

The background of the page features a photograph of two individuals, an older man and a younger woman, sitting at a table and engaged in a painting activity. The man is on the left, wearing glasses and a blue cardigan, and is using a paintbrush to work on a colorful drawing on a piece of paper. The woman is on the right, wearing glasses and a light-colored top, and is looking down at the drawing. The entire scene is overlaid with a semi-transparent blue geometric pattern of overlapping squares and triangles. The text 'People helping people' is centered over the image in a white, sans-serif font.

People helping people

Year two of the pioneer programme

People helping people

Year two of the pioneer programme

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The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England
- Care Quality Commission
- Health Education England
- Monitor
- The National Institute for Health and Care Excellence
- NHS Trust Development Authority
- Public Health England.

Equality and Health Inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it
- given regard to the need to reduce inequalities between patients in access to and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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1

Introduction and summary

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1.1 Foreword

The year 2015 has been one of good progress and learning for the integrated care pioneer community against a backdrop of change for the health and care sector and also for the programme itself.

During 2015 we have continued to drive the integration of services, delivering more services in the community and closer to people's homes, transforming the health and care system to ensure high quality care is accessible to everyone when and where they need it. Changes are being led locally by clinicians, staff and patients working with their local partners. We see the pioneer programme as a key part of this transformation.

We started the year with the announcement of a second wave of pioneers in January – 11 areas all focused on improving the delivery of integrated, person-centred, coordinated care services. These additional members of the community have brought a further dimension to our shared learning and were warmly welcomed by the first wave pioneers.

Now sitting alongside the new models of care vanguard sites, the pioneers support a shared aim to bring economics of scale in aligning both national and local support and in building stronger learning communities that support each other through sharing expertise and experience. This alliance is growing in strength and this report provides an opportunity to share our progress with the vanguards and the rest of the health and social care sector, and to give back to those who have inspired us with their own stories.

Delivering

This report on our second year sets out to describe the lessons learned across the pioneers and the progress made to date. We recognised that delivering integrated, person-centred care might not be a quick process, yet already early

results are showing positive signs – indicating this is the right direction of travel. The pioneers' stories illustrate these findings and share the core elements of their care models, which are no doubt familiar to others.

Community

Throughout the report, you will find stories of inspiring relationships between people that have secured improvements in individuals' health and wellbeing. Many of the stories highlight the important work of the voluntary and community sector, which has been a key feature of the pioneer work. We recognise there is much further to go to ensure our vision of integrated person-centred care is the new norm, however we hope these stories provide food for thought for others working on integrated care provision in their own local areas.

We look forward to the journey continuing throughout 2016 and thank you for your part in it.



Alistair Burt MP
Minister of State for Community and Social Care



Frances Martin
Integrated Care Director, Worcestershire and Co-Chair of the Pioneer Support Group



Samantha Jones
Director of the New Care Models Programme

1.2 What are integrated care pioneers?

The 25 integrated care pioneer sites (the pioneers) are developing and testing new and different ways of joining up health and social care services across England, utilising the expertise of the voluntary and community sector, with the aim of improving care, quality and effectiveness of services being provided.

Their shared goal is to put the needs and experiences of people at the heart of the health and care system; to move away from reactive, episodic healthcare and toward a system of preventative, holistic care and support and to tailor care to the needs and preferences of individuals, their carers and families. Our hypothesis is about providing better support at home and earlier treatment in the community, which will mean fewer people needing emergency reactive care in hospitals and an improvement in people's experience of care.

Collective learning

This report aims to highlight projects and initiatives within the pioneers and others to help share learning across the country – until integrated care and support becomes the new norm. National partners, subject matter experts, pioneer and vanguard peers provide central support to all the pioneers to help break down any barriers that could prevent them from rapidly implementing and sharing lessons learned across the programme.

Collective commitment

To facilitate this learning, a shared commitment exists between the pioneers and national partners. Together, we work on the principle of local ownership of the programme, supported by national partners. These values are also shared with the broader new care models programme.

“The idea of being in the [pioneer] programme is that we get help and support to deliver our objectives around improving outcomes and experience for patients and carers.”

Accountable officer of pioneer CCG

“In one pioneer area, we’ve been involved in workshops around what is care and support planning? How do you make it work so that it’s not just a management plan or a treatment plan for the professional? It’s a plan for living for the person who needs support. I guess in a sense, we’re seen as a group that helps keep the pioneer programme honest to those goals.”

Director of Policy, National Voices

1.3 High-level aims of the pioneer programme

When the programme was launched in the spring of 2013, a collaborative of national partners called for expressions of interest from the “most ambitious and visionary” local areas to become integrated care pioneers capable of driving change “at scale and pace, from which the rest of the country can benefit” (Department of Health May 2013¹).

While there is no single defined “exam question” that pioneers were asked to answer, the high-level aims of the programme could be described as:

1. showcasing the benefits of providing person-centred, integrated care²
2. sharing evidence and practical support with others seeking to adapt and adopt pioneer experience in their own health and care economies.

No explicit measures of success were established at the start of the programme. This means there is no single metric to describe or measure success. Some areas have adopted the triple aim as developed by the Institute of Healthcare Improvement (IHI³). They are:

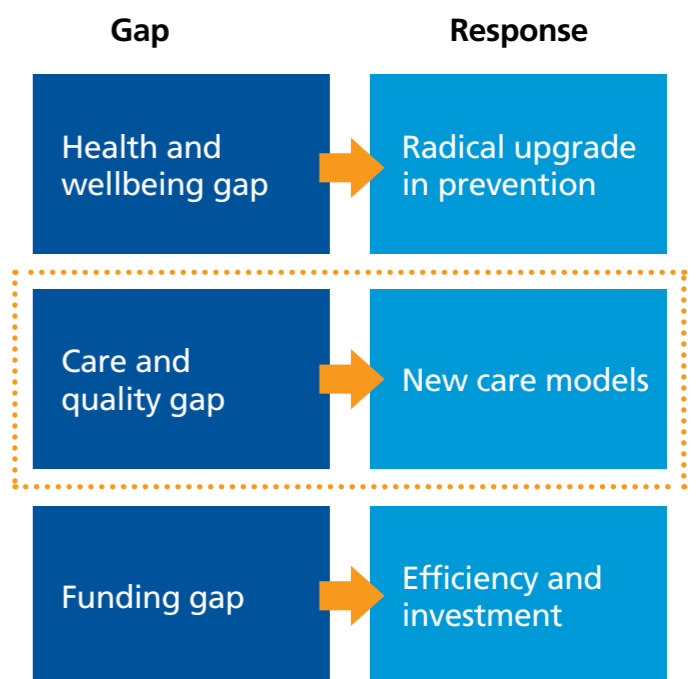
1. improving the experience of care
2. improving the health and wellbeing of the population
3. reducing the per capita cost.

Areas may measure achievement differently based on local needs and priorities but these broader improvement goals are shared across all. They are also intrinsically linked to the three gaps identified in the Five Year Forward View.

This report shares the evidence developed by the pioneers and reflects the metrics they themselves have chosen to monitor their progress.

The following criteria (Department of Health November 2013) were used to select the wave one pioneers:

- clear vision of own innovative approaches to integrated care and support
- whole system integration
- commitment to integrating care and support across the breadth of relevant stakeholders and interested parties within the local area
- demonstrated capability and expertise to successfully deliver a public sector transformation project at scale and pace
- commitment to sharing lessons on integrated care and support across the system
- vision and approach based on a robust understanding of the evidence.



Connecting Care in Wakefield

Over the past few years, the Wakefield pioneer has talked to local people about what is important to them.

Pioneer: Wakefield

Population: <500,000

Geography: Urban

Life cycle stage: Test



People in Wakefield have said that they want:

- to be supported to stay well
- not to be in hospital unless they really have to be
- to be more in control of their own health either at home or as close to home as possible.

They also want their care professionals to work in a connected way so they don't have to keep repeating their story to different people, delaying their care.

That's Connecting Care – joining up health and social care so residents of Wakefield live longer, healthier lives.

Developments so far

The Wakefield pioneer's Connecting Care work already includes:

- extended access to evening and weekend appointments with health professionals
- pharmacists working alongside health workers to make sure people get the right medication
- better joined-up working between health, social and community workers for older, vulnerable people
- use of technology to help people look after themselves better at home.

Connecting Care hubs

Health, social care and voluntary organisations across Wakefield are making this better by working together on one site, known as Connecting Care hubs. There are three Connecting Care hubs in Wakefield so far.

One hub, in Bullenshaw, is home to pharmacists, occupational therapists, physiotherapists, therapy support staff, community matron and staff nurses, carers, Age UK and social services.

Carol, locality lead for Mid Yorkshire Therapy, said: "For residents, this new way of working means rapid access and seamless care – because we are all based together. In the past, it could have been a week to organise a referral and now it can be done the same day."

Watch their video

What does this mean in practice?

In autumn this year, the ambulance service contacted the hub. An elderly man had fallen at home – but both husband and wife were adamant they did not want to go to hospital.

Within four hours, an occupational therapist assessed the man in his own home; a bed and mattress were delivered so he could sleep downstairs; a community matron assessed him and prescribed antibiotics for an infection; and a social worker and care coordinator visited to make sure the husband and wife had the support they needed going forward.

The husband avoided going to hospital and instead stayed at home with his wife, which is what they had both wanted.

Supporting carers

Carers Wakefield and District (CW&D) is a local organisation that provides unpaid carers with emotional support, information and advice. The benefits include social activities, access to respite and other services. It also provides one-to-one support, group support and befriending.

Now its support staff are an integral part of the Connecting Care team, CW&D has seen a significant increase in referrals, particularly from health staff.

Social Contact Scheme

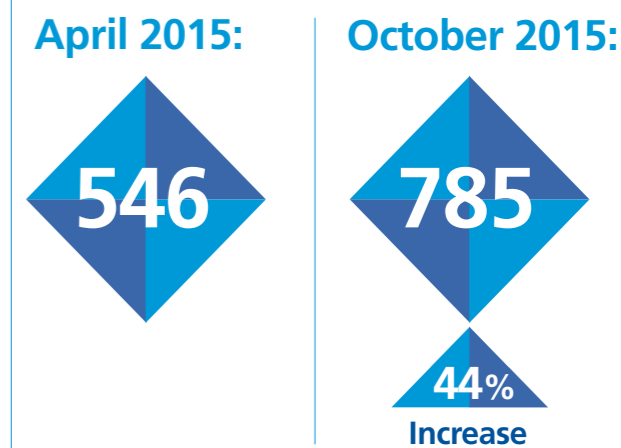
Wakefield Council has contracted Age UK Wakefield District since 2006 to provide a Social Contact Scheme. The schemes aim is to enable early hospital discharge and to encourage older people to regain their independence following admission. It also offers support to any older person who needs it in the wider community following illness, bereavement or other life-limiting events.

Age UK captures outcomes for the scheme through the holistic assessment tool known as LEAF-7. Overall, this tool demonstrates a 20 per cent rise in the Life Satisfaction (LS) rating.

"There's the council, there's the voluntary sector, there's the hospitals, there's lots of different parts of the NHS. Where do you start? Who do you go to? Making all of that simpler is absolutely critical for people."

Andrew Balchin, Wakefield Council

Referrals received by CW&D:



“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.”

Overarching I statement

1.4 The I statements

In 2012, National Voices was commissioned by the NHS Commissioning Board to develop a compelling narrative of the integration of health and care based on the experiences of patients, service users, carers and their organisations. These personal “I statements”, developed with the help of Think Local Act Personal (TLAP) and through national workshops and consultations, detail how the integration of care and support looks from the perspective of the person using the services and further prove the importance and benefit of delivering care that is person-centred and coordinated.

Delivering quality, integrated community care as confirmed through the I statements is essential to improving outcomes for people who use health and social care services. It has helped to reduce:

- confusion
- repetition
- delay
- duplication and gaps in service delivery
- people getting lost in the system.

... I statements about: care planning

- I work with my team to agree a care and support plan.
- I know what is in my care and support plan.
- I know what to do if things change or go wrong.
- I have as much control of planning my care and support as I want.
- I can decide the kind of support I need and how to receive it.
- My care plan is clearly entered on my record.
- I have regular reviews of my care and treatment, and of my care and support plan.
- I have regular, comprehensive reviews of my medicines.
- When something is planned, it happens.
- I can plan ahead and stay in control in emergencies.
- I have systems in place to get help at an early stage to avoid a crisis.

... I statements about: goals and outcomes

- All my needs as a person are assessed.
- My carer/family have their needs recognised and are given support to care for me.
- I am supported to understand my choices and to set and achieve my goals.
- Taken together, my care and support help me live the life I want to the best of my ability.

Watch the video ↘



Pioneers have embedded the I statements within their local visions – Worcestershire is a great example of this.

... I statements about: communication

- I tell my story once.
- I am listened to about what works for me, in my life.
- I am always kept informed about what the next steps will be.
- The professionals involved with my care talk to each other. We all work as a team.
- I always know who is coordinating my care.
- I have one first point of contact. They understand both me and my condition(s).
- I can go to them with questions at any time.

... I statements about: decision making (incl. budgeting)

- I am as involved in discussions and decisions about my care, support and treatment as I want to be.
- My family or carer is also involved in these decisions as much as I want them to be.
- I have help to make informed choices if I need and want it.
- I know the amount of money available to me for care and support needs and I can determine how this is used (whether it's my own money, direct payment or a "personal budget" from the council or NHS).
- I am able to get skilled advice to understand costs and make the best use of my budget.
- I can get access to the money quickly without over-complicated procedures.

... I statements about: information

- I have the information, and support to use it, that I need to make decisions and choices about my care and support.
- I have information, and support to use it, that helps me manage my condition(s).
- I can see my health and care records at any time.
- I can decide who to share them with. I can correct any mistakes in the information.
- Information is given to me at the right times. It is appropriate to my condition and circumstances. It is provided in a way I can understand.
- I am told about the other services that are available to someone in my circumstances, including support organisations.
- I am not left alone to make sense of information.
- I can meet/phone/email a professional when I need to ask more questions or discuss the options.

... I statements about: transitions

- When I use a new service, my care plan is known in advance and respected.
- When I move between services or settings, there is a plan in place for what happens next.
- I know in advance where I am going, what I will be provided with and who will be my main point of professional contact.
- I am given information about any medicines I take with me – their purpose, how to take them, potential side effects.
- If I still need contact with previous services/professionals, this is made possible.
- If I move across geographical boundaries I do not lose my entitlements to care and support.



