PUBLIC SERVICE REFORM: HEALTH & SOCIAL CARE

Integrated Care for Older People in Salford

Salford's Integrated Care Model and Operational Plan

11 June 2013 (Final Version)

NHS Salford Clinical Commissioning Group

Salford City Council

Salford Royal NHS Foundation Trust
University Teaching Trust
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Greater Manchester West NHS Mental Health NHS Foundation Trust

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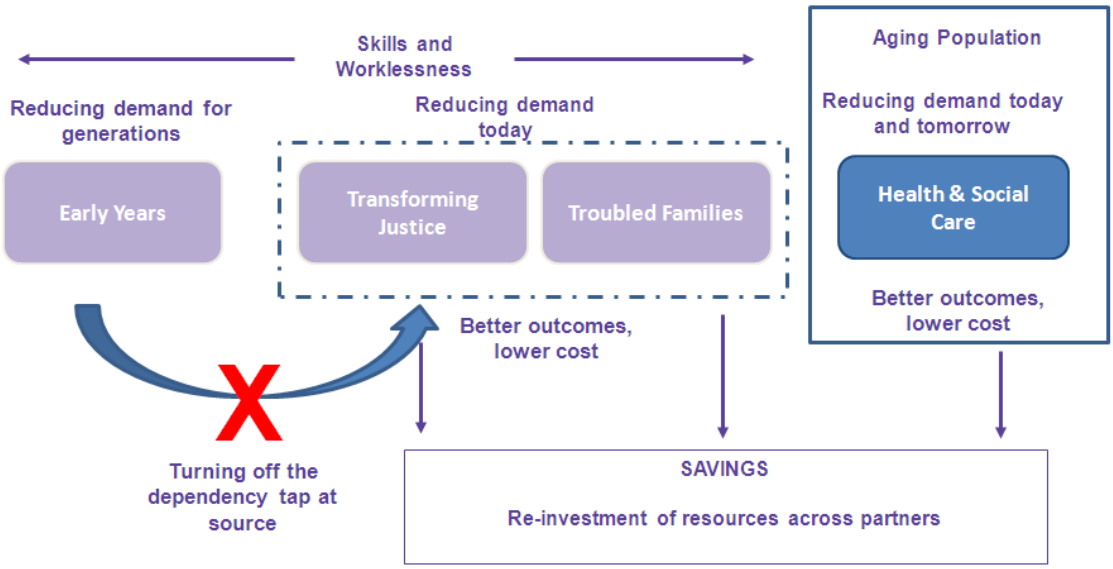
1 Context and Purpose

1.1 This plan describes how Salford's intends to transform care for older people, supporting greater independence and delivering a triple aim of: (1) better outcomes, (2) improved experience, and (3) reduced care costs.

1.2 Although this document has been produced in response to Greater Manchester's Public Service Reform (PSR) programme (figure 1), partners in Salford have been working together as part of a whole-system Integrated Care Programme (ICP) since early 2012.

Figure 1: Greater Manchester Public Service Reform Programme



1.3 Whilst there is still much to be done, Salford has made significant progress over the last 18 months to lay the foundations for a more integrated health and social care system for older people. This includes:-

- Establishment of strong multi-agency partnership, supported by robust governance and programme management arrangements
- Clearly defined aims and improvement measures
- Significant engagement with the third and independent sector, with effective arrangements for engaging and involving older people
- Development of a comprehensive, integrated care model
- Clear understanding of baseline data and existing expenditure
- Agreed risk and benefit sharing principles

1.4 Of course, this is only one strand of work within Salford. Parallel work is being developed in the other PSR thematic areas: work and skills, early years, transforming justice, and troubled/helping families.

1.5 Salford welcomes the opportunity to share learning across Greater Manchester and, where appropriate, to pursue common approaches. It is our belief, however, that solutions need to reflect local circumstances and build on existing assets. Our focus is therefore first and foremost on doing what is right for the people of Salford.

