a single route of referral
- Focus on support provided to older people with LTCs and through a fully integrated service delivery model in primary and community care built around multi-disciplinary teams.
- Rolling out further multi-disciplinary teams – e.g. by developing practice level MDTs to single-handed-GP population (50% of population) and targeting re-admissions
- Taking forward Year of Care pilot work by focussing on 2 areas (shadow currencies for an LTC Year of Care and the testing of a concept that considers post acute Recovery, Rehabilitation and Reablement).
- Developing integrated locality teams and pathways – through joining existing health and social care teams and piloting new pathways for stroke rehab and intermediate care beds.
- Developing further community based specialist services that avoid the need for a hospital referral or more expensive forms of care

Who's involved?

- South Essex Partnership University NHS FT
- Southend University Hospitals NHS FT
- Southend Borough Council
- Southend CCG
- Southend Health and Wellbeing Board

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Stoke and North Staffordshire - Transforming the way people with cancer are looked after at the end of life

- Led by Macmillan Cancer Support
- To transform cancer and end of life care through the development of a principal provider model (by April 2015) where one provider is accountable for entire patent experience and outcomes through an integrated care pathway (improving cancer services linked to increased survivor rates).
- Co-design of an outcome based integrated pathway across all stages, appointment of principal provider for end of life care, restructuring of contracts, outcome based.
- Co-designed specification, scoping and tendering of contracts, clinical and service integration to ensure best use of resources across the system.

Who's involved?

- MacMillan Cancer Support
- Cannock Chase CCG
- East Stafford CCG
- North Stafford CCG
- South Stafford & Surrounds CCG
- Stoke on Trent CCG

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WELC - Putting the patient in control of their health and wellbeing, with a focus on reducing hospital admissions

- Focus on empowering individuals by providing responsive coordinated and proactive care, and ensuring consistency and efficiency across physical and mental health and social care.
- The 3 boroughs have agreed a common set of principles:
  - Systematic, regular risk stratification of the whole population to support case finding for those most at risk of hospitalisation.
  - Care that is centred on an individual's needs to enable individuals to live independently and remain socially active.
  - Care that is evidence based and cost-effective.
  - Preventing admission to hospital wherever possible by supporting care at home or in the community.
  - Avoiding duplicated effort in situations where a patient has many people involved in their care.
  - Actively developing local providers and supporting collaboration in contracting.
  - Continual evaluation and revision, and learning from others.
  - Single point of contact responsible for co-ordinating older people's entire healthcare needs
- Aiming to reduce non-elective spend by 24-40% over the next 5 years

Who's involved?

- NE London FT
- East London FT
- Barts NHS Trust
- UCLP
- Waltham Forest CCG
- Newham CCG
- Tower Hamlets CCG
- London Borough of Waltham Forest
- Newham Council
- Tower Hamlets Council

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Worcestershire - *Well Connected* places the needs of individuals and their families at the heart of health care

- Establishment of jointly funded team - 'well connected' - to refocus care from acute hospitals into the community:
  - reducing A&E
  - piloted 'GP with an ambulance' where paramedics could draw on a dedicated GP
  - promotes telemedicine
  - quicker transfer to community beds from acute care - hospitals have electronic white boards with real time information on acute and community beds
- To be achieved by a process of improved integration, support for people with long term conditions, promoting health and wellbeing and prevention, clustering services around GPs/ local hubs and establishing new service partnerships.
- Finance through social impact bonds and risk-sharing.

Who's involved?

- Worcestershire Acute Hospitals NHS Trust
- Worcestershire Health and Care NHS Trust
- Worcestershire County Council
- South Worcestershire CCG
- Redditch & Bromsgrove CCG
- Wyre Forest CCG
- VCS representation
- Healthwatch Worcestershire

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Wave 2 Integrated Care Pioneers

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NHS Airedale Wharfedale & Craven– creating a sustainable health & care economy

- The Right Care programme aims to create a sustainable health and care economy that enables people to be healthy, well and independent.
- Health and care provision should be based on the patient's individual needs.
- Three key principles:
  - No one in hospital unless their care cannot be delivered safely in the community 24/7.
  - No one discharged to long term care without the opportunity for a period of enablement.
  - 24/7 access to, and delivery of, co-ordinated care which is needs driven and not about age, condition or location.
- Features of the Enhanced Primary Care Model (EPC):
  - Integrated, multidisciplinary wraparound care that empowers patients.
  - Care targeted to those with greatest need, supported by information systems.
  - Capitation payment based.
  - Delivered as part of a wider local agency partnership.

Who's involved?