1.5 Alignment across the new care models programme

Since spring 2015, the pioneers have been part of the new care models programme, working alongside the vanguards. The two programmes began with different perspectives; however there is a shared aim across both vanguards and pioneers that bind them together.

Several areas are both pioneers and vanguards. The Fylde Coast Local Health Economy is one such area that spans both communities.



Fylde Coast

Blackpool and Fylde Coast CCG recently introduced a new care model – Extensive Care – in two early implementer sites focused on people with more complex care needs.

It works by re-orientating care around the needs of the person, encompassing all aspects of health and social needs: medical, social, psychological, functional and pharmaceutical. This is designed to ensure early intervention and, over time, proactive prevention.

Commissioners and providers undertook a thorough design process during 2014-15 to produce a detailed blueprint for the new service.

But before “go live” in summer 2015, the CCG ran a series of pioneer programme-funded simulation events with clinicians, managers and patient representatives to “stress test” the models in a safe environment.

This exercise helped identify key development areas for the final weeks before launch and gave the CCG a better understanding of services from a patient perspective. It’s an approach other pioneers or vanguards might consider if looking to launch or pilot new models of care.

Shared aim

Pioneers and vanguards are both focused on addressing the **care and quality gap** identified in the Five Year Forward View. As a result of the improvement in care and quality, there is an expectation that health and wellbeing as well as efficiency will improve.

Watch the video ↘



Southend’s single point of referral system is one such area that is addressing the care and quality gap.

Shared support

The support available to pioneers and vanguards has been aligned to maximise resources and impact. Examples of the shared support provided include the international care model alliance work, which supports budding relationships between care systems in England and their international counterparts to learn from each other’s approaches to developing care models. You will find reference to some of these international care models within the report, as they have provided insight and inspiration to pioneers and vanguards that may be of interest to others.

Different starting points

The pioneer programme aims to increase the scale and pace of providing integrated, person-centred coordinated care. The pioneers may have different population focuses and different local aims; yet they share a common goal of improving care for local communities. During implementation, pioneers identified that a new care model was required. Their work on the key enablers for integration led to some pioneers successfully applying to become vanguards when the Five Year Forward View invited expressions of interest.

For those pioneers who are not vanguards, their work on implementing integrated care is very much supported by the new care models programme. Pioneers work alongside vanguards as part of the new care model programme, delivering replicable care models.

1.6 What this report contains

This report intends to answer two different but related questions:

1

What can we learn from pioneers and their progress in 2015?

In answering the first of these questions, the report shares an overview of learning across the pioneer community and provides more in-depth pioneer and international care model stories. To help navigate throughout the document, a separate list of the stories and where to find them in the document is provided.

2

How does the national support provided for pioneers help them deliver?

The report provides a summary of the support provided to pioneers in section five. Our support work is co-designed by pioneers and focuses on addressing priority areas they have identified.

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“ The projects that I’ve seen that have had the strongest patient and public involvement are the projects that have delivered the biggest difference.”

Executive Director of Policy and Impact, MacMillan Cancer Support

2

Our operating environment in 2015

2.1 Operating context

2.1 Operating context

During 2015, the environment we operate in changed and this has impacted both positively and negatively on the advancements made by our pioneer community.

Local health and social care systems are dealing with a growing population with changing needs, a challenging financial position and workforce pressures, along with other factors.

There has also been a significant focus on driving integration forward through initiatives such as

devolution and a continuation of the Better Care Fund. Building on this, the government has pledged to integrate health and social care services by 2020. Each part of the country will develop plans for this by 2017, to be implemented by 2020. Local areas, building on work already under way, will integrate in different ways using a range of models the government supports. We anticipate the pioneer work will be a helpful source of material to support this planning.

“I think integrated care is at the heart of what we believe as an organisation because we believe it’s all about patients and patients living their lives.”

Executive Director of Policy and Impact, MacMillan Cancer Support

Our population has grown and is getting older – influencing the demand for our services

The impact our growing and ageing population has on the future provision of health and social services is well documented. With the UK's population projected to increase by 9.7 million over the next 25 years from an estimated 64.6 million in mid-2014 to 74.3 million in mid-2039, we will continue to see the influence this increase will have on the demand for our services.

The median age of the population (the age at which half the population is younger and half the population is older) at mid-2014 was 40 years – the highest ever estimated. The number and proportion of older people continues to rise, with more than 11.4 million (17.7 per cent of the population) aged 65 and over in mid-2014, up from 11.1 million in 12 months. It is projected that, by mid-2039, more than one in 12 of the population will be 80 or over, compared to less than one in 20 in 2014.

Thanks to improved living standards and advances in care and treatment of many long-term conditions (LTCs), a greater proportion of the population is now able to lead a longer and more active life. It is estimated that 70 per cent of total expenditure on health and care in England is associated with the treatment of 30 per cent of the population with one LTC or more, and the number of people in England with one or more such conditions is projected to increase from 15 million to around 18 million by 2025. Care for people with LTCs accounts for 55 per cent of GP appointments, 68 per cent of outpatient and A&E appointments and 77 per cent of inpatient bed days.

This has led to many pioneers focusing transformation projects on the elderly and/or those with long-term conditions as a starting point for their person-centred care plans. Many are now moving to include a stronger focus on the broader population, most notably with a focus on prevention and self care. The key themes explored in section four of this report describe how different models of care are being developed to focus on different population needs.

Our financial position looking across health and social care is challenging – influencing the allocation of our resources

During the last Parliament, the NHS budget was protected against a backdrop of reductions to other government departments as the Treasury sought to address the national budget deficit. However, demand pressures in health and social care exceeded the growth in funding, leaving the NHS having to find unprecedented productivity savings. In response to this, the NHS has committed to deliver its £22 billion in efficiency savings by 2020-21 to deal with this rising demand.

In social care terms, the spending review announced in 2015 also represented a challenging settlement for social care. Other factors such as the introduction of the living wage from April 2016 are expected to put additional pressures on finances for health and social care providers.

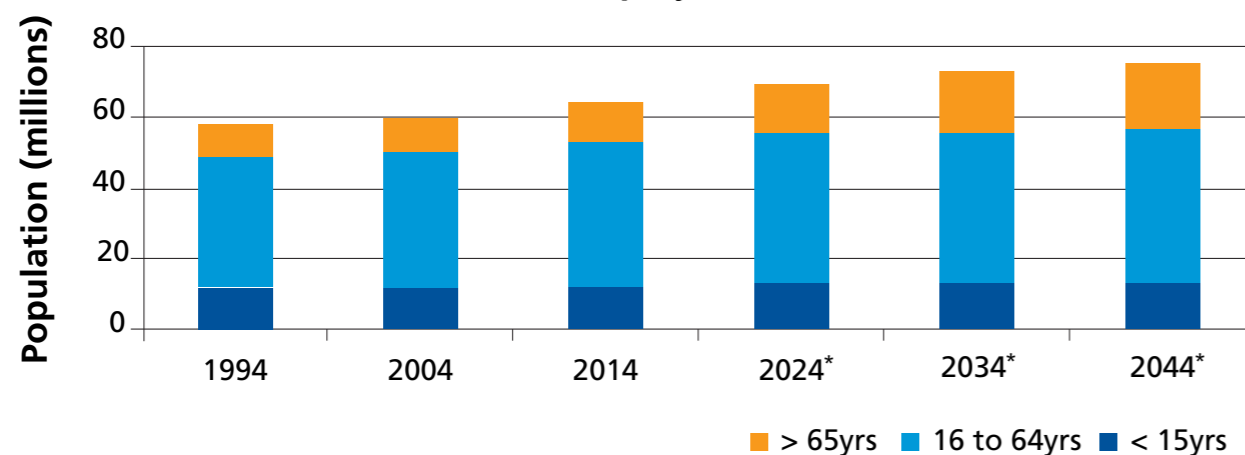
The financial position impacts upon how health and care systems approach investment in new care models and the focus pioneers have placed upon sustainability. Over the medium to long term, new care models and approaches, once proven, will need to be embedded within business as usual.

Our workforce is changing – influencing the supply of our services

In 2012, 1.56 million people worked in the adult social care sector⁵ and more than 1.3 million worked in the NHS in England. Of those working in the NHS, the clinically qualified staff include 40,236 general practitioners (GPs), 351,446 nurses, 18,576 ambulance staff and 111,963 hospital and community health service (HCHS) medical and dental staff⁶. It is vital the service invests in making the best use of staff to ensure they can deliver the care people will require in the future.

Looking outside the health and care sector, the rate of employment in the UK (the proportion of people aged from 16 to 64 who were in work) has been improving. September 2015 saw the highest overall employment rate since comparable records began in 1971. However, the number of vacancies for health and social care workers is increasing, which is putting pressure on organisations.

Age distribution of the UK population, 1994 to 2044 (projected)



Three Cities



Trying to address these vacancies, NHS organisations have used more temporary staff, with the number of temporary hours more than doubling between April 2012 and January 2015.

The move to more community based care models and integration is also changing the shape of the health and social care workforce, creating different roles such as the care navigator. Delivery of these community based care models will rely on the availability of a well-trained and motivated workforce.



Watch the videos ↗

Nottingham City describe how their care navigator role is impacting upon care.

All these factors have made our operating environment a challenging place in which to deliver integrated care. Combined together, pioneers have reported that, in 2015, they felt resource constraints have weakened their ability to deliver integrated care.



Kent describe their approach to these challenges and the need for new care models.

Communities of practice

Pioneers have come together to discuss and share their reflections and responses to these and other issues, building smaller communities of practice, groups that work collaboratively on shared challenges and issues.

In response to the sustainability challenges facing health and care, three large metropolitan pioneers – Leeds, Greater Manchester and North West London – have established a community of practice.

This community meets periodically to highlight their approaches to common challenges and to see which shared learning and joint approaches would make sense for their local communities.

They are exploring new and innovative ways of working to reduce and prevent demand, join up health and social care services so they are responsive to people's needs and deliver a seamless high-quality experience to improve outcomes for local populations and the local health economy "system" as a whole.

Specifically, the sites have identified the following as "game changers":

- Collaborative cross-sector leadership.
- Funding and efficiency: investment and funding certainty to enable longer term planning and delivery.
- Workforce: a "challenge" across all sites in particular responding to the rapid shift in community based multi-disciplinary care.
- Information governance: in particular, the ability to share data where it demonstrates benefits and impact to service users and the health economy.
- Place-based systemic perspective and oversight: as opposed to silo-based inspection-regulation regimes. More streamlined "light touch" regulation and oversight.

Leeds

The vision for Leeds is to be a healthy and caring city for people of all ages, where people who are the poorest will improve their health the fastest. The ambition is to be the best city in the UK by 2030, including for health and wellbeing.

Greater Manchester

Greater Manchester's vision is to ensure the greatest and fastest possible improvement to the health and wellbeing of its 2.8 million citizens.

Devolving powers to Greater Manchester will enable it to have a bigger impact, more quickly, on the health, wealth and wellbeing of its people. Devolution is designed to allow Greater Manchester to respond to the needs of local people by using their experience to help change the way it spends the money.

North West London

North West London wants to improve the quality of care for individuals, carers and families, empowering and supporting people to maintain their independence and to lead full lives as active participants in their community. This is underpinned by three key principles:

1. People will be empowered to direct their care and support and receive the care they need in their homes or local community.
2. GPs will be at the centre of organising and coordinating people's care.
3. Systems will enable and not hinder the provision of integrated care.

In order to share learning, the community is developing a progress report articulating the three cities' findings in 2015 which will be available in early 2016.

3

Highlights of the year

3.1 Highlights of the year

3.1 Highlights of the year

Despite the challenges identified, pioneers made significant progress with the integration of health and social care in 2015/16.

This has taken different forms, with pioneers choosing to focus on enablers for integration such as information and technology, workforce, organisational forms, communications and engagement and contractual mechanisms. Many of the highlights reported by pioneers have taken 18 months to come to fruition, sometimes longer, as sites continue to grapple with the balance of short-term operational requirements and longer-term sustainable transformation.

2015

- January**
 - Launch of second wave of pioneer sites
- February**
 - Announcement of [Devo Manc](#) 
 - South Somerset Symphony Care hub opened
- March**
 - Barnsley "right care" launch
- April**
 - International care model immersion tours and conference held
- June**
 - Cornwall roll-out of Living Well to a wider footprint
 - Fylde Coast launch their extensivist care service
- July**
 - Nottingham City launch self-care pilot in Bulwell
 - Wakefield produce report into Trinity Care pilot
- September**
 - Second pioneer assembly held focusing on co-production with communities and voluntary care sector
- October**
 - South Devon and Torbay launch Integrated Care Organisation
- November**
 - South Tyneside launch "A Better U" in self-care week

Working with you, for you

The country's first Integrated Care Organisation (ICO) to combine acute, community and social care is striving to improve the care people with complex needs can access at home and in the community.

<p>Pioneer: South Devon and Torbay</p>	<p>Population: <500,000</p>	<p>Geography: Semi-urban</p>	<p>Life cycle stage: Test</p>
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The creation of Torbay and South Devon NHS Foundation Trust (TSDFT) on 1 October 2015 was a significant step towards delivering the aims of the pioneer programme in South Devon and Torbay. It is the first Integrated Care Organisation (ICO) in the country to bring together acute and community and social care services to form a single provider organisation.

TSDFT aims to provide safe, high-quality health and social care services to a local population of 375,000 people. A new, wellbeing-focused approach to delivering care will empower individuals to live healthier, happier and more fulfilling lives and making best use of the assets available to them within their own families and local communities reducing reliance upon statutory services to ensure a more sustainable model of care. The trust's strapline, which encapsulates its vision and was voted for by its 6,000 staff, is "Working with you, for you".

The Trust also aims to increase partnerships with other organisations supporting the health and wellbeing of local people to offer person-centred care that feels seamless. Greater integration with primary care, mental health and pharmacy services will be a key step towards achieving this; as well as closer links with voluntary and independent sector organisations.