1.6 The document is structured as follows:-

- Section 2: provides the background to Salford's Programme and sets out the case for change for integrating care for older people
- Section 3: describes the Programme's aim, scope and improvement measures
- Section 4: identifies the partners involved in the Programme, its governance and programme management arrangements
- Section 5: explains the rationale for focussing on older people and Salford's approach to segmenting and stratifying the population
- Section 6: describes the new model of integrated care for older people
- Section 7: explains the methodology that is being adopted to implement change
- Section 8: identifies the resources currently committed to older people, initial proposals to reduce health and social care costs and alter contractual arrangements
- Section 9: describes how Salford's Programme will be reviewed and evaluated
- Section 10: sets out next steps for the Programme

2 Background and Case for Change

2.1 Closer integration of health and social care has been a pervasive and recurrent theme of public policy. The recently published national framework document, *Integrated Care and Support*, and the associated call for 'pioneers' clearly signal the Government's commitment to integrated care and the willingness of national organisations to work together to ensure that policy and regulatory levers support this approach.

2.2 Salford has a long history of collaboration. Salford's Health Investment for Tomorrow (SHIFT) programme was one of the first whole health economy approaches to the redesign of care pathways, resulting in a transfer of care away from a hospital setting into community and primary care services. Salford has well developed and integrated intermediate care services, jointly commissioned through section 75 arrangements.

2.3 There has been a tradition of partnership working between health and social care, with integrated services supporting people with mental health problems, learning difficulties and physical disabilities. More recently, both the Unscheduled Care and Better Life Chances programmes have underlined the mutual inter-dependence of organisations and a shared commitment to develop integrated solutions that deliver more appropriate and effective care, whilst enabling costs to be reduced.

2.4 Since early 2012 senior leaders from partner organisations have been working together to develop an *integrated care system* within Salford.[1] Although it was recognised that the other client groups could benefit from integrated care solutions, it was agreed that the principal focus should initially be on older people. The rationale for this is threefold:

a. Older people account for a high use of health and social care services (and therefore cost), straddling the care and cure boundaries
b. Older people often have long term care needs (frequently associated with chronic health conditions) and therefore are likely to benefit from better care planning and coordination across health and social care
c. There is good evidence that integrated care for this client group can deliver better outcomes, improve experience and support cost containment

2.5 Older people are frequently socially isolated, with a poor quality of life (see overleaf). They often receive fragmented care, and are not enabled to care for themselves. Salford has some of the highest rates of emergency admissions and admissions to residential/nursing care, with too many people receiving end of life care in hospital rather than at home. Services can fail to address the needs of older people and where care is provided it can be disjointed and not delivered in the most appropriate setting.

[1] This has been supported through a successful application to participate in a two year Integrated Care Discovery Programme, jointly run by AQuA and the King's Fund.

Figure 2: Increased Care Needs for Older People

2.6 A significant proportion of health and social care expenditure in Salford relates to older people (in excess of £100 million per annum), which will increase substantially as the population becomes older. The number of older people is forecast to rise by 28% by 2030, from 35,000 to 43,300. At the same time, Salford faces unprecedented financial challenges and the prospect of a sustained period of public spending reductions.

2.7 UK and international evidence suggests that integrating care for older people can deliver better outcomes, improve the experience of older people and support cost containment, and that significant improvements can be made through a dual focus on redesigning services and supporting people to self-care (building on the assets around them). System level integrated care addresses the fragmentation of care, shifts the focus away from individual organisations and can provide powerful incentives to focus on prevention, self-care and cost reduction at a neighbourhood level.

3 Aims, Scope and Improvement Measures

3.1 Salford's Integrated Care Programme seeks to transform the health and social care system, promoting greater independence for older people and delivering more integrated care. It has a triple aim of:

- Delivering better health and social care outcomes
- Improving the experience of service users and carers, and
- Reducing health and social care costs

3.2 Whilst recognising the need to respond to short term challenges, the overall approach has been to take a long term view. This includes balancing the short term goals of reducing service duplication and waste with the longer term aim of securing greater population health and thereby reducing future service demand. A key issue will be how the Programme significantly raises the aspirations of the population.

