Working together:

a summary of health and social care integration projects

Skills for Care and Skills for Health have worked closely for a number of years and have recently taken stock of our work with many employers across both sectors. Our review has resulted in the development of engaging case studies. These share valuable lessons and outcomes in workforce development which will benefit many organisations in both health and social care.

We have collated the case studies and you can access them in two ways, by the:

- type of **change** and **impact** achieved by the projects
- **context** or **topic** for the study.

You can find a list of all the case studies in the index and each is numbered and has key word highlighting to help you identify it.

Skills for Health

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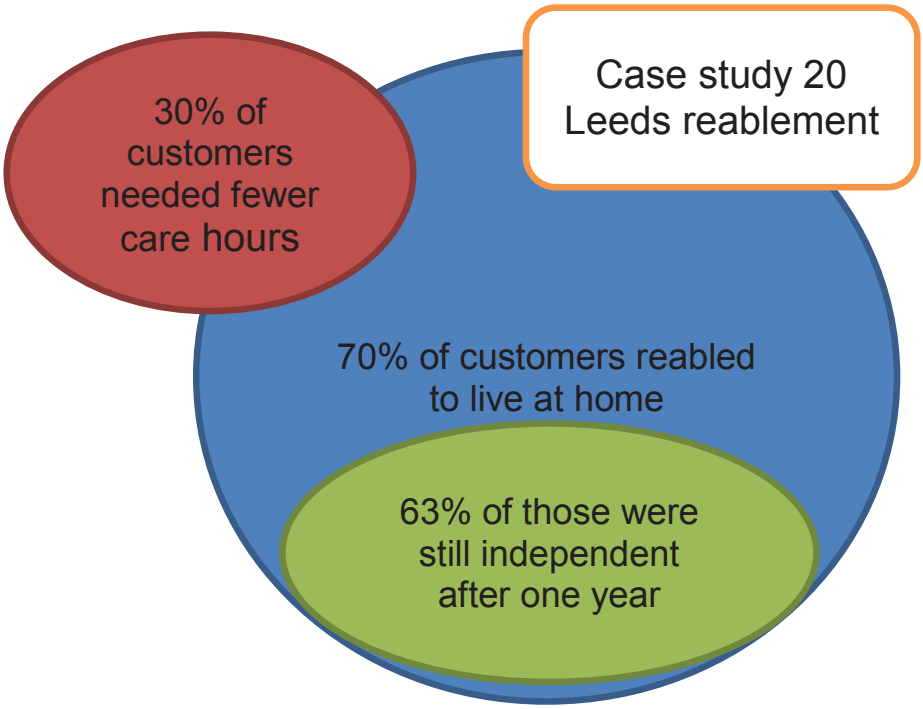
Impacts

We examined projects which demonstrated impacts on key objectives which are important to people in health and social care.



The four key impacts are:

- reducing avoidable hospital admissions
- reablement and timely hospital discharges
- smoother transitions
- better use of resources.

Examples of the project impacts and related case studies are listed below.

Reducing avoidable hospital admissions

See case studies: 3 (Assessment), 5 (Champions), 8 (Culture change), 9 (Intervention), 11 (Home first), 13 (Integrating), 14 (WRAP), 15 (Growing need), 16 (Seamless service), 17 (Partnership), 18 (Peer support), 21(Right team), 24 (Technology), 25 (Case management).

- Reduction in hospital admissions—the number of potential hospital admissions for dementia services in West Sussex was reduced by almost 100 in the past year – study 3.
- Quality of life is improved for service users with learning disabilities as a result of targeted training in learning disabilities and end of life care – study 5.
- Supporting people with dementia in the community is costly but prevents more expensive admissions to hospital or residential care – study 13.
- Recovery approaches for mental health users result in fewer accident and emergency visits and fewer hospital admissions – study 14.
- A rapid response team for Thurrock residents, which identifies need, results in fewer hospital admissions – study 21.
- Reduction in hospital based services in Norfolk—10.5% identified as avoiding hospital admission – study 24.
- Ambulance attendances down from 11.6 per month to 5.3 per month and hospital admissions reduced – study 25.

Reablement and timely hospital discharges

See case studies: 3 (Assessment), 5 (Champions), 8 (Culture change), 9 (Intervention), 11 (Home first), 13 (Integrating), 14 (WRAP), 15 (Growing need), 16 (Seamless service), 17 (Partnership), 20 (Reablement), 21 (Right team), 22 (Modernisation), 23 (Providers).

- Reduction in hospital in-patient bed use for dementia services in West Sussex —between January and December 2011 the average length of stay was 40 days, twenty fewer than the target of 60 days – study 3.
- From 2011-2012 the average length of stay across the three acute trusts in the county of West Sussex fell from 14 to 10 days for people with a secondary diagnosis of dementia – study 3.
- Staff from sensory and deaf services in Hampshire County Council were based in five NHS trusts and linked with hospital discharge teams and specialists to provide a seamless journey for the service users – study 9.
- Dementia team develop support programme when person first referred to ensure personalised care, achieving some of the lowest rates for delayed hospital discharges in England – study 11.
- In Leeds 70% of customers were reabled to live independently at home, 63% of those reabled customers continued to live independently a whole year later; 30% of customers showed a reduction in the number of care hours they needed – study 20.