In 2016, TSDFT is shifting the focus of care delivery from a hospital-based, bed-reliant model to a more flexible one that provides:

- increased access to specialist services and diagnostics in the community
- enhanced ability to care for those with complex needs at home rather than in a hospital bed, working to the philosophy that "your own bed is the best bed".

A more proactive approach with an emphasis on prevention and self-care will support the Trust's aim of supporting people to remain independent and in their own homes for as long as possible.

Your own bed is the best bed

This philosophy was certainly true for Torquay resident Rick. As well as being diabetic, one Christmas Rick became one of just 300 people in the UK to be diagnosed each year with transverse myelitis – a rare condition that often leads to paralysis.

Following his diagnosis, Rick was moved to the Duke of Cornwall Spinal Treatment Centre in Wiltshire. His wife Sandra was only able to make the journey from Torquay on weekends, so of course both were keen for him to come home. But by this point Rick could only breathe with the aid of a ventilator and few places had the specialist equipment and knowledge to manage his needs.

Allison Moloney, one of Torquay's three community matrons, was instrumental in bringing Rick home. Along with a social worker and an occupational therapist, Allison visited Rick in hospital to gain a detailed understanding of his complex needs. She then liaised with Pulse Healthcare to organise a team of carers to support Rick at home around the clock.

Everyone involved in Rick's care, including Sandra and the carers, must know what to do in a power cut or if his breathing tube becomes blocked or dislodged. They also need to understand how his diabetes and transverse myelitis – and the treatments for both – interact and affect each other.

The family home has now been adapted for Rick's wheelchair, ventilator and special bed. With a specially adapted car, he can still take trips to the beach. His team provides all the daily help he needs at home, whether that's treatment for his diabetes, physiotherapy, occupational therapy, dentistry, podiatry – or

something he could never have had in a hospital ward or nursing home, like a cooked breakfast or the company of his dog Suzy.

"The last few years have been really tough for us both," said Sandra. "We're both really grateful for all the support we've received. The care Rick's had is second to none – nothing is too much trouble for his team of health and care professionals."

"I can't always make someone better, but I can support them on their journey and help them through their ongoing health issues. Working with people like Rick and Sandra is a real joy."

Allison Moloney, Community Matron



Living Well, learning well



[↑ Watch the video](#)

Cornwall's Living Well programme is aiming to move people away from unscheduled health management to more structured, planned use of services over the long term.

The approach identifies people's priorities through a guided conversation with a voluntary worker, which leads to small confidence-building steps and social activity that ultimately have a positive effect on the person's health, independence and wellbeing.

In 2015, the Living well model was rolled out from Newquay and Penwith to include east Cornwall and the Isles of Scilly, expanding the cohort of patients on the programme to more than 2000. There have been more than 3,301 visits and 7,747 contacts recorded to date.

The model is also being expanded to include "Starting Well" and "Developing Well". These approaches will be targeting young children and families who do not necessarily meet criteria for other existing pathways, including Children and Adolescent Mental Health services, but need some form of support to keep them well in their own home and community. The pioneer is also considering how to adapt the approach to

actively support residents in care homes before the end of 2015/16 and has received some support from the pioneer investment request fund to enable a pilot.

Local acute providers are also supportive of the model, with West Cornwall Hospital this year launching "Welcome Home", a hospital discharge support scheme following the Living Well approach. Referrals received to date show a high need for social wellbeing support as well as for basic support such as shopping, home safety checks and transport. Voluntary sector attendance at MDTs and rapid ward rounds has supported better discharge outcomes for people, impacting upon length of stay. The most significant impact, however, has been seen in the culture and environmental change, with West Cornwall Hospital now reporting a waiting list for bank staff shifts.

Following on from positive evaluation results for the initial Living Well cohort (see page 66 for detailed information on the evaluation) and the positive impact seen in individual providers, Kernow CCG and system partners have confirmed their ambition to mainstream the model across the county as part of the deal for Cornwall by 2020.

4

Key themes

4.1 How the themes were identified

4.2 Pioneers at a glance

4.3 Themes in detail:

Population segmentation

Using the experience of people

Providing proactive care

Providing integrated care services

Supporting integration through using shared care records

Using technology to support different access points

Analysing impacts through data

Removing financial disincentives

4.1 How the themes were identified

By looking across the care models developed by pioneers in aggregate, the community also identified consistent themes. To help others embarking on or reviewing their existing integrated care model, these themes are noted below. We would

recognise that this is not a definitive list, rather it is an evolving position based on what the community has learned in 2015.



4.2 Pioneers at a glance

The table overleaf shows the 25 pioneer sites and their position as at 30 November 2015 regarding integrated care models for their population. We adapted the product life cycle methodology to help describe the stages of implementation of person-centred coordinated care. This approach is aligned to the “Plan Do Study Act” cycle approach already used in some areas.



Stage three – Test

It is important to test out the design and concepts behind the care model to understand what works in practice and what impact the model has. The test phase allows areas to study what worked well and what areas need to be improved.



Stage one – Initiate

The first stage is defining the model of care and what the model is intended to do and bringing together those involved in the design and delivery of the model. The outputs from this stage should describe the aims clearly and provide a common purpose for those working on the model.



Stage four – Grow

After understanding the results of the test phase, pioneers incorporate the findings and grow their models, by changing aspects of the model design and/or changing the number of people the model covers.



Stage two – Design

During this stage, the detailed design and specification of the care model is developed.















Stage five – Improve

The improvement work does not end when a care model has been designed, tested, adapted and rolled out. By incorporating continuous improvement methods into the care model, there is an opportunity to review and adapt the model to ensure it is always fit for purpose.



Pioneer site	Population	Geography	Life cycle stage	Population segmentation		Using the experience of people	Providing proactive care	Providing integrated care services	Using technology	Analysing impacts through data	Removing financial disincentives
				a. Data analysis	b. Patient selection						
Airedale, Wharfedale and Craven	1	Urban	Test	4	4	4	4	4	3	3	2
Barnsley	2	Urban	Test	3	3	3	4	3	4	3	1
Camden	2	Urban	Test	2	3	2	2	3	3	2	1
Cheshire	3	Urban	Test	3	3	3	3	3	3	2	2
Cornwall and Isles of Scilly	3	Rural	Grow	3	2	4	4	3	2	3	1
Fylde Coast	2	Urban	Test	3	3	3	3	2	2	3	1
Greater Manchester	4	Urban	Grow	3	3	3	3	3	3	4	3
Greenwich	2	Urban	Improve	2	4	3	3	3	2	2	2
Islington	2	Urban	Grow	3	4	3	4	3	3	3	2
Kent	3	Urban	Design	3	3	3	3	3	3	2	2
Leeds	3	Urban	Grow	4	4	2	3	3	4	4	3
North West London	4	Urban	Test	4	4	4	3	3	2	2	3
Nottingham City	2	Urban	Grow	3	4	4	4	3	4	2	4
Nottingham County	3	Urban	Test	2	3	3	3	3	2	2	2
Sheffield	3	Urban	Design	4	4	4	3	3	2	3	2
South Devon and Torbay	2	Urban	Test	3	4	3	2	3	3	3	1
South Somerset	3	Rural	Test	4	4	3	3	3	2	3	3
South Tyneside	1	Urban	Test	3	4	4	3	4	3	3	3
Southend	1	Urban	Grow	4	3	4	4	3	4	4	2
Staffordshire and Stoke-on-Trent	3	Urban	Design	3	3	4	2	3	1	3	3
Vale of York	2	Urban	Grow	4	4	4	4	4	2	3	2
Wakefield	2	Urban	Test	3	3	4	4	4	3	4	2
Waltham Forest and East London	3	Urban	Grow	4	3	2	4	3	3	3	3
West Norfolk	1	Rural	Test	2	3	3	2	2	2	2	2
Worcestershire	3	Urban	Test	3	4	4	3	3	3	3	3

KEY

	<200,000
	<500,000
	<1,000,000
	<2,000,000
	<3,000,000
	Semi-urban
	Rural
	Urban
	Design
	Test
	Grow
	Improve

4.3 Themes in detail



Population segmentation

High-level overview

Understanding how people currently use and access health and care services is the important first step that underpins the development of many integrated care models. Many areas use population segmentation to identify groups (or cohorts) within their population who may benefit from different approaches to their care. For example, people with long-term conditions may benefit from a care model that is different to those requiring children's services. The pioneer stories help explain how population segmentation works in practice.

How pioneers approach population segmentation

Most pioneers have brought together data from across health and social care to analyse key trends and usage patterns in order to identify opportunities to improve care and better respond to people's needs or proactively address risks before they materialise. Segmenting the population according to similar care needs and demands may help achieve a more meaningful understanding of these needs for the purposes of system planning and efficiency. It allows for more consistent comparisons both within and across localities and helps make it easier to understand the drivers of care demand at a more nuanced level.

By examining how people currently use and experience health and care services, irrespective of who provides them, pioneers are able to assess a person's needs holistically. This allows them to plan for better care tailored to individual requirements.

Segmentation is based on a person's characteristics that determine their needs and care demands, such as the number and nature of their medical



Population segmentation is linked to the following I statements:

- All my needs as a person are assessed.
- Taken together, my care and support help me live the life I want to the best of my ability.

The three gaps:

By examining population data, it will enable:

- an understanding of where health and wellbeing and preventative services are likely to have most impact
- an understanding of current quality and outcomes generated
- a picture of where efficient resource allocation could have the biggest impact.

conditions and their age. The resulting segmentation provides a framework by which to analyse needs and current use of resources (for example, those with two or more long-term conditions).

This data can support service planning and improved patient outcomes, for example, to understand different patterns of care and resource utilisation associated with different segments. This enables both providers and commissioners to assess where the highest areas of demand are and where to target efforts to improve care.

To reduce the chance of a person not receiving the right care package which have found helpful, pioneers have been using the segmentation analysis and creating criteria to help identify

those who would benefit most from a particular care pathway. In the best examples, criteria and professional discretion are brought together to ensure the right patients receive the right care pathway that best fits with their needs. This often involves the use of risk stratification tools, either locally built or using standard risk stratification tools such as the Combined Predictive Model (CPM), which helps identify people at risk of adverse events (such as admission to hospital to receive emergency care).

In the stories shared, pioneers demonstrate how they approach population segmentation and then use this information to signpost the right population to receive the most appropriate care pathways.

“ When somebody has person-centred coordinated care it means they can get access to the kinds of support they want in the way they want it.”

Director of Policy, National Voices

A new model for complex care

To respond to an increasing ageing population and challenges to the future of the local health and care economy, Airedale, Wharfedale and Craven (AWC) are developing new models of care, supported by new proactive services for patients with complex care needs.

Pioneer: Airedale, Wharfedale and Craven

Population: <200,000

Geography: Semi-urban

Life cycle stage: Test



[Watch the video](#)

AWC has a population older than the national average and corresponding higher levels of heart conditions, dementia and stroke.

The age profile and level of deprivation of the population varies across the wards. Inner city wards such as Keighley Central in the Airedale area have a younger population, while the older population is concentrated in the CCG's more rural areas of Craven and Wharfedale. Some wards of Keighley and Skipton are in the top 20 per cent of deprivation nationally. In comparison, Ilkley, Burley in Wharfedale and areas of Craven are in the least deprived 20 per cent. Craven covers an area of

450 square miles and so rural deprivation can be an issue, with some people experiencing difficulties in accessing services and support.

By supporting people in a different, proactive way, and with the services integrated around that person, the AWC new models of care programme aims to deliver better quality of care in the community.

Segmentation

Sue Pitkethly, Chief Operating Officer for AWC CCG, said: "We have performed population segmentation which identified that the top three per cent of our population accounts for 39 per cent of our budget, with the 11 per cent underneath accounting for 35 per cent.

"What we're aiming to do for the top three per cent is provide an intensive team that will support them to be cared for more proactively, providing the right care, in the right place, at the right time."

Any individual's care needs at any one time will be different. AWC's pyramid of care demonstrates the various types of care a person may require.

Proactive, assisted self care – the care people can provide themselves once they have been empowered to do so – is the golden thread through the care models. General care relates to that traditionally delivered in the general practice, either by GPs or nurses. The next part of the pyramid is enhanced care, which covers those who need more time and exploration of their issues. Complex care recognises there is a group of the population that has complex medical problems.



Complex Care service

AWC's complex care service builds on existing local partnerships between health, social care and voluntary and community services to deliver holistic care that is personalised to people's individual needs, supported by key enablers such as telemedicine and other technologies.

The model is founded on the underlying principle of supporting individuals to have the confidence and knowledge to manage their own care, supported by a 'Personal Support Navigator'. Access to the service will be based on the proactive identification of individuals who are experiencing high cost, inefficient and fragmented care.

Once these individuals are identified, the complex care team ascertains their physical, psychological and social needs through a single assessment develops a person-centric plan to address those needs and provides them with a single point of access that's available 24 hours a day, seven days a week, 365 days a year.

Involvement will be subject to the individual's consent as well as professional judgement based on criteria such as age, service usage, independence, the number of co-morbidities or risk factors and risk of crisis.

The service is due to be launched as a "proof of concept" in January 2016. The CCG, in conjunction with its commissioning partners City of Bradford Metropolitan District Council and North Yorkshire County Council, has agreed to implement the model for a sub-set of the total number of individuals with complex care needs (26,497) to test its effectiveness. During the 12 month pilot, 563 people will be seen by the service.

The expected benefits are extensive, not only to the individual and their carer but to the care system and the individuals who deliver the care.

Using the experience of people

High-level overview

Creating services in partnership with citizens and communities is not just about delivering traditional approaches to public involvement; it is about mobilising communities' strengths and working together to co-design and provide services. The pioneers have demonstrated the importance of understanding the views of those who run and use services to ensure care is designed and delivered in a way that is focused on what matters to them.

How pioneers approach using the experience of people

Pioneers have used different ways of ensuring that co-production happens at all stages of the care model design and implementation. This includes:

- communities and local services working together at any stage of the planning cycle, from identifying needs and procurement of services through to implementation and evaluation
- building on community capacities to take action together
- expanding volunteer and peer roles
- connecting people to community resources
- using patient and carer feedback on their experience of care
- delivering care in a person-centred way, reflecting what is important for each individual and what works for them.

Watch the video ↘



North West London's lay partners show how much value pioneers are getting back from their communities.



Using the experience of people is linked to the following I statements:

- 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.
- I am listened to about what works for me in my life.