- Bradford Metropolitan District Council
- North Yorkshire County Council
- Airedale, Wharfedale and Craven CCG
- West Yorkshire Area Team
- Airedale FT
- Bradford District Care Trust
- Yorkshire Ambulance Service NHS Trust
- Voluntary/ Community Sector
- Independent sector provision
- GPs

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Blackpool (Fylde Coast) – seamless care spanning health and social care

- Aims to provide more personal and co-ordinated community-based care for older patients with a number of complex long-term conditions and greatest health needs.
- To support much more effective condition management, helping patients to stay well for longer.
- Two models: Extensivist and Enhanced Primary Care
- Extensivist Services:
  - Focused on a person's individual needs
  - Designed to ensure early intervention and, over time, proactive prevention which breaks the current cycle of slow reactive care provision.
  - For people 60 and over with a risk score of 20 and two or more co-morbidities.
- Enhanced Primary Care:
  - For the larger group of patients at the level below those of the extensivist service.
  - For people with one long term condition.
  - Designed to prevent individual's health deteriorating.
- Aims to reduce unscheduled A&E attendances for the target population by 20-30%

Who's involved?

- Blackpool Teaching Hospitals FT
- Lancashire Care FT
- North West Ambulance NHS Trust
- Blackpool CCG
- Fylde and Wyre CCG
- NHS England
- Blackpool Borough Council
- Whitegate Health Centre
- Primary Care Centres

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Camden – Minimising admissions and readmissions through the Enhanced Home Care Project

- Focus on providing community services and avoiding admissions to hospitals and residential placements.
- Services focused on delivering 7 day working between social care, reablement, rapid response teams to respond more quickly to residents in crisis.
- Enhanced Care Project:
  - Provides continuity between health and social care, with patients having a minimal number of carers involved in their care, and helping them understand their condition and develop self – management strategies
  - Use of assistive technologies and reablement packages making it more accessible for more clients, including those with mental health issues
  - The RAPIDS service ensures residents coming out of hospital, going through A&E or being referred through the ambulance service rapidly receive support packages to minimise admissions or readmissions
- Helping to reduce pressure on acute sector

Who's involved?

- Camden Council
- Camden CCG
- Camden Local Authority
- London Borough of Camden
- Hillingdon Council
- Camden & Islington NHS FT
- University College Hospital NHS FT
- Royal Free NHS FT
- Milton Keynes NHS Trust

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Greater Manchester – ten individual integrated care programmes

- Develop robust and deliverable Out of Hospital care plans that wrap around the in-hospital Healthier Together reforms and provide person-centred integrated community, adult social care and primary care services to a population of nearly 3 million people.
- Each locality works together with primary, community and social care to develop the right services for their local communities.
- Care Model :
  - Established multi-disciplinary teams at neighbourhood level bringing all relevant providers together on the basis of GP registered population. Teams Provide:
    - Individual care plan for each patient identified
    - Named accountable professional for each patient
    - Agreed process and timetable for full borough coverage
- Formalising learning network with Wave 1 pioneers (NW London & Leeds)
- Developed community based indicators representing primary, community and social care

Who's involved?

- CCGs - North Central and South Manchester CCG, Bolton, Bury, Tameside & Glossop , Salford, Stockport , Oldham etc
- Councils - Bolton, Bury, Manchester, Oldham, Rochdale, Tameside, Trafford, Salford, Stockport, Wigan
- 22 Local Authorities

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Nottingham (City) – providing seamless care and helping keep people healthy and out of hospital

- Currently eight care delivery groups made up of GP practices and neighbourhood teams
- Intermediate care and reablement services have been aligned and plan to integrate access point so that citizens no longer need to differentiate between health and social care
- Continuing to review specialist support services, integrating them into neighbourhood teams, where appropriate
- Developing an integrated, locally provided assistive technology service for the area
- Aims to build on the progress achieved to date by further reducing duplication and repetition in our services and providing more holistic care and support
- Patients will be empowered to manage their own condition(s) – with the support of accessible, connected, co-ordinated and caring services when they need them.

Who's involved?

- Nottingham City CCG
- Nottingham City Council
- Nottingham City Care Partnership
- Nottingham University Hospitals NHS Trust
- Nottinghamshire Healthcare NHS Trust
- Nottingham
- Emergency Medical Services (NEMS)
- Nottingham City Homes

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Nottinghamshire – encouraging people to become actively involved in care planning

- Delivering transformation at a county level, but also ensuring services are tailored to meet the needs of the local people
- Commissioners working with third sector to roll out 'self-care hubs' accessible to all.
- Focused on community bases services, though for people with an urgent need to access care there will be a crisis hub providing a contact point for healthcare professionals seeking the most appropriate health, social care or voluntary sector services.
- Services will be led by a Care Delivery Group made up of GP practices and neighbourhood teams comprising multi-disciplinary health and social care staff providing 24/7 access to support, integrating services and providing rapid response where appropriate

Who's involved?

