Health and Wellbeing Board

Other pioneer sites

Barnsley

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

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

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Cheshire

Connecting Care across Cheshire will join up local health and social care services around the needs of local people and take away the organisational boundaries that can get in the way of good care.

Local people will only have to tell their story once – rather than facing repetition, duplication and confusion. Also the programme will tackle issues at an earlier stage before they escalate to more costly crisis services.

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

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Cornwall and Isles of Scilly

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

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

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Greenwich

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

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

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Islington

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

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

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Kent

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

Patients will have access to 24/7 community based care, ensuring they are looked after well but do not need to go to hospital. A patient held care record will ensure the patient is in control of the information they have to manage their condition in the best

way possible. Patients will also have greater flexibility and freedom to source the services they need through a fully integrated personal budget covering health and social care services.

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North West London

The care of North West London's 2 million residents is set to improve with a new drive to integrate health and social care across the eight London boroughs. Local people will be supported by GPs who will work with community practitioners, to help residents remain independent. People will be given a single point of contact who will work with them to plan all aspects of their care taking into account all physical, mental and social care needs.

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

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North Staffordshire

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

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

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South Devon and Torbay

South Devon and Torbay already has well-co-ordinated or integrated health and social care but as a Pioneer site now plans to offer people joined up care across the whole spectrum of services, by including mental health and GP services. They are looking at ways to move towards seven day services so that care on a Sunday is as good as care on a Monday – and patients are always in the place that's best for them. The teams want to ensure that mental health services are every bit as good and easy to get as other health services and coordinate care so that people only

have to tell their story once, whether they need health, social care, GP or mental health services.

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

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

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Southend

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

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

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

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South Tyneside

People in South Tyneside are going to have the opportunity to benefit from a range of support to help them look after themselves more effectively, live more independently and make changes in their lives earlier.

In future GPs and care staff, for example, will have different conversations with their patients and clients , starting with how they can help the person to help themselves and then providing a different range of options including increased family and carer

support, voluntary sector support and technical support to help that person self-manage their care

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

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Waltham Forest and East London and City

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

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

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Worcestershire

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

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