The three gaps:

By using the experience of people, it will enable:

- better understanding of what matters in terms of health, wellbeing and the outcomes that matter.
- everyone to participate in deciding best use of resources.

Sweden

The Esther Model

In Jönköping County, in the south of Sweden, a multidisciplinary team was set up to look at ways of improving care for chronic disease patients.

The team conducted more than 60 interviews with patients and providers. They came up with a theoretical patient – “Esther”, an elderly woman with complex health needs – to help find practical ways to improve patient flow and care coordination through the complex network of providers.

Mats Bojestig, Chief of Höglandet Hospital's Department of Medicine, said: “It is very important that we called this work ‘Esther’. It helped us focus on the patient and her needs. We can each imagine our own Esther. And we can ask ourselves in our work, what is best for Esther?”

The Esther Model proved inspirational for the team, who worked hard to align capacity with demand and to strengthen coordination and communication among providers. It resulted in an overall reduction in hospital admissions of more than 20 per cent over a three-to-five year period and a redeployment of resources to the community.



“It is very important that we called this work ‘Esther’. It helped us focus on the patient and her needs. We can each imagine our own Esther.”

The new care models programme supports pioneers and vanguards to take part in knowledge exchanges with international counterparts including Jönköping County.

Find out more at the NHS European Office website: nhsconfed.org/eumodelsofcare

Jönköping County: in numbers



Patients shape future care delivery

By listening to patients and better understanding their needs, the pioneer programme in Staffordshire and Stoke-on-Trent is set to change the way it delivers cancer and end-of-life care.

Pioneer:
Staffordshire and
Stoke-on-Trent

Population:
<1,000,000

Geography:
Semi-urban

Life cycle stage:
Design



↑ Watch the video

According to Andrew Donald, Chief Operating Officer for Cannock Chase, Stafford and Surrounds and South East Staffordshire and Seisdon Peninsula CCGs, there is excellent clinical care in Staffordshire. But feedback from patients suggests it is not 'joined up', with many saying they feel lost in the system or frequently have to repeat their circumstances to different healthcare professionals.

End-of-life care patients say they want to be able to choose where they die, while research shows there are marked differences in cancer survival rates and expenditure in the area.

Having more than 60 contracts for cancer and end-of-life services in the area means there are significant barriers to delivering a joined-up

approach and this large number of different healthcare providers has caused frustration among patients and carers alike because communication can be poor between the different organisations.

As a result, four CCGs – North Staffordshire, Stoke-on-Trent, Stafford and Surrounds and Cannock Chase – have joined forces with Macmillan Cancer Support, NHS England and two local authorities to deliver more coordinated cancer and end-of-life care services across the region.

Partnership

Creating services in partnership with citizens and communities is not just about delivering traditional approaches to public involvement; it is about mobilising communities' existing strengths and working together to co-design and produce services.

Patients and their carers have therefore been at the heart of the programme as the commissioners wanted to harness their unique insight and experience to allow them to address the problems patients are reporting.

The programme team has undertaken extensive work with the community to understand what is working, what is not working and taking that learning into a procurement process to appoint two service integrators, one for cancer and one for end of life. The service integrators will work with the providers to coordinate care and improve communication.

The programme has a network of Patient Champions who have been at the heart of developing the programme. Some of the Patient Champions are trained to evaluate bidders during the procurement and use their unique experience to inform the whole process. In addition, the bidders have to show how they will engage fully with clinicians, patients and the public throughout the initial two-year co-design stage and subsequently show the way those experiences will inform the measurement and improvement process over the main eight-year contract phase.

Patient champions

An integral part of the process has been cooperation between commissioners and Patient Champions.

Patient Champions might have experienced or be going through treatment or be a carer for a relative or friend. Their role is to represent local communities and their voices and opinions were at the heart of the process to define how services will be delivered in future.

This programme has adopted a co-design approach, which means patients, carers and health and social care professionals have been consulted and involved from the beginning. Co-design captures the experiences of patients,

carers and staff to help shape service improvement at the outset and throughout the lifetime of the contract.

Patient Champions and patients have had an input into every major document and sign off so far. Nothing that has been agreed without some kind of patient involvement. Most importantly, patients recognise the role they have played in shaping the future.

Carl Rushton, Patient Champion, said: "What's reassuring is both the NHS and bidders are actually listening to us. They are actively engaging with us and they are listening and reporting back to us regularly. So we're definitely having our voice heard."

Future care provision

Justine Palin, Director for the Transforming Cancer and End of Life Care Programme in Staffordshire and Stoke-on-Trent, said: "In terms of what will make a difference to patients, there will be better communication and coordination and, as a result, they won't have to repeat their story. It's much more around a personalised approach to integration in care, meaning that patients and their carers will have a choice and feel informed and involved in their care. Patients tell us they can feel lost in a complicated system, this programme is about making the system easier to navigate."

In Staffordshire and Stoke-on-Trent around 22,000 people currently live with cancer, but this is projected to rise by 68 per cent to 36,600 by 2025.

Providing proactive care

High-level overview

Proactive care is used by many of the pioneers to support people, including those with long-term conditions or complex health and social care needs to maintain their wellbeing. It describes care services that offer to provide additional support and care to help prevent deterioration in the health and wellbeing of people.

How pioneers approach providing proactive care

Stepping in with support at an early stage can prevent conditions from worsening and ensure people:

- have the right help and support to continue living independently for as long as possible
- know what to expect and find services easy to use
- receive a single package of care from all of the professionals who support them
- are supported to take control of their own care, if they want to
- know their carers will also be supported.

Pioneers are moving towards “scaling up” this approach; providing proactive care to a wider section of the population to help prevent them from developing complex care needs. This proactive care is not always health focused but looks at other elements impacting upon a person’s wellbeing, for example, housing.



Providing proactive care is linked to the following I statements:

- I can plan ahead and stay in control in emergencies.
- I have systems in place to get help at an early stage to avoid a crisis.

The three gaps:

By providing proactive care, it will enable:

- prevention rather than cure
- better outcomes for health and wellbeing to minimise the risk of requiring emergency services
- more efficient use of resources as proactive care is more efficient than emergency activity.

“Patient involvement and clinical involvement are the two things that can often break down barriers that have been there culturally... been there for a long, long time.”

Executive Director of Policy and Impact, Macmillan Cancer Support



Changing conversations to make “a better u”

Self care will address demand on health and care services in South Tyneside – if professionals and the public alike can be supported to change their behaviour.

Pioneer: South Tyneside

Population: <200,000

Geography: Urban

Life cycle stage: Test



[Watch the video](#)

South Tyneside has a strong voluntary sector, providing communities with keep fit classes, clubs and other sociable activities.

Yet there are still many older people living alone and increasing numbers of people with combinations of unhealthy behaviour such as smoking and drinking.

South Tyneside’s pioneer programme is working with the voluntary sector to raise awareness of community-based services, encourage and support people to self-care and so improve health and wellbeing while reducing demand on statutory health and care services.

The programme, branded “a better u”, has been trialled in Hebburn and began rolling out across the borough in September 2015.

Integrated community teams

The integrated community teams in Hebburn and Jarrow promote self care at every opportunity. The teams include social navigators, who help any patients and service users who come into contact with team members (whether routinely or in response to an incident) to access relevant community-based services – where possible, without calling on statutory services.

This has involved significant shifts in culture and behaviour for the teams. One of the programme’s voluntary sector partners, healthy behaviour change specialist First Contact Clinical, has trained around 360 staff and community partners to change the conversations they have with patients.

Effective conversations about self care are not as simple as telling someone smoking causes cancer.

They need to help people understand their own drivers and provide the capability, opportunity and motivation to care for themselves. This could mean joining a local exercise group or learning how to manage a condition such as diabetes at home – to name just two of many possibilities.

Community engagement

To gauge the public’s current understanding of self care while also raising awareness of the programme, “a better u”:

- conducted street surveys and focus groups
- issued questionnaires to targeted populations
- recruited student “roving reporters” in two schools.

This research influenced the programme’s focus. For example, a session with Hebburn Community Area Forum suggested services could support self-care better by improving:

- communication
- education and training
- access to support and activities.

First Contact Clinical also introduced members of the public to the idea of self care with a series of “scene setting” workshops, which helped kick-start a number of new community initiatives.

Healthnet, a voluntary sector health and social care forum, has proved useful for discovering, engaging with and coordinating voluntary sector partners. Local voluntary organisations collaborated to develop a new quality standard, recognising initiatives that contribute to their communities’ improved wellbeing.

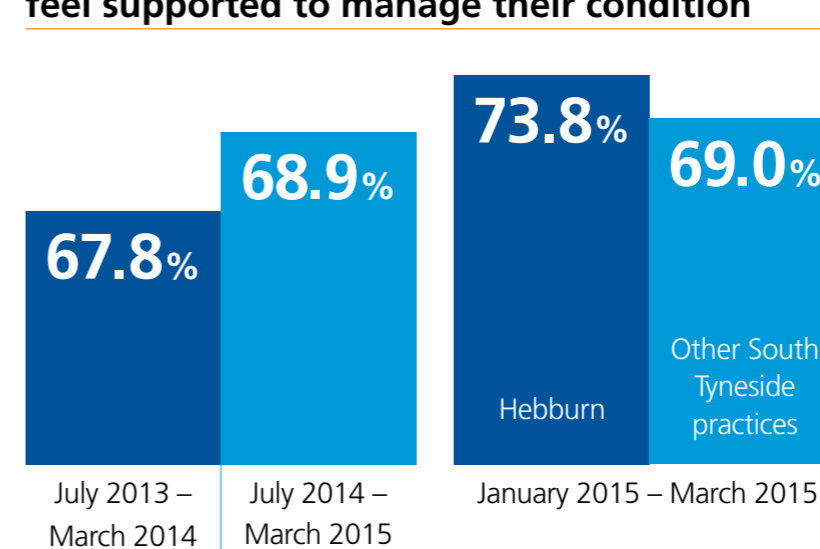
Achieving change

It takes time and effort to achieve culture and behaviour change among both staff and the public, but Hebburn is already feeling the difference. The proportion of people who feel supported to manage their condition – one of the NHS Outcomes Framework indicators – has noticeably improved.

The report “Securing our future health: taking a long-term view” by Derek Wanless suggests that for every £100 invested in encouraging self care, around £150 worth of benefits are realised.

As well as expanding activity throughout the borough, the programme now aims to increase the number of specific groups it targets and to establish links with Change4Life – a social marketing campaign that helps people improve their health and wellbeing by changing their diet and activity levels.

Percentage of South Tyneside residents who feel supported to manage their condition



believe taking care of their health is their responsibility.

(based on a survey of more than 1,000 residents in Hebburn)

Extending integrated care

After successfully rolling out integrated care to the site's most at-risk patients, Waltham Forest and East London (WEL) is extending its pioneer activity to a new medium-risk cohort.

Pioneer: Waltham Forest and East London

Population: <1,000,000

Geography: Urban

Life cycle stage: Grow



Watch the video

WEL uses risk stratification to identify the residents most at risk of admission to hospital. The site initially focused on the top one per cent: patients with very complex care needs. To date, integrated care has been rolled out to the top six per cent, many of whom are elderly and/or living with long-term conditions.

WEL's integrated teams have focused on providing this cohort with treatment at or close to home – avoiding the strain of repeated hospital visits and reducing the risk of hospital-acquired infections.

The programme is now extending into the top 20 per cent of residents. These medium-risk patients benefit from more proactive health promotion, including help with understanding

and managing their condition as well as aspects of social care.

The vision for all cohorts is for people to live longer, more independent and more socially active lives.

At-risk patients

A complex patient living with heart failure and Chronic Obstructive Pulmonary Disease was being managed solely by the respiratory team. His GP confirmed he was being admitted to hospital as often as twice a week.

An individual patient assessment and an interview with his family revealed why his admission rate was so high: he was frightened and his family didn't understand his condition, so he felt hospital was the safest place to be.

The local multidisciplinary team provided the patient and his family with a single point of access number to call instead of the emergency services including out-of-hours support. This takes the pressure off families to know which department or service deals with which situations: the single contact can liaise with organisations throughout the system to arrange the right care.

Medical team members helped family members understand the patient's condition better and to manage his medication, pain, breathlessness and anxiety, while the team psychologist helped the patient and his family cope emotionally with his condition and its consequences.

The team arranged for carers to help out while the family gained confidence with the social aspects of the patient's care, supported by social care professionals on the team. The family then took over fully and is now adept at managing the patient's care (medical and emotional). He and they now mostly interact with the health and social care system during routine checkups. As a result, the patient stayed out of hospital for nearly a whole year.

Medium-risk patients

Lower down the pyramid, the teams aren't always dealing with medical needs. Multidisciplinary teams include physiotherapists and occupational therapists who can recommend physical inputs – for instance, frames and railings to prevent people living alone from falling or buttons they can use to call for help if they fall out of reach of a phone.

When a patient is given a call button, the team also installs a box outside their home containing a spare key. Only the team knows the code to open the box. This means if the person falls and needs help, no one has to break down the door.

Care coordinators play an important role for medium-risk patients. They create packages of care designed to empower patients and improve their quality of life, reducing the likelihood of them entering hospital or a care home.

One patient, Alec, had damp and black mould in his house until he was assigned a care coordinator, Pauline. Seeing how the mould exacerbated Alec's rheumatism, Pauline arranged for contractors to remove it and damp-proof the house. The care package Pauline designed for Alec includes help with showering, laundry, shopping and making breakfast.

In 2016

Though the roll-out of integrated care to the medium-risk cohort is still in progress, WEL has already started to see reductions in hospital activity for all its integrated care cohorts.

Staged roll-out using risk stratification

Initial project focus: top 1% of patients

Roll-out to date: top 6% of patients

Currently extending to: top 20% of patients

Providing integrated care services

High-level overview

Pioneers were selected because they are developing innovative ways to coordinate care around people's needs, so it is no surprise to see a wealth of experience on integration across primary, secondary and community care, across physical and mental health and between health and social care, as well as strong partnerships with the voluntary and community sectors.

How pioneers approach providing integrated care services

Integrated care provision means health and care professionals can focus on what they do best – by ensuring they can refer people quickly and easily to expert support and guidance. It also recognises that health and social care alone have limited reach to tackle many of the determinants of people's health and wellbeing, such as social isolation, housing quality and lifestyle.