- Nottinghamshire County Council
- Mansfield and Ashfield CCG
- Newark and Sherwood CCG
- Nottingham North and East CCG,
- Nottingham West CCG
- Rushcliffe CCG
- Local authority
- Providers
- Voluntary sector

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Sheffield – a single approach to long term care using cost-effective methods

- Pooled single budget £250m 2015/16 from primary, clinical and social care.
- Vision to be delivered by development of provider alliances to deliver integrated care:
  - VCF organisations working with practices and community health services
  - Hospital, community & social care services working together to provide active support and recovery services when people need extra care
- Benefits:
  - Better health for those most at risk of health crises through care planning, better management of long-term conditions and reduction of clinical and social risk factors
  - More care & support provided at home, enabling people to remain independent for longer
  - Single approach to long term care that focusses on maintaining independence and providing cost effective care
- Outcomes:
  - Reduction in non-elective hospital admissions Increased identification of at risk patients via risk stratification
  - Patient satisfaction

Who's involved?

- Sheffield City Council
- Local Health and Well Being Board
- Sheffield CCG
- Local Voluntary, Community Faith (VCF) organisations

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South Somerset – focusing on collaborative working and personalised care plans

- The Symphony Project focuses on effective personalised care planning, self-management support and care co-ordination.
- First model developed: Integrated care model for people with multiple long term conditions, it includes:
  - A comprehensive assessment of the individual's physical, mental health and social care needs to develop a single personalised care plan
  - Support and coaching for patients and carers to understand and manage their own conditions and to access support in the community;
  - Routine monitoring of patients' and carers' health conditions and care needs;
  - Escalation plans ensuring that patients and carers recognise deterioration triggers, and that there is early intervention through a co-ordinated and planned response.
  - Rapid response in the event of a crisis, an unplanned deterioration or a change in the patients' or carer's circumstances.
- Estimated savings from the acute sector: £2.1m
- Providing 20% of social care at home

Who's involved?

- Yeovil District Hospital FT
- Somerset Partnership FT
- Symphony Primary Care Group
- Somerset CCG
- Somerset County Council
- Bristol, North Somerset, Somerset and South Gloucestershire Area Team

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Wakefield District – focused on connecting Care Services

- Connecting Care Service vision - *'For citizens to live longer, healthier lives, through well-co-ordinated care delivered as close to home as possible.'*
- Integrating health, social care teams, community and voluntary sector – focus on adults (>18 years old) and older people.
- Fully Integrated Care Team Model across Wakefield District supporting both admission avoidance and supporting early discharge arrangements.
- "Care Closer to Home" – Outcomes based approach shared with partners
  - Care is co-ordinated and seamless.
  - Nobody is admitted to or kept in hospital or residential care unnecessarily.
  - People are supported and in control of their condition and care, enjoying independence for longer.
  - Care is cost-effective and within available budgets.
  - All staff understand the system and work in it effectively.
  - Unpaid carers are prepared and supported to care for longer.

Who's involved?

- Wakefield District
- Wakefield CCG
- Wakefield Council
- VCS

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West Norfolk – sustainable coordinated services with patients in control

- Principles of the West Norfolk Alliance programme: patients should have independence, choice and quality, one assessment and one care plan; no organisation boundaries and shared information and decision making.
- Promotion of independence
- To support information/voluntary care systems in local communities wherever possible
- Connecting older people with their communities, their specialist health and care services and their local care providers
- Easy access to key professionals
- Data will be shared appropriately across partner agencies to ensure safe delivery of services
- Will ensure budgets can be pooled or transferred to ensure that they follow patient needs

Who's involved?

- Norfolk and Suffolk FT
- Norfolk Community Health and Care NHS Trust
- The Queen Elizabeth Hospital FT
- Freebridge Community Housing
- NHS West Norfolk CCG
- West Norfolk Community Housing
- Norfolk County Council
- Borough councils
- Voluntary organisations

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Vale of York CCG – Focus on delivering proactive, community-centred care (Care Hubs)

- Uses a “Care Hub” approach which provides proactive, community-centred care for around 50-100,000 people.
- Joined up support and care that supports residents achieving best quality of life in the most appropriate setting.
- 3 pilot projects will initially focus on the frail and those with long term conditions, enabling individuals to remain at home or return there as early as possible following ill-health or crisis.
  - Wraps around the individual
  - Provides care outside of hospital settings where possible and rapid discharge
  - Holistic delivery of care and support
  - Better end of life and care
- Expected benefits:
  - Reduce avoidable hospital admissions
  - 14% reduction in time spent avoidably in hospital
  - Increase the proportion of older people living independently at home following discharge from hospital.
  - Reduce the number of falls related injuries for residents over 65.

Who’s involved?

- Vale of York CCG
- City of York Council
- North Yorkshire County Council
- East Riding County Council
- York Teaching Hospital NHS FT
- GPs
- Partnership Commissioning Unit
- Leeds Partnership FT
- Yorkshire Ambulance Service NHS Trust

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