3.3 The scope of the Programme is as follows:

- A focus on change at the system level (encompassing health, social care and community resources)
- Older people (defined as anyone aged 65 or over) as the principal client group
- A focus on health, social care and wellbeing
- A twin approach of 'putting the fires out' (targeting high users of service / those at greatest risk) and 'fire prevention' (primary prevention / early intervention)
- Stratification of the population to target older people that will benefit from different interventions (from self-care and community support through to intensive treatment)
- Salford-wide programme but implemented through a neighbourhood approach

3.4 Seven associated improvement measures have been agreed, with targets set for 2020 (see figure 3 overleaf). The measures incorporate commitments contained within the three national outcome frameworks. Indicators were selected on the following basis:

- They primarily or exclusively relate to older people
- Are consistent with the overall aims of the ICP
- Achievement is outside of the control of a single organisation
- There is a prima facie case that the measure could be positively affected by integrated care solutions

3.5 Salford has also collected time series data and, where available, benchmarked its performance against peers both within the North West (see Appendix A) and nationally.

Figure 3: Salford's 2020 Improvement Targets

Improvement Measures	2020 Targets	Rationale
1. Reduce emergency admissions and re-admissions	▪ 19.7% reduction in non-elective admissions (from 315 to 253 per 1000 ppn): a reduction of 2,071 against a 2011/12 baseline of 10,521 emergency admissions. ▪ Reduce readmissions from the baseline of 19.6%: absolute readmissions to be lower than the 2011/12 baseline of 2062.	Presently in bottom quartile in the North West for both admissions and readmissions. Emergency admissions improvement target is to move mid-point between top quartile (best) and 2nd quartile.
2. Reduce permanent admissions to residential and nursing care	▪ 26% reduction in care home admissions (from 946 to 699 per 100,000 ppn): a reduction of 84 admissions, against a 2011/12 baseline of 322 admissions.	Presently in bottom quartile in the North West. Improvement target is to move to the top quartile.
3. Improve Quality of Life for users and carers	▪ Maintain or improve ranking position (or equivalent) from 2011/12 baseline.	Presently in upper quartile position nationally. Subjective and difficult nature of measures recognised. Given infrequent national measurement, local 'proxy' measures will also be required.
4. Increase the proportion of people that feel supported to manage own condition		
5. Increase satisfaction with the care and support provided		
6. Increase flu vaccine uptake	▪ Increase flu uptake rate to 85% (from baseline position of 77.2% in 2011/12).	Presently ranked 17th nationally (top decile). Improvement target would enable Salford to exceed the top performing area (the best performing area achieved 81.5% in 2011/12).
7. Increase the proportion of people that die at home (or in their usual or preferred place of dying)	▪ Increase to 50% (from baseline of 41% in 2011/12).	Presently in third quartile in the North West, though this position has improved over time. Improvement target would move Salford into the upper (best) quartile.

3.6 Interim targets have also been set for 2013, for the initial phase of work in two of Salford's neighbourhoods.

4 Partners, Governance and Programme Management

4.1 Salford's ICP is underpinned by a formal partnership between four statutory strategic partners:

- Salford Clinical Commissioning Group (CCG)[2] – lead NHS commissioner, with 48 GP Practice 'members'
- Salford City Council (SCC) – public health commissioner, provider and commissioner of adult social care and community support, commissioner of supported housing
- Salford Royal NHS Foundation Trust (SRFT) – provider of acute and community health services and some primary care (out-of-hours, Care Homes Practice)
- Greater Manchester West Mental Health NHS Foundation Trust (GMW) – provider of community, secondary and specialist mental health services