Pioneer activity includes:

- introducing new roles, such as care navigators and health coaches, to help people access the right care and support at the right time, often in partnership with community and voluntary sector organisations
- professionals working together in different ways and across organisational boundaries in networks and multidisciplinary teams, often on a locality basis to provide holistic care to a local population
- physically bringing services together
- joint assessment and care planning, increasingly supported by integrated care records.



Providing integrated care services is linked to the following I statements:

- The professionals involved with my care talk to each other. We all work as a team.
- I am told about the other services that are available to someone in my circumstances, including support organisations.
- When I move between services and settings, there is a plan in place for what happens next.

The three gaps:

By providing integrated care for the local population, it will enable:

- the holistic needs of the individual to be recognised
- improved experience and quality of care – the right support, at the right time, from the right person
- recognition of the contribution of the community and voluntary sector and building its capacity.

“Pioneers that have gone slowly and taken the time to build the relationships are where we’ve seen the fastest progress over time.”

National Director of Systems Leadership, The Leadership Centre

The health and social network

Islington's integrated care programme is working to deliver a better experience of care and improved outcomes through its more coordinated approach.

Pioneer:
Islington

Population:
<500,000

Geography:
Urban

Life cycle stage:
Grow



⤴ Watch the video

Islington's integrated care programme is a partnership of local people, health and social care providers and commissioners, working together to deliver better care for the people of Islington.

Working with primary care, secondary care, mental health, social care and the voluntary sector, the partnership is co-designing integrated networks that will support those most at risk.

Integrated Networks

The networks are designed to improve experiences and outcomes by:

- working with patients/service users to identify their own goals
- developing coordinated, joined-up care plans

- providing a named professional who takes responsibility for the coordination of the care plan
- delivering interventions that create new approaches and solutions to long-term problems
- delivering seamless, coordinated and proactive care.

The integrated network's approach includes initial patient/service user identification, weekly multidisciplinary team meetings to agree the way forward, outcomes and performance monitoring, action plans and team learning reflection meetings.

By spring 2016, there will be five integrated networks in place, covering approximately 114,000 patients, which is just under 50 per cent of the population, with more networks forming throughout 2016.

Sharing data across the full range of care services is also critical to the success of the programme, so the pioneer has procured an Integrated Digital Care Record (IDCR) system that will provide a holistic view of patient and service user data from multiple care providers. Records access is a major barrier for professionals and the IDCR will be a key enabler for more joined-up care and a better experience. Patients and service users will be able to view their records through the Person Held Record portal being developed alongside the IDCR.

Alan Jones, Nurse Consultant, Mental Health Trust, said: "Patients assume the different professionals involved in their care are talking together and are communicating in a timely manner. Unfortunately that isn't the case: separate files exist in separate offices, so this is an opportunity to take an overview and to take a different perspective on that patient's care."

Professional development

Also key to the success of the programme is equipping the workforce with the requisite skills and knowledge and ensuring they are working in the right place at the right time.

To deliver this, the pioneer is working with Islington's community education provider network to develop and deliver an integrated workforce development training programme. The programme will ensure all members of the workforce understand the integrated care programme and have the right skills and knowledge to be able to work together to deliver it. It will build on existing skills and expertise and has been developed following input from across the workforce that has helped identify training requirements and opportunities.

The training will be delivered by a range of specialist training organisations that are all leaders in their field and will be rolled out in 2016.

In 2015, the programme team developed blended roles to support the development of improved knowledge and skills across the primary/secondary care interface. Community matrons are now in place to deliver and coordinate high-quality nursing services to patients and service users within the Integrated Networks. There will be continued focus on further engagement and developing these networks in the coming year.

Dan Windross, Commissioning Manager for Integrated Care, said: "We want to improve patient care: we want better outcomes and to understand people holistically in a really joined-up way that we haven't previously. But we also want to make sure we're making the best use of the money that we have and that it's being spent where it's most effective."

Personalisation

A central tenet of the programme is supporting patients and service users to take greater control of their care by empowering them to work collaboratively with health care professionals to manage their long term conditions.

This involves a 'whole-person' approach to care planning and there is a plethora of condition-specific and generic self-management programmes that are available, for example the Expert Patient Programme and Pulmonary Rehab. Developing personal health budgets and making lifestyle interventions such as weight management can also play a role.

LTC 6, a patient survey about long-term conditions, shows this approach is working and that Islington residents are more able to manage their conditions themselves. The 2014/15 LTC 6 results showed 87 per cent of Islington CCG patients feel supported to manage their long term condition.

From pilot to Care Hub

NHS Vale of York CCG's integration pilots are keeping people out of hospitals and in more familiar surroundings.

Pioneer: Vale of York

Population: <500,000

Geography:  Semi-urban

Life cycle stage:  Grow



[Watch the video](#)

Historically, NHS Vale of York CCG depended heavily on acute care. In the more rural parts of the region this could mean long stays in hospitals or nursing homes far outside patients' own communities.

By installing a network of Care Hubs providing integrated care services for their local areas, the CCG aims to help individuals stay out of acute care settings – either remaining at home or returning there as soon as possible.

Reducing hospital admissions will free up resources and speed up responses for those in urgent need of acute care.

Integration pilots

The CCG's operating area is a geographically large site that crosses three local authority boundaries – the City of York, North Yorkshire and the East

Priory Medical Group pilot Launched: June 2014

Target population: Top two per cent of local adults most at risk of hospital admission – focusing on those with common complaints such as chest infections, urinary tract infections or needing intravenous antibiotics or rehydration outside hospital (identified through daily review of admissions and discharges)

Led by: Priory Medical Group

Partners: Unity Health, Haxby Group, My Health, City of York Council, York Teaching Hospital, NHS Foundation Trust

Riding of Yorkshire. The landscape it operates in is complex, involving various acute trusts and primary care partners.

To discover ways to coordinate care in this environment, the CCG is running one pilot project in each local authority area:

- Priory Medical Group, City of York
- Selby, North Yorkshire
- Pocklington, East Riding of Yorkshire.

While these are still integration pilots and not yet fully fledged Care Hubs, patients and service users are already noticing positive effects.

Caring for the whole patient

All three pilots now have working integrated teams made up of doctors, nurses, social workers, occupational and physiotherapists, generic and specialist reablement support workers, among others. Each team meets face to face on a regular basis to share, discuss and plan care for patients and service users – each of whom has a single, named point of contact for all their care needs.

Patients report that their care feels more joined up. For instance, 72-year-old Mrs X had an unstable back fracture and was sent home from hospital with a back brace. A few days later, her husband told their GP Mrs X was distressed and in pain. A holistic carer visited the same day and returned once a day to assist, improving Mr X's confidence. A social worker arranged for the reablement team to learn how to change the brace and after two weeks they took over Mrs X's support.

In Pocklington, a patient's painful knees were affecting his mobility at home. The specialist nurse referred him to the physiotherapist, who provided a frame; the GP increased his dose of Ibuprofen gel to control the pain and the social worker prepared his meals until a carer was available – all of which prevented a hospital admission and ensured the patient stayed in his preferred, familiar environment.

The next step will be to expand the programme beyond the current select communities and target population segments, spreading the benefits throughout the Vale of York.

Selby pilot Launched: January 2015

Target population: Individuals in crisis (identified by referral); elderly patients needing complex care (identified through risk stratification); Selby and District GP practice patients living in care homes

Led by: York Teaching Hospital NHS Foundation Trust

Partners: North Yorkshire County Council, Selby and District GPs

Pocklington pilot Launched: December 2014

Target population: Top two per cent of local adults most at risk of hospital admission (identified using a combination of clinical judgement, local knowledge and the RADAR tool)

Led by: Pocklington Group Practice

Partners: Humber NHS Foundation Trust, East Riding of Yorkshire Council

Supporting integration through using shared care records

High-level overview

Pioneers along with other areas have been developing digital, integrated health and care records to facilitate the appropriate flow of information from one health and care provider to another to enhance the provision of direct care services.

The amount of information that needs to be shared can vary. For example, if an individual is moving from one GP to another, it may be the whole care record. However, more usually, single or multiple documents include information such as lists of medication being taken will be shared between health and care professionals providing direct care.

Information will only be shared between professionals where it is fair and lawful to do so. Cheshire's shared care record shows the importance of this to their integration projects.



Using shared care records is linked to the following I statements:

- I tell my story once.
- My care plan is clearly entered on my record.

The three gaps:

By using shared care records to enable integrated care provision, it will enable:

- the ability to view all appropriate aspects of a person's care needs
- the ability to significantly increase the complementary nature of care provision across organisational boundaries
- the removal of unnecessary duplication in care provision.

“The Shared Care Record is absolutely fundamental to our working better together.”

Chair of Cheshire Health and Wellbeing Board

“When we think about innovation, we think about doing things in radically different ways. At the heart of that, always, is the issue of diversity bringing lots of different voices and perspectives and people into the process of change and I see the pioneers doing that really, really well.”

Chief Transformation Officer

A single source of truth

The Cheshire pioneer programme board believes that, without the site's Shared Care Record, integration would be impossible.

Pioneer: Cheshire

Population: <1,000,000

Geography: Semi-urban

Life cycle stage: Test



[Watch the video](#)

Patients and residents across Cheshire only want to tell their story once. That was the clear conclusion from the three transformation integration projects that originally prompted Cheshire to apply for pioneer status.

The Shared Care Record – successfully piloted in Cheshire West and scheduled for site-wide roll-out in 2016 – enables Cheshire's two local authorities and four CCGs to achieve that ambition for their residents.

The system gives clinicians a single point of access to patient data from primary care, cancer care, social care and community-based health services.

Improvements for patients

For patients, the Shared Care Record means less

repetition of their history and less confusion and stress overall.

The pilot has proved particularly helpful when older citizens experience emergencies and find themselves in the hospital A&E department. Ambulance crews are not always able to pick up patients' medication on a call-out; in these cases, the Shared Care Record helps health professionals identify and administer the right substances and dosages, maintaining the all-important continuity of care.

Similarly, in emergency admissions of patients at or approaching the end of life, the system can alert health professionals to conditions such as end-stage heart failure or advanced cancer – and to advanced directives and other indications of the patient's or their family's wishes. This ensures

people are taken care of in the way they've chosen – and helps clinicians make quick decisions about whether to focus their efforts mainly on treating the patient or on making them comfortable.

Improvements for clinicians

Before the Shared Care Record pilot, clinicians in Cheshire West had to gather each patient's primary care information from various sources in various formats, including faxes and paper print-outs. Accessing social care information usually involved finding the right person – and the right time – to phone.

The alternative – asking the patient to recite their history – was always time-consuming, rarely appropriate, and often impossible.

Being able to access all a patient's information in one system, at any time of day or night, is a huge time-saver. It's also more secure than sifting through sheaves of paper records, which can get scattered and lost all too easily.

But it's not just about efficiency. Better patient information enables a better standard of care. The ability to access a patient's information helps clinicians plan their care holistically: mapping out a care plan stretching from emergency care, through discharge, to care in the community, almost as soon as the patient enters the hospital.

Findings

Because the Shared Care Record has to access so many different IT systems to compile its patient records, download speeds can sometimes be an issue; the pilot version of the system is not always as instantaneous as health professionals would like.

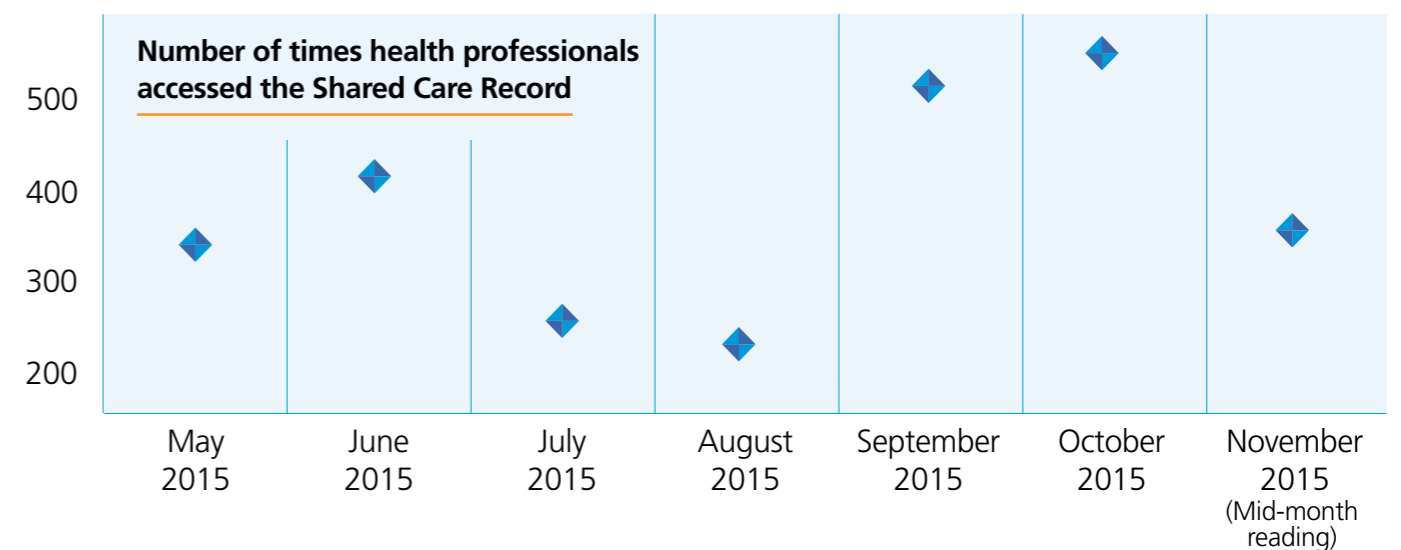
There are also information governance issues to be resolved. It's important to users of the system to be able to reassure both patients and colleagues in other health and social care organisations that the sensitive data is being handled appropriately.

Countess of Chester Hospital is involved in two different care record pilots:

- the Cheshire Shared Care Record, in the A&E department
- the National Summary Care Record, in the pharmacy department.

The two systems have been developed almost in parallel. While the Cheshire record offers richer data, including from GPs and community care, the national record has a wider footprint, with data on patients from outside Cheshire.

Clinicians in Cheshire see the two as complementary, but how (or whether) they will co-evolve or integrate is yet to be seen.