Smoother transitions

See case studies: 8 (Culture change), 9 (Intervention), 15 (Growing need), 18 (Peer support), 19 (Personalisation), 22 (Modernisation), 23 (Providers), 24 (Technology).

- A comprehensive review of an early intervention service led to streamlined referrals for service users and partnership working with audiology, ophthalmology and voluntary sector partners – study 9.
- End of life resources supported multidisciplinary teams to be more proactive in working with extra care schemes to support people – study 15.

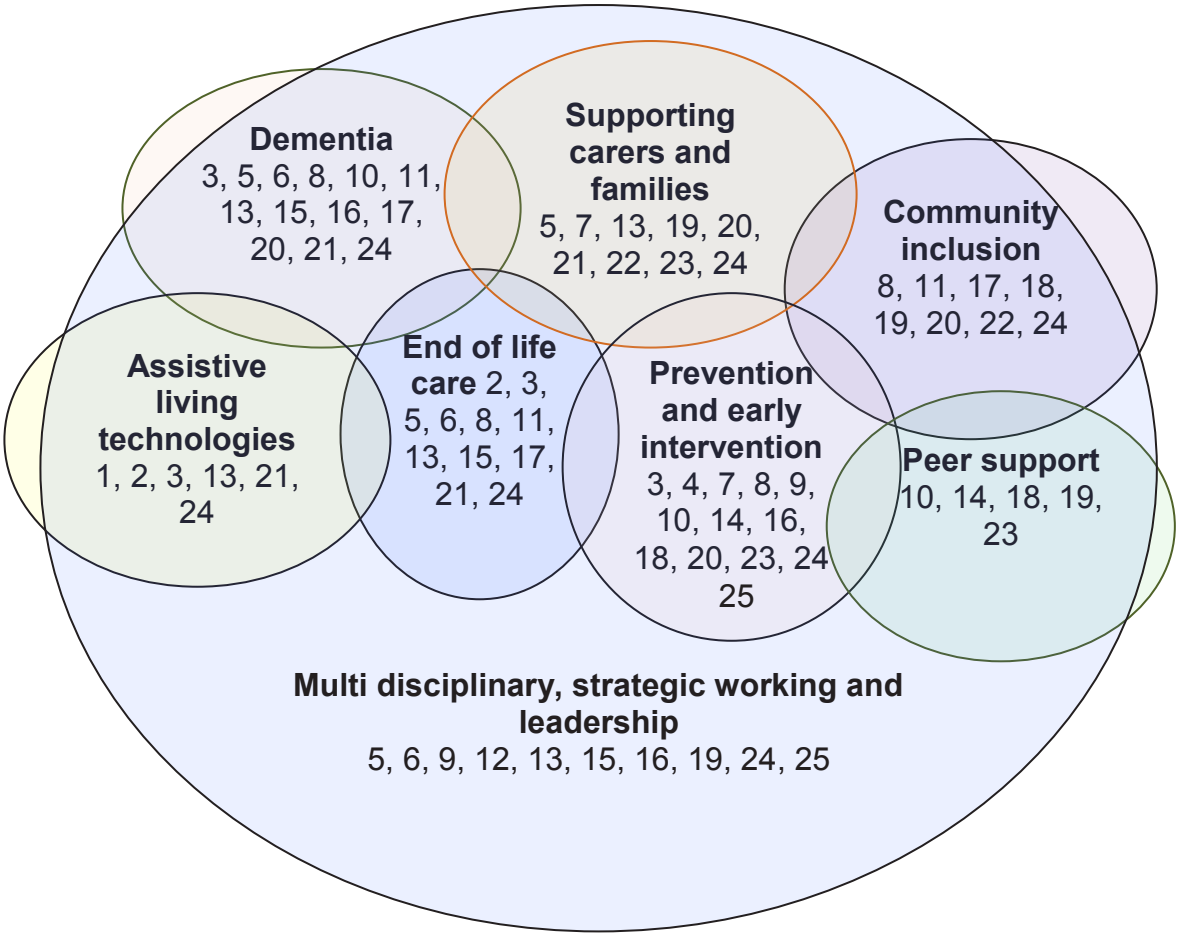
Better use of resources

See case studies: 1 (Low vision lifeline), 2 (Adapting materials), 4 (Assistant practitioners), 6 (End of life care training), 7 (Counselling), 8 (Culture change), 9 (Intervention), 10 (Holistic), 11 (Home first), 12 (Commissioning), 13 (Integrating), 14 (WRAP), 15 (Growing need), 16 (Seamless service), 18 (Peer support), 20 (Reablement), 21 (Right team), 22 (Modernisation), 23 (Providers), 24 (Technology) 25 (Case management).

