Programme	System benefit	Case study
Public Health 1 st Contact+ & Local Area Co-ordinators	Early intervention & prevention Customer access self help and/or early intervention services before becoming dependant on health and/or social care Mitigates future costs of care Develops strength of prevention offering	Audrey lives alone, she has arthritis, she is in pain and often feels the cold. Audrey visits a small craft group at her local library, where she sees a poster advertising First Contact Plus. Audrey goes home and contact s the IPoA. The agent, Carrie, taking Audrey's call listens, Carrie asks Audrey how she s feeling and engages her in a conversation. Carrie, from the IPoA recommends to Audrey that First Contact Plus can offer some help, Carrie puts Audrey's call through First Contact Plus. Soon Audrey has help with managing her heating through Warm Homes, Lightbulb have visited Audrey to make sure she is as safe as possible at home and someone has tended Audrey's garden for her. Audrey still has arthritis, but overall she is happier and her therefore wellbeing is improved,
Home First	IPOA becomes access point for the provision of suite of step up / step down services . Especially rapid deployment of urgent response. ➤ A simplified and integrated process to facilitate the timely discharge of patients for appropriate services ➤ A single point from which to organise the provision of care	Arthur's GP makes a home visit to see him. Arthur has COPD and is suffering with a sudden change in weather. Arthur is finding any activity makes him breathless. The GP calls In to the IPOA to arrange for an urgent Home First response integrated package of care for Arthur. Within two hours, a nursing team has bought additional equipment, including oxygen, to assist Arthur. At the same time, a carer arrives to start to make Arthur some food and help him get ready for bed,. The package of care continues for 3 days, The GP visits again to review Arthurs condition as the Home First care comes to an end. Arthur is now well enough to resume his normal attendance at the COPD clinic and continue to get well.
Integrated Locality Teams	Integrated referral out of IPOA to ILT ➤ Facilitates seamless and faster process for the provision of care ➤ Ensures standardisation and complete referral information	IPOA receive a call from 111, the customer is already on the phone. The 111 colleague explains that the customer does not need care at UHL but does require community nursing., the customer is then put through to the IPOA. A discussion follows and the call agent in the IPOA establishes that there are some needs for short term self-care help at home whilst the customer recovers, The agent ends the call, once all information is gathered. The referral is sent through to the ILT. The ILT co-ordinate the care and visit the lady to deliver the full and integrated care package.
Clinical Navigation Hub	Provides for system wide integration ➤ Professionals able to refer for non –urgent Health and/or Social Care into IPOA for that care to be scheduled ➤ Capacity for warm transfer of call to enable set up of care provision. ➤ Access point to arrange for step up and step down	