Using technology to support different access points

High-level overview

The integration of technology into health and social care systems will help promote and maintain independence and health of patients and/or citizens. There is a wealth of evidence from across the pioneers of where technology is being used to support people in managing their own care and maintaining independence in the home, through the use of technologies to support communication with professionals.

How pioneers approach using technology

The use of remote patient monitoring (RPM), telephony, video conferencing and other digital solutions to connect people offers many advantages for patients, carers and provider organisations. These assistive technologies offer the ability to monitor patients outside of traditional care settings and encourage people to maintain their independence by facilitating care at home.

These technologies have been proven to detect early deterioration of a patient, thus reducing the number of emergency visits to care providers, hospitalisation and length of stay at the hospital. They also enable improved communication between patients, service users or carers with health and care professionals. All of these can have a positive impact on the patient experience and health and care outcomes and can support efficient allocation of resources.



Using technology is linked to the following I statements:

- I have information, and support to use it, that helps me manage my condition(s).
- I am listened to about what works for me in my life.
- Taken together, my care and support help me live the life I want to the best of my ability.

The three gaps:

By using technology to support different access points, it will enable:

- the ability to detect early deterioration of the patient
- the ability to increase the quality of life and independence of a patient by administering care in the comfort of their own home
- greater efficiency in accessibility.

“I see the quality of the people and the commitment within the pioneer group as a whole, despite the barriers that can get in the way. I have confidence that we’re going in the right direction and we are still moving forward.”

Director of Policy, National Voices

Treating people through technology

Nottingham City is aiming to transform care for citizens with complex needs by equipping them with the technology they need to administer care in the comfort of their own home, as part of integrated social care and health delivery.

Pioneer:
Nottingham City

Population:
<500,000

Geography:
Urban

Life cycle stage:
Grow



Nottingham has ambitious plans to transform the health and care system to enable people to live longer, be healthier and enjoy a better quality of life.

As a wave two pioneer, it is building on the progress it has achieved so far by further reducing duplication and repetition of its services and providing more holistic care and support. Patients will be empowered to manage their own conditions with the support of accessible, connected, coordinated and caring services when they are needed.

Nottingham City is one of the few areas in the country developing an integrated, locally provided assistive technology service. Through

this service, it is aiming to transform the care provided for its citizens with one or more long-term conditions and enable people with complex health and social care needs to live healthy, fulfilling, independent lives.

Integrated care through technology

Central to the project team's success is the Assistive Technology (AT) project for adult integrated care, which brings together the city's telehealth and telecare services.

Telehealth uses electronic equipment in the patients' homes that measures vital signs such as weight, blood oxygen levels, pulse and respiration and captures this data for healthcare professionals. This helps GPs and nurses check

96%

People who say they feel more independent as a result of using the technology

94%

Telehealth and telecare service users who feel safer at home

86%

Carers who say they can improve the lives of the people they care for because of the technology

(based on staff and service user interviews and questionnaires conducted by Cordis Bright)

on patients, reducing the need for visits and appointments, while also helping reassure patients their health is being monitored. The system is able to support chronically ill patients at risk of frequent hospital visits and those with a variety of other conditions, such as diabetes and hypertension.

Telecare is a telephone-based monitoring service that helps people with frailty or capability issues and alerts carers if, for example, they have had a fall. It can include electronic sensors in homes so people can live safely and independently for longer.

By integrating the two services, Nottingham City aims to deliver a package of equipment to help meet patients' entire health and care needs and ensure social care and health professionals only need to make one referral and patients have all equipment installed at the same time.

The aim is also to ensure health and social care colleagues no longer think about technology in siloes and start viewing it in a more holistic,

joined-up way. Colleagues can also use AT equipment to promote prevention, meaning patients' conditions will be less complex as they will be treated earlier and will need less support.

Progress

Through dedicated project management and detailed planning, the CCG has successfully rolled out telehealth to more than 300 users. Telecare has more than 5,000 current users.

Progress has already been made integrating both into a single AT service: there is now one single referral point for telehealth and telecare, while all the installations and monitoring are performed by Nottingham City Homes.

A shift to early intervention through supported self care is now being piloted and this includes the introduction of a web-based directory of services, self-care hubs, community clinics and social prescribing.

Self-care training is available for all health and social care staff to ensure they are able to move away from traditional models of care and be more proactive in their approach. Feedback from patients includes comments stating their experience of care is more "joined up".

Further ahead

Next steps are to identify, target and support other priority groups, such as disabled children (telecare) and patients with respiratory conditions (telehealth). The CCG is also working on increasing awareness of assistive technology among primary care services and linking it to secondary care so the whole process is more seamless.

Ultimately, it aims to have around 10,000 people supported by assistive technology by 2018.

The Assistive Technology Programme is also working on other areas it can support through connective technologies. These include teledermatology, which seeks to support those with skin conditions, and telemedicine, which allows clinicians to check on their patients remotely.

Tele X marks the support

The suite of initiatives known collectively as Tele X is helping Leeds become a smarter, more connected and overall more compassionate city.

Pioneer: Leeds

Population: <1,000,000

Geography: Urban

Life cycle stage: Grow



[Watch the video](#)

The Leeds pioneer programme’s objectives are to treat people as close to their own home environment as possible and empower patients to improve their own health and wellbeing – minimising demand on the health system.

Tele X is the umbrella term for all the ways Leeds is using technology to support these aims.

For example:

- Telecare helps older and vulnerable people to live safely and independently at home.
- Telehealth lets individuals interact with health and social care professionals from the comfort of their own homes.

As the initiative expands, so will the possible meanings of the X in Tele X: Tele-consultations, for instance.

Joined Up Leeds

Technology like Tele X plays a crucial role in Leeds’ parallel ambitions: to be the best city for health and wellbeing and to become a digital or “smart” city.

As a digital city, Leeds hopes to be able to collect information from its citizens, which health and care professionals can then use to achieve richer insights into the needs of the population.

But it would be a mistake simply to assume citizens would be on board with this, so the pioneer team launched Joined Up Leeds: a public consultation to determine how people think information

anonymised from their health and social care should be used.

Some 93 per cent of people supported this information being used for one or more reasons:

- to plan the best services for people in Leeds (89 per cent)
- to help people stay healthy (74 per cent)
- to help cure diseases (74 per cent)
- for general research for the public good (65 per cent)
- for commercial research (18 per cent).

Telecare

Not long ago, Telecare technology consisted simply of a pendant and a base unit provided to older and vulnerable people living alone. When in need of assistance, service users could press the button on the pendant and the base station would alert the integrated neighbourhood team.

Now the range of equipment Telecare can install is much greater and is still expanding rapidly. Around 16,000 service users can now benefit from smoke alarms, heat detectors and flood detectors, all linked via the base unit to a response centre, which is active around the clock. So the integrated neighbourhood team and the emergency services, such as the fire brigade, can respond quickly even if the service user doesn’t realise anything is wrong. Minor incidents can be prevented from escalating, protecting the service user from distress and saving health and care system resources.

Telehealth

Telehealth provides digitally-enabled diagnostic equipment for people with long-term conditions.

For instance, people with diabetes need to monitor their body weight and blood glucose levels. Telehealth provides diabetic people with

digital scales and glucometers that automatically transfer readings to that person’s GP.

This gives people the peace of mind that comes with knowing their GP has the data they need to spot changes in their condition – without the inconvenience of regular trips to the practice.

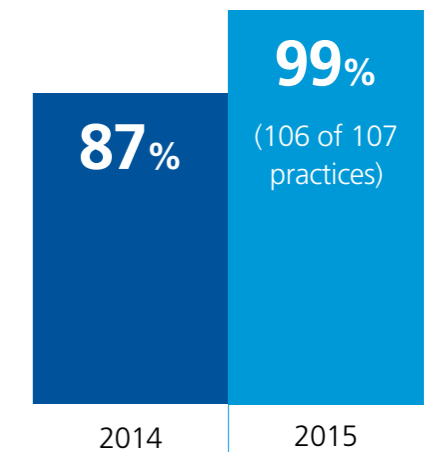
Social networking

Tablet devices provided to older people to promote self-management have also proved useful for combatting social isolation.

Older people were given training on how to use the devices, which came with a range of health-related apps pre-installed.

Helping each other to use the devices became a social activity. Some participants are now using messaging and telephony apps to stay in touch with family and friends, and feeling less isolated as a result.

GP practices signed up to the Leeds Care Record



The roll-out of integrated digital patient records, a highlight of the Leeds pioneer’s first year, is now almost complete.

Analysing impacts through data

High-level overview

As the changes are being implemented, it is essential we understand if the change made is an improvement. To measure if an improvement has been made, pioneers have been working to implement integrated data sets and establishing local metrics that can answer the question: "Has the care model made the improvements it was trying to accomplish?"

How pioneers approach analysing impact

Evaluation is key to analysing the impact of new care models implemented in pioneer sites. As pioneers measure the impact of their pilots locally, there is also a national evaluation under way, led by the Policy Innovation Research Unit (PIRU). The stories included here focus on the local evaluation underway but you can [find out more](#) on the work of PIRU.

"We are aspiring to make a radical difference here. It doesn't happen overnight. It needs time and attention, it needs headspace, it needs commitment, it needs partnership."

Executive Director of Policy and Impact,
[Macmillan Cancer Support](#)



Analysing impacts through data is linked to the following I statements:

- I have regular reviews of my care and treatment and of my care and support plan.
- Information is given to me at the right times. It is appropriate to my condition and circumstances. It is provided in a way I can understand.
- I have systems in place to get help at an early stage to avoid a crisis.

The three gaps:

By analysing impacts through data, it will enable:

- the ability to address problems sooner
- the ability to modify care as required to improve outcomes and experience
- the ability to avert or limit future complications with the hope of decreasing hospitalisation or duration of stay.

The Alzira Model

Originating in Valencia, Spain, the Alzira Model is a collaboration between private partners and the government.

The regional government pays Ribera Salud Hospital a set amount per citizen per year to provide the local population with free, universal access to health services. Ribera's profit is restricted to 7.5 per cent of turnover and any surplus is reinvested in improving healthcare.

Incentives for different providers are aligned, and there is also an incentivised payment system for staff, based on productivity and annual objectives. Last year, staff met 94 per cent of these objectives.

The Alzira Model uses an integrated IT system to provide:

- a single electronic patient record, covering all primary and acute care, which is accessible to patients and third parties such as nursing homes. In certain areas, as many as 50 per cent of patients use this to book appointments, review the outcomes of blood tests, provide self-managed health data and more
- population-level healthcare metrics, born out of patient records and national trend data. These identify trends in given areas and enable targeted interventions – keep fit or substance misuse, for instance
- financial data to cost and measure the outcome of each intervention. Such data is open access to all staff and the cost/quality outcomes are posted in real time.

The Spanish government provides real-time birth and death data that is also factored into the model.

Find out more at the NHS European Office website: nhsconfed.org/eumodelsofcare



50% of patients in some areas can book appointments online



94% of staff productivity objectives were met last year



Reducing emergency admissions through Living Well

Cornwall have been analysing the impact of their Living Well programme through a matched cohort evaluation, which has shown encouraging results, including a reduction of 34 per cent in emergency hospital admissions.

Pioneer: Cornwall and Isles of Scilly

Population: <1,000,000

Geography: Rural

Life cycle stage: Grow



The Living Well programme aims to move people away from the risk of unscheduled health management to more structured, planned use of services over the long term. It is about relieving pressures on the system and making sure people’s whole life needs are considered rather than focusing on clinical conditions. Instead of waiting for people to fall into ill-health and a cycle of dependency, the pioneer team is working proactively to support people to improve their health and wellbeing.

Following in-depth research into the first 12 months of the programme’s operation, impressive results for the target population were found, including:

- a 34 per cent reduction in emergency hospital admissions
- a 21 per cent reduction in emergency department attendances
- a 32 per cent reduction in hospital admissions overall.

Matched cohort evaluation approach

A research project involving 325 people supported by Living Well in Penwith from January 2014 to January 2015 found the programme has had a

significant impact on hospital admissions and attendances in Cornwall.

This evaluation was undertaken to identify whether any attributable change in use and costs of health and social care services could be shown among the Living Well cohort compared to a similar group of people not in receipt of the Living Well intervention.

To be a match of a member of the Living Well cohort, a person had to:

- be the same gender and be the same (or similar) age
- have the same profile of long-term conditions (from the six key conditions the Living Well programme prioritised i.e. Stroke, COPD, Dementia, Diabetes, Heart Failure and Hypertension)
- use the same primary care services in the six months prior to the Living Well initial guided conversation
- live in the same geographic area.

If all of the above criteria and an age match were found, a person was deemed to be a match. If not, the age criteria were relaxed.

Results

In its first year of operation, the approach has proven highly successful. Cell Consulting tracked the activities and cost of the Living Well cohort against those of their matched cohort in the following settings:

- attendances at A&E and their cost
- non-elective hospital admissions and their cost
- elective hospital admissions and their cost
- all hospital admissions (grouped) and their cost
- primary care GP practice activity.

Among highlights of the findings were:

- a **20 per cent** improvement in wellbeing
- a **41 per cent** reduction in acute hospital costs
- an **8 per cent** reduction in social care costs
- a **28 per cent** reduction in community hospital inpatient activity
- a **20 per cent** reduction in community hospital length of stay.

Joy Youart, NHS Kernow’s Managing Director, said: “We are at the start of a journey to transform the way care is coordinated by bringing together health, social care, the volunteer sector and communities. Our vision is an integrated system that enables people to access seamless care to help them live the lives they want.

“We are beginning to see improvements across the entire system to support people from being admitted to hospital and, when they do, getting them home as soon as possible, with high levels of care in place to reduce their risk of being readmitted.”

What next?

The pioneer are now beginning phase three of their evaluation, with support from the South West Academic Health Science Network (SWAHSN), which will involve a review of 1,000 patients involved in the Living Well programme. Additionally, the first 100 patients on the programme will continue to be tracked, forming the start of a longitudinal study on the long term impacts of the programme.

Cornwall has shared their evaluation approach widely with the pioneer and vanguards, running a learning webinar in December, the recording of which can be found [here](#).