- Sub-regional approach and multi-professional team provide patients with joint appointments and mean that equipment is shared – study 1.
- Reduction in appointment times for oncology patients, down by 20 minutes – study 4.
- Strategic approaches to training result in staff putting skills into practice – study 8.
- Complementary therapy relieves stress and anxiety related symptoms for mental health patients – study 10.
- Reduction in expenditure on dementia services of £100,000-300,000 per year for Bracknell Forest Borough Council as a result of 'home first' policy – study 11.
- Reduction in use of statutory services and hospital admission for peer support workers – study 18.
- Reduction in residential or nursing care in Norfolk—38% resulted in an average cost reduction of £11,152 per service user who would otherwise be redirected to residential or nursing care – study 24.
- Home-based Assistive Living Technologies services in Norfolk—28% of people required less domiciliary care input. Creating an average saving of £139.21 per week, enhancing people's quality of life and helping them be independent – study 24.
- Pilot of case management approach led to savings of £67,332 in 3 months by reducing accident and emergency attendances and hospital admissions – study 25.

Contexts and topics

The studies cover a wide range of situations and topics and all examine the workforce implications and the improvements in outcomes for people using services. Some of the topics, with their corresponding case study number are shown in the diagram below.



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While the case studies bring us up to date with the projects' achievements, many of them also produced materials, including: videos and resources, such as action plans, joint protocols and job descriptions. Web links to this material are in the case studies and you can find other relevant projects at: http://www.skillsforcare.org.uk/workforce_strategy/workforce_innovation_programme/partnership.aspx and www.skillsforhealth.org.uk

9. Embracing change for early intervention (Hampshire County Council Sensory and Deaf Services)
   A comprehensive review of an early intervention service led to streamlined referrals for service users and partnership working with audiology, ophthalmology and voluntary sector partners.

10. Holistic mental health care (Mind in Taunton and West Somerset)
    The SUCH project promotes well-being through complementary therapies to anyone suffering mental distress.

11. 'Home first' policy saves money (Community Dementia Support Team, Bracknell Forest Borough Council)
    A dedicated community team delivers a person-centred, cost-saving service. Partnerships with other professionals, training for providers and carers, along with personalised budgets, complete the picture.

12. Integrated commissioning (NHS Norfolk and Norfolk County Council)
    A blueprint for achieving integrated commissioning which involves comprehensive planning and attention to detail.

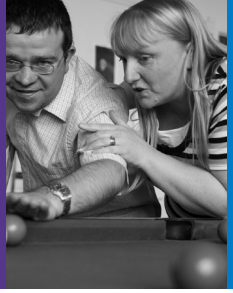
13. Integrating health and social care (Nottingham City Council, JackDawe Service)
    Taking an open approach to partnership working delivers high quality home care for people with dementia.

14. It's a WRAP! (Hampshire County Council and Southern Healthcare Trust)
    The Wellness Recovery Action Plan (WRAP) ® is a self-management and recovery system for good mental health.

15. Meeting a growing need (Housing 21, End of Life Care Learning Resource Pack)
    Housing 21 worked with the End of Life Care Programme to produce a learning resource pack. It has practical information and advice for managers and support staff working in extra care housing schemes. It covers a range of issues relating to the care of residents with a life-limiting or progressive condition.

16. New job role delivers seamless service (St Monica Trust)
    A new job role successfully blends nursing with care assistant duties and effectively uses resources.

17. Partnership with health that delivers (Care2Care Services Ltd)
    End of life care training helps people stay at home longer and minimises hospital admissions.



18. Peer support provides solutions (Sutton Mental Health Foundation)
    Peer support workers have personal experience of mental distress and support others in mental distress.

19. Personalisation through play (Whose Shoes? Nutshell Communications)
    'Whose Shoes? - Putting People First' is a board game which promotes dialogue between a range of different people, encouraging them to see the world from others' points of view and work together effectively.

20. Reablement for independent living (Leeds Adult Services)
    Adapting its home care service to meet demographic challenges has resulted in a successful reablement service.

21. Right place, right time, right team (Thurrock Rapid Response – Eastern region)
    A joint Thurrock social care and South West Essex Community Services initiative helps residents in Thurrock get a rapid response and assessment for their health and care needs.

22. Rolling out modernisation (County Durham Care and Support Learning Disability Day Services)
    Learning Disability Day Services redesigned to offer high quality person centred care and support for adults with learning disabilities.

23. Service users can also be service providers (Gateshead and South Tyneside Sight Service)
    Angel Eyes Enterprise is a successful social enterprise which offers peer advocacy for visually impaired people.

24. Using assistive technology to improve lives (Norfolk County Council)
    Norfolk County Council successfully uses assistive technology to support its service users and carers.

25. Case management makes savings (Bennett House)
    Case management pilot shows the quality of care can be improved, whilst saving resources and reducing hospital admissions.

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Further information

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