Removing financial disincentives

High-level overview

Financial systems such as contracts and payments in the health and care system were initially designed to work between individual organisations; one organisation providing services and one organisation “buying” the services for their local populations. As our work on integration grows, commissioners and providers of services are working together and are looking for ways to remove any unnecessary financial disincentives that reinforce working separately.

How pioneers approach removing financial disincentives

Together with our partners, the NHS Confederation’s European Office, we have been developing a European care model alliance and have examined other countries approaches to removing financial disincentives. Two of these models (Alzira and Gesundes Kinzigtal) have used different financial mechanisms to enable their care models to work. The features of these approaches include longer contract lengths, payments that are in part linked to outcomes (for patients and for employees) and payments that are linked to the size of the population rather than using activity levels alone.

	Contract length?	Outcomes linked to payment?	Population based payment?
Alzira model, Valencia Spain	15 years	Employees rewarded for quality	Yes – capitated payment system
Gesundes Kinzigtal, Germany	10 years	Balanced payment system aimed at achieving the Triple Aim ⁷	Regional care company as “integrator” + part ownership through local providers

Pioneers are looking at these different approaches and have been working collaboratively to see which elements can be replicated to best effect in an English setting.

The Gesundes Kinzigtal Model

The Gesundes Kinzigtal Model was developed around a decade ago through a partnership between a network of south-west German physicians and a management company, which decided to create a regional integrated care management company to provide better, more integrated, more efficient care for the local population.

Since 2006, that company, Gesundes Kinzigtal GmbH, has held long-term contracts with two non-profit sickness funds (AOK and LKK), offering their members – around 31,000 people – enrolment in its integrated care system.

The principle is that enhancing patients’ self-management capabilities and emphasising health promotion and prevention, will lead to improved population health – and the resulting benefits can be shared between the partners.

The health promotion and prevention programmes include health literacy and healthy lifestyles initiatives for certain groups of the population, with emphasis on chronic conditions and specific risk groups such as residents of nursing homes, elderly people, smokers, people with depression and those at risk of osteoporosis.

This focus on public health is complemented by a patient-centred approach to healthcare provision, with:

- individual treatment plans agreed between doctors and patients
- a named doctor (or other health professional) chosen by the patient taking responsibility for ensuring seamless care for that patient, including follow-up care and rehabilitation after discharge from hospital.

Find out more at the NHS European Office website: nhsconfed.org/eumodelsofcare



This integrated care approach is made possible by Gesundes Kinzigtal GmbH:

- holding “virtual accountability” for the healthcare budget for the population group
- negotiating cooperation contracts with a range of local providers who have agreed to adhere to a set of guiding principles, standards and procedures.

An integrated IT system supports the approach by providing electronic access to patient data (with patient consent).

The Gesundes Kinzigtal Model has led to improved health outcomes, a better patient experience and reduced costs.

If we take 2012 as a year of reference, the model generated around a seven per cent saving against the population budget for members of one of the sickness funds, which equates to a saving of €4.6 million for the 31,000 affiliated in the Kinzigtal region. Reduced emergency hospital admissions are an important contributor to this saving.

The contract for the Gesundes Kinzigtal Model expired at the end of 2015, but one of the sickness funds committed to extend the contract for an unlimited period and expand it to other regions.

The success of the model depends on its combination of logistical re-engineering of care processes, IT integration, public health and prevention measures, and – importantly – alignment of the financial interests of payers and providers in the system.

Breaking down barriers to collaborative care

North West London continues to progress towards implementing an outcomes-based system for health and social care enabled by a capitated system of payment.

Pioneer:
North West London

Population:
<3,000,000

Geography:
Urban

Life cycle stage:
Test



Across North West London, health and care partners are developing new ways of delivering integrated care to help people stay healthy, maintain their independence and lead full lives as active participants in their communities.

This means working closely with people and their carers to ensure they have a full say in their care through jointly developed care plans supported by health, social care and third sector staff all working together.

To make sure this happens consistently, North West London is removing barriers that stop health and social care working collaboratively together. One of the main barriers to collective working is the way care funding is allocated.

Outcomes and capitation system

Commissioners in North West London intend to pay for population-level outcomes that will give healthcare providers the freedom to move resources to where they will most effectively be used.

Under this new “capitated payment” approach, groups of providers will assume joint accountability for the health and care needs of a population group and share the associated financial risk and savings. Capitation encourages coordinated, preventative care and a focus across the whole care pathway, which gives providers the level of flexibility they need to achieve an agreed set of outcomes for patients.

After working with partners, including patients and carers, to design this integrated approach to care, North West London is now gathering the information required to develop capitated budgets that can be tested in some areas in 2016/17.

Why pool budgets?

Combining funds will allow organisations to build on previous joint working experience to deliver integrated care in the most appropriate setting. It will mean North West London can avoid fragmentation, duplication, gaps and delays, leading to improved coordination and joined-up working.

A pooled budget will allow some services to be jointly delivered and administered. For example, as a result of a joint pool for older people with mental illness, service users might find themselves looked after by a single team with both health and social care capabilities, meaning physical and mental health care becomes better integrated with social care.

Progress

The capitated payment approach is still being developed and the structure and pricing model is expected to change over time following an agreed period of testing and review with providers.

So far, North West London has gathered data on expenditure and how services are used from across the health system, including primary care. Social care data will be added to this when it becomes available in a compatible format. This will provide a per-patient cost that can be aggregated up into a population-level budget and will allow providers to direct resource towards proactive and preventative care.

“Capitation encourages coordinated, preventative care and gives providers the flexibility they need.”

The future payment system is likely to be based on current spend per population segment, with Accountable Care Partnerships sharing both risk and surplus depending on performance against population-level outcomes.

The next step will be to develop and design the payment structure, working with providers using the linked dataset. A small number of areas are expected to start using the new system during 2016-17, with a more extensive roll-out of the system likely the following year.

Plans for the future

North West London intends to evaluate each of the pilots it is currently running and make improvements where necessary.

While it still faces significant challenges, such as access to good quality linked data and maintaining stability within the system while transforming the way care is commissioned and delivered, the project teams will continue implementing the new system, documenting process, forming teams, communicating successes and keeping everyone in the loop with progress and business plan objectives.

5

Our programme

- 5.1 How we support pioneers
- 5.2 Overview of work streams
- 5.3 Pioneer funded support 2015/16
- 5.4 Engagement

5.1 How we support pioneers

The pioneer programme is supported by a small team of account managers hosted by NHS England and supported by representatives of the Local Government Association (LGA), whose role is to oversee the support offered to local sites and facilitate the shared learning network. Other national partners such as Monitor, Department of Health (DH), Health and Social Care Information Centre (HSCIC) and National Voices also provide support as part of the national work streams.

The support provided is targeted at enabling the implementation of person-centred care as

described in the pioneer stories shared in this report. The combination of technical, financial, leadership and peer support may not always be explicit in how pioneers describe their success, but has been an integral factor for many in supporting progress in 2015.

The focus of the support offer in 2015 was co-designed with pioneer sites during the early part of the year. A series of diagnostic visits took place with sites between April and June to discuss priorities and the challenges for the year ahead. By working together, we identified work streams where national and bespoke support should be targeted.

5.2 Overview of work streams

Many of the work streams are collaborations between national and local organisations such as Leeds pioneer and HSCIC on testing a new approach to tackling network and infrastructure issues.

Outputs from the work streams depend on the specific project and pioneers involved. They are all based on principles of shared learning and support, facilitated by webinars, events, workshops, articles in Relay (the pioneers' newsletter) and through communities of practice.

Outputs also include practical tools and guides to support others, within the new care models programme and others, to deliver person-centred care.

1 Technology and information sharing (Pioneer Informatics Network) Information management and technology

Involved – Pioneers alongside national organisations including HSCIC, NHS England, DH and LGA.

Summary – The Pioneer Informatics Network was formed out of pioneers coming together in 2014 and identifying a series of challenges and barriers to integration from a technology and information perspective. In addition, it presents the opportunity to share good practice.

A key focus of the network is working with national leads to address these challenges through delivery and testing of new approaches. The network encourages the sharing of good practice and facilitates production of materials to support the pioneers and vanguards as well as the sector as a whole.

The emphasis of the network is to “simplify current ways of working; standardise the variety of local approaches and share the approaches with the rest of the health and care system” as critical requirements for the informatics work.

The areas of focus in 2015/16 are to:

- support health and care professionals, patients, service users and their carers to access an individual’s joined-up health and care record through the development of local integrated digital care records
- enable health and care professionals to effectively work from different locations and hubs without the need for new or separate infrastructure and networks
- enable information to be shared effectively and appropriately, while using the NHS number as a consistent identifier both for direct care and commissioning in a way patients and the public understand
- enable patients, service users and their carers to easily communicate with professionals as well as supporting communications between professionals across health and care using new technologies
- support local delivery of local digital roadmaps that articulate plans for how technology will be deployed to support integrated care.

The work stream has involved piloting new ways of working within pioneer sites, producing common guidance and support tools that other sites (both within the pioneer programme and beyond) can utilise and supporting collaboration and peer-to-peer learning.

Information sharing and information governance

Involved – Pioneers (including North West London, WEL, Leeds and Southend) alongside NHS England, HSCIC, DH, LGA, Information Commissioner’s Office, Information Governance Alliance (IGA) and Centre of Excellence for Information Sharing.

Summary – The pioneers highlighted information sharing as one of the key challenges to integrating health and care. In March 2015, a national summit was held bringing together pioneers and national organisations to help understand the purposes for sharing, the challenges and the options.

The summit led to a 13-point action plan for which delivery has been overseen by the New Care Models Information Governance Group. One of those actions was for intensive work to be undertaken with four pioneers (North West London, WEL, Leeds and Southend). This has led to the production of a five-step blueprint for information sharing alongside delivery of templates that can be used locally.

Alongside this work, pioneers, supported by the LGA and NHS England, have led on the production of an information-sharing user framework⁸, which brings together a range of materials to support local work on information sharing. The framework will be used to support regional events in January and February 2016 in collaboration with the Better Care Fund.

2 Payment, pricing and incentives Integrated Care Payment Forum

Involved – Five pioneers participate in the Integrated Care Payment Forum hosted by Monitor and NHS England which meets every six weeks.

Summary – To date, support has been focused on those sites that participate in the forum. However, Monitor and NHS England are planning to roll out a “support offer” for sites developing capitated payment approaches, with a launch event in January 2016 followed by a series of monthly webinars. This work stream is aligned with the corresponding vanguard work stream and it is intended to develop outputs that can be shared with the wider health and care community.

3 Organisational legal forms Organisational forms and governance

Involved – Initial scoping conversations have been held with a number of pioneers and the work stream plans to engage with the wider pioneer community in late 2015/early 2016 through a series of workshops.

Summary – This work stream is aligned with the corresponding vanguard work stream and it is intended to develop outputs that can be shared with the wider health and care community.

4 Harnessing community involvement Community of practice – co-production

Involved – Eight pioneers, National Voices, the Leadership Centre and NHS England.

Summary – The community of practice was developed following the September pioneer assembly event, hosted by the Staffordshire and Stoke-on-Trent pioneer, which shared its

learning and approach to patient, voluntary and community sector co-design. Eight pioneers expressed an interest in forming a community of practice focusing on this topic, with support from national partners. The group has come together virtually to start scoping out their collective priorities.

5 Designing person-centred care Serious Illness Conversations

Involved – Two pioneers, not yet selected, Clatterbridge Cancer Centre and Ariadne Labs.

Summary – Serious Illness Conversations is a clinically-led intervention originating from the Ariadne Laboratories in Boston, USA. Ariadne Labs’ mission is “to create scalable moments that produce better care at the most critical moments in peoples’ lives everywhere” (Dr Atul Gawande – Being Mortal 2015).

The Serious Illness Care Programme (SIP) is designed to improve the lives of all people with serious illnesses by having meaningful conversations about their values and priorities.

Training with the two selected sites is anticipated to begin in early 2016. Their participation will contribute to a clinical evaluation that demonstrates the impact of implementing this approach. Pending the results of the evaluation, there is potential for consideration for wider roll-out.

6 Professional and support workforce redesign Intensive workforce support

Involved – Six pioneers, NHS England, Skills for Health and Skills for Care.

Summary – Skills for Health and Skills for Care have been commissioned to work intensively

with six pioneer sites to support progress with workforce redesign. Work began in October 2015 with a series of scoping events. Each pioneer has a slightly different support requirement, but the learning from each is transferable across the wider pioneer and vanguard network.

Expected outputs from this work that may be of benefit to the wider health and care community include:

- a career framework across voluntary sector, health and social care
- a model for integrated workforce for frail elderly care
- a blueprint of workforce change needed for world-class models of care.

Intensive support will be delivered through to March 2016, at which time the learning and outputs will be shared with all pioneers.

7 Modelling, benefits realisation and evaluation

Evaluation of programme

Involved – All pioneers, DH, Policy Innovation Research Unit (PIRU).

Summary – The DH has commissioned the (PIRU) to undertake both a short-term and long-term (five-year) evaluation of the pioneer programme.

Through this process, pioneers will have the opportunity to share their learning with others as well as use the information and intelligence gathered to add to their own local evaluation programmes. The year one evaluation report is due to be published early 2016.

8 Systems leadership

Involved – All pioneers, The Leadership Academy and Leadership Centre.

Summary – Each pioneer has access to eight days of funded systems leadership assistance in 2015/16. It can be accessed from the Leadership Centre or The Leadership Academy and can be tailored locally to support a variety of purposes.

Due to the bespoke nature of the work, outputs are often individual to each pioneer site. Shared learning from across the systems leadership work stream, including support to communities of practice or smaller networks such as the Three Cities network, is regularly shared in the pioneers' newsletter and at pioneer events.

“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 organisation is ‘in charge’. This support has helped stakeholders find solutions to overcoming difficulties between organisations or individuals. Supporting and developing the ‘softer’ skills required for systems leadership is difficult but vital.”

Senior integration lead, pioneer CCG

9 International care model exchange

Involved – Open to all pioneers and all vanguards, NHS European Office.

Summary – In April 2015, pioneers had access to a number of international care model experts both via immersion tours (international experts visiting six selected pioneers) and an international care model conference. Pioneer sites heard first hand how care models had developed across America and New Zealand, the challenges they faced and how they had overcome these.

In addition, a partnership with the NHS European Office is developing links and sharing learning with four systems at the leading edge of integrated care in Europe. This support offer consists of a webinar with each care model, followed by a study visit open to a small number of pioneers and vanguard sites. An international conference will bring together the participating EU models with the wider pioneer and vanguard community in May 2016.

“The opportunity to hear from international organisations and to meet with them to understand the challenges they have addressed has been an invaluable part of the pioneer support programme. Their knowledge and experiences have helped us shape our work and approach.”

Senior integration lead, pioneer CCG



5.3 Pioneer funded support 2015/16

The pioneer support team was allocated a programme budget of £3,100,000 in 2015/16 to support the development of new and innovative integrated models of care across the 25 sites. Current financial forecasts suggest the programme will be delivered on budget for 2015/16.

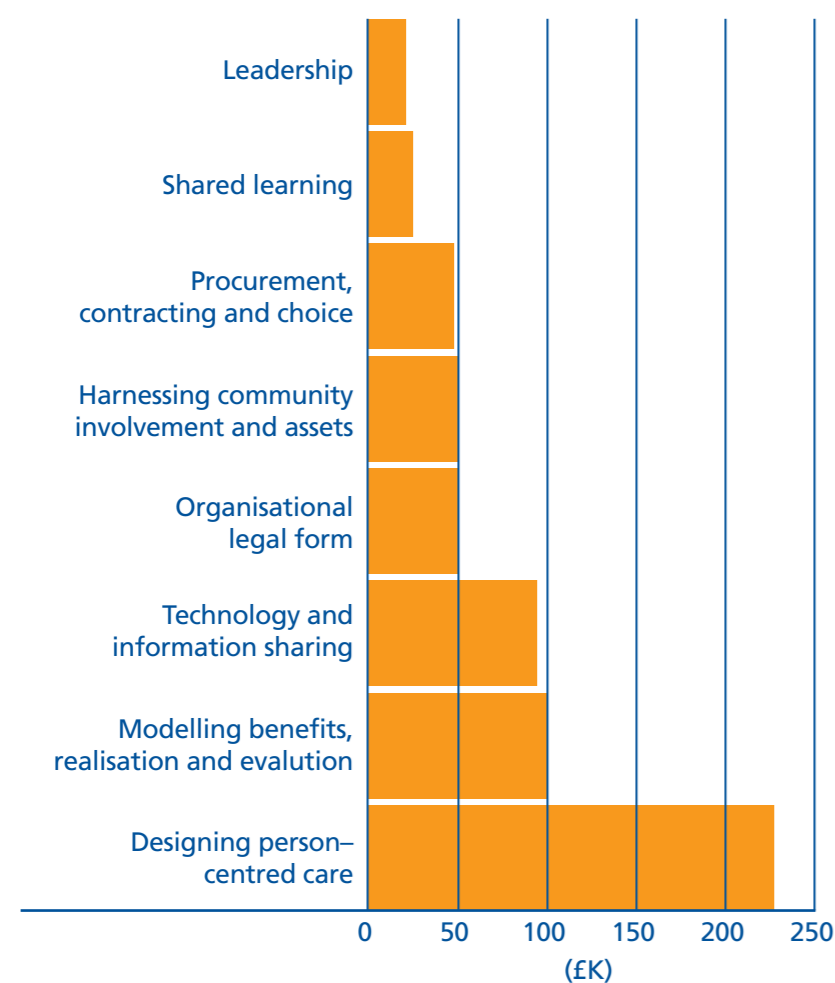
Investment requests

Pioneer sites requested direct support with their local programmes, resulting in the development of the investment request process that was launched in June 2015. This process enabled sites to bid for direct financial support to deliver

integrated care programmes that would benefit their local population and also provide wider learning opportunities for all pioneers.

The largest proportion of investment has been made in designing person-centred care models. In some areas, this support has been used to enable the spread of a pilot care model to test replicability in alternative localities or with alternative population cohorts. Cornwall's roll-out of Living Well is one example of this. Other investment requests are focused on supporting a specific aspect of a pioneer's work, such as simulation events or evaluation of changes made.

Investment requests approved by work stream as at 31 October

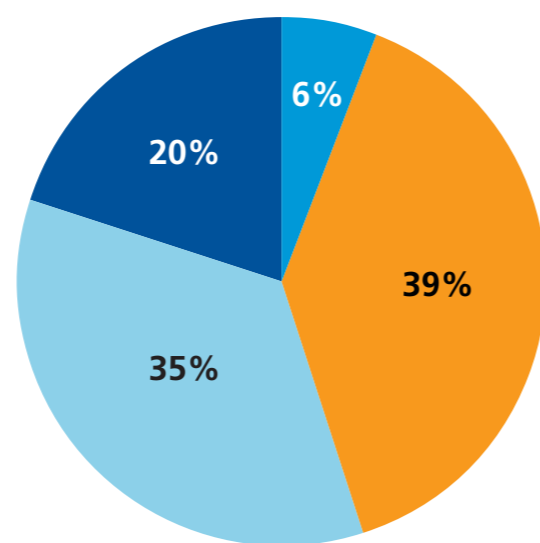


£3,096,645

FY FORECAST OUTTURN

£3,100,000

FY BUDGET



- Funding nationally run networks
- Funding local investment requests
- Support team costs
- Shared learning events webinars, materials

5.4 Engagement

A key aim of the programme is to share learning and resources across the community. This ensures sites are getting the most out of their change programme and are learning from each other as well as from experts in the field. Shared learning is facilitated in a variety of ways.

Relay

Relay is the monthly newsletter, developed by the pioneers, which aims to share information, learning and support among the pioneer community. Each issue is overseen by a different pioneer site acting as guest editors. Relay is circulated to more than 700 people in the pioneer community.

Workshops, webinars and events

In addition to the virtual sharing of information, there has been a number of workshops, events and webinars held in the last year. These are key tools for sharing information and expert advice across the community.

Key facts

18,082
page views

2:04
average time on Relay

Top 5 articles in Relay			
Page content	Theme	Month	Views
International care models conference videos	Thinking differently	April	484
Information sharing update	Technology and information sharing	May	392
Co-production assembly registration and agenda	Learning from each other	August	261
Connecting care in Wakefield	Guest editorial	October	247
Patient experience in Staffordshire and Stoke-on-Trent	Guest editorial	August	209



More than 850 attendees

6

Looking forward

6.1 Looking forward

6.2 Pioneer advice

6.3 Our actions in light of this for 2016/17

6.1 Looking forward

As we move into 2016, the challenges identified in 2015 seem likely to continue if not increase in significance.

Based on the progress made during 2015, pioneer sites will be focused on evaluating the work delivered to date and will be looking to grow successful projects in a sustainable way across a broader footprint in their local communities. For some, this will also mean seeking to increase their use of system levers to underpin these changes.

It will be essential that any national support provided is focused on the areas likely to generate most impact and returns. But most importantly, our support will be locally led and based on the lessons we have already learned.

In 2016, there will also be closer alignment with the vanguard support under way to maximise use of existing national resources. The priority areas for vanguards and for pioneers have such a large overlap that not aligning would be wasteful. More information on how this will work in practice will be shared in 2016.

“It’s fascinating and inspiring to see the way in which the pioneers are continuing to push the boundaries and be out there on the leading edge in terms of integration of care and person-centredness. So what I hope I might be able to do over the next period is to help really get that message out so the rest of the world gets to learn from the amazing things the pioneers are doing.”

Chief Transformation Officer

6.2 Pioneer advice

Ensure the system shares a common focus

- Always place the patient at the heart of your plans.
- Never forget who and why it is you are doing this.



Look at the Sheffield story to see what happens when the needs of people are placed first.

- Consider different models that fit with your local assets and gain early agreement from all key stakeholders of objectives/mission.
- Secure solid agreement on common purpose.

Be ambitious

- Be brave and bold, take risks. Be creative around solutions.
- Avoid the tendency to think small.

Measure how far you have come and be prepared to adapt to achieve your overall vision

- Ability to accurately measure impact of specific schemes across a health and social care economy is crucial and much harder than anticipated.
- Be clear about the fact the change/programme is a journey and that you may need to change some aspects but there is a due north.

Engage at all levels and across the system

- Listen to frontline staff and involve people at all levels.
- Relationships are key.
- Ensure you have engagement with the project and keep revisiting this issue.
- Putting in the legwork at the beginning of your project will pay dividends and will ensure your key partners feel valued and integral to your project.
- Involve a broad range of partners in the design stage, keeping the public closely involved and informed of the reasons why change is essential and engaging strong clinical participation to ensure the solutions are evidence-based and produce the best outcomes for patients (and local clinical ownership).
- Get the operational basics right and bring people with you by engaging early to help buy in for when you implement the various elements of the "model of care".

Focus on leadership and engagement

- Systems leadership and shared vision are key to success.
- The strength of leadership, relationships and ambition is as important as anything else.

Face forward

- Don't underestimate the need for committed and enthusiastic people to drive the change, backwards-looking people are not helpful. You need future-facing people.

Don't expect a quick solution

- It takes time. Learn from the previous experience of others, but there is probably no one solution for all.
- Don't underestimate the energy and focus needed to keep going and keep having the conversation; energy required to keep leaders on board; difficulties keeping people engaged when it's no longer a new concept/when newer, more exciting things come up; sustaining enthusiasm when you've found it hard; being flexible enough to be able to change tack but not destination.

6.3 Our actions in light of this for 2016/17

Based on the findings of the report, the pioneer programme will continue to provide support to the 25 pioneers, but will do so based on sharing areas of expertise with other national programmes to ensure we take advantage of all economies of scale.

Key aspects of support such as the investment request process have proved popular and have assisted pioneers in implementing their local visions. The investment request process also provides a good opportunity for sites to learn from each other and encourages collaboration. We would look to continue providing investment funding and would ringfence at least a third of our budget for this purpose.

In addition, the programme is seeking to specialise our support in a number of smaller areas and seeks to share support with other integration programmes such as the integrated personal commissioning programme and, of course, to continue sharing support with vanguards.

Identifying our priority areas for support

This report identifies a long list of priority areas for the programme to consider in 2016/17. We propose taking this report to the next pioneer assembly for discussion and to decide the priority areas, which will then form the basis of the support programme moving forwards.

7

Further information

7.1 How to get involved

7.2 Other resources

7.3 Glossary

7.4 References

7.1 How to get involved

You can find out further information on the integrated care pioneers on the NHS England website and the individual websites of the pioneers themselves.

We have also created pen portraits that provide a summary of the pioneers' plans and contain details of which organisations are involved in each pioneer site. These are available to [view online](#).

7.2 Other resources

- Age UK ageuk.org.uk
- The Alzheimer's Society alzheimers.org.uk
- Association of Directors of Adult Social Services adass.org.uk/home
- Association of Directors of Children's Services adcs.org.uk
- The British Heart Foundation bhf.org.uk
- Cancer Research UK cancerresearchuk.org
- Care Quality Commission cqg.org.uk
- Centre for Excellence in Information Sharing informationsharing.org.uk
- Department of Health gov.uk/government/organisations/department-of-health
- Depression Alliance depressionalliance.org
- Diabetes UK diabetes.org.uk
- Health Education England hee.nhs.uk
- Information Governance Alliance systems.hscic.gov.uk/infogov/iga
- Local Government Association local.gov.uk
- Macmillan Cancer Support macmillan.org.uk/Home.aspx
- Monitor gov.uk/government/organisations/monitor
- National Institute for Health and Care Excellence nice.org.uk
- National Voices nationalvoices.org.uk
- NHS England england.nhs.uk
- NHS European Office nhsconfed.org/eumodelsofcare
- Public Health England gov.uk/government/organisations/public-health-england
- Social Care Institute for Excellence scie.org.uk
- Stroke Association stroke.org.uk
- Think Local Act Personal thinklocalactpersonal.org.uk

7.3 Glossary

Accountable Care Organisation (ACO)

An ACO is a network of doctors and hospitals that shares financial and medical responsibility for providing coordinated care to patients. ACOs create an incentive to be more efficient by offering bonuses when providers keep costs down; in turn, providers must meet specific quality benchmarks, focusing on prevention and carefully managing patients with chronic diseases. In other words, providers get paid more for keeping their patients healthy and out of the hospital.

Better Care Fund

Announced in June 2013, the fund creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well being as the focus of health and care services.

Capitated Budget

A payment arrangement for health and care service providers that pays a set budget for each enrolled person assigned to a provider, per period of time, whether or not that person seeks care. It may be adjusted to consider quality outcomes achieved during that period.

Care Act

The Care Act 2014 builds on recent reviews and reforms, replacing numerous previous laws, to provide a coherent approach to adult social care in England. The Act (and its Statutory Guidance) consolidates and modernises the framework of care and support law; it sets out new duties for local authorities and partners and new rights for service users and carers.

Combined Predictive Model

The Combined Predictive Model uses inpatient, outpatient, A&E and GP data to stratify populations by their risk of admission.

Gross Domestic Product

The total value of goods produced and services provided in a country during one year.

Health and Social Care Act

The Health and Social Care Act 2012 puts clinicians at the centre of commissioning, encourages providers to innovate, empowers patients and gives a new focus to public health.

Health and Social Care Information Centre (HSCIC)

HSCIC is the national provider of information, data and IT systems for health and social care.

Integrated Personal Commissioning (IPC)

IPC is a blended comprehensive health and social care funding method. The IPC programme went live in April 2015 enabling more than 10,000 high-need service users to gain control of their own integrated health and social care budgets.

Long-Term Conditions (LTC)

Long-term conditions are health conditions that last a year or longer, impact on a person's life and may require ongoing care and support. The definition does not relate to any one condition, care group or age category.

Think Local Act Personal (TLAP)

TLAP is a national partnership of more than 50 organisations committed to transforming health and care through personalisation and community based support.

7.4 References

1. www.gov.uk/government/uploads/system/uploads/attachment_data/file/198746/2013-05-13_Pioneers_Expression_of_Interest_FINAL.pdf
2. We use the I statements as our definition of person-centred care
3. www.ih.org/engage/initiatives/tripleaim/Pages/default.aspx
4. www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/Research/Size-and-structure-2013-vweb2.pdf
5. www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx
6. Triple aim refers to improving health of the population, enhancing the patient experience and reducing per capita cost of care
7. systems.hscic.gov.uk/infogov/iga/consultations





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