4.2 Importantly, however a range of independent and third sector partners are also involved in the Programme.

Figure 4: Independent and Third Sector Partners

- Age UK
- Care Homes (multiple)
- Chamber of Commerce
- Citizens Advice Bureau
- City West Housing Trust
- Community Pharmacy
- Domiciliary Care Providers
- General Practice
- Helping Hands
- Inspiring Communities Together
- Mature persons group
- Salford Community Leisure
- Salford CVS
- Salford Multi-Faith Forum
- Unlimited Potential
- Your Housing Group
- Other third sector organisations

4.3 A Citizens Reference Group is in place to support engagement and involvement.

4.4 Since May 2012, when this work was put on a formal footing, an Integrated Care Board has overseen the Programme. The ICB was given delegated responsibility to:

- Set improvement targets and timescales
- Determine the neighbourhood(s) that would be the focus for the first phase of the integrated care programme
- Establish arrangements to enable the development of new models of care.
- Secure appropriate resources to complete the design phase of work
- Review existing initiatives to align complimentary workstreams and consolidate projects

[2] Formerly this included NHS Salford, when the CCG was in 'shadow' form.

- Establish clinical leadership and project management arrangements
- Develop a financial model, including risk and benefit sharing, proposing changes to existing payment mechanisms and contractual arrangements where necessary
- Establish arrangements for engaging with patients, service users and local communities
- Develop a robust evaluation framework to ensure progress can be measured against the Programme's aims and improvement targets
- Promote learning that could be shared with other programmes and / or applied to different client groups

4.5 The ICB is jointly chaired by Salford CCG's Local Authority Liaison Clinical Lead and the City Council's Strategic Director of Community, Health and Social Care, with chairing responsibility rotated between meetings. Healthwatch Salford and Salford's Local Medical Committee (LMC) are both members of the Board. The Assistant Mayor for Adults and Older People's Services also has a place on the ICB.

4.6 The ICB reports both to the constituent organisations, to Salford's Health and Wellbeing Board (H&WBB) and to the relevant Neighbourhood Partnership Boards (Appendix C).

4.7 The work of the partnership is driven by a core set of principles, agreed during the establishment of the ICP:

- A partnership of equals, enabling a shift in organisational cultures and creating a new balance between system and organisational interests
- Service redesign has to deliver a reduction in costs whilst assuring safe and effective standards of service
- New care models should be developed by health and social care staff in partnership with citizens and communities
- Significant engagement with service users, carers and local communities
- Costs must be reduced at a rate greater than any loss in income
- Cost reduction, income loss and any reinvestment will need to be reconciled across the partnership so that all parties benefit from the service change
- Each party will be held to account for ensuring the delivery of agreed changes within their own area of responsibility, unless accountability agreements are approved enabling one organisation to manage services on behalf of another
- Each organisation remains sovereign: whilst responsibilities can be delegated, accountability cannot without explicit approval from the boards of each organisation

4.8 The ICP is managed through a Programme Office, hosted by SRFT. A range of enabling workstreams have been established, which are overseen by a Steering Group which meets on a weekly basis (see Appendix C).

4.9 Salford's Programme is being delivered in five phases. It is presently part way into the second phase – neighbourhood 'tests of change'.

Figure 5: Programme Phases

- Phase 1: **Refine Scope and Prepare for Implementation** (completed)
- Phase 2: **Neighbourhood 'Tests of Change'** (started February 2012, scheduled for completion end of December 201313)
- Phase 3: **Interim Review of Impact** (scheduled January 2014 to March 2014]
- Phase 4: **Extend to other Neighbourhoods / City-wide** (April 2014 onwards)
- Phase 5: **Formal Evaluation** (April 2014 to March 2019)

4.10 Although the aim is to improve outcomes and experience for all older people within Salford, changes are initially being implemented in two of Salford's neighbourhoods (Eccles, Barton & Winton and Swinton & Pendlebury).

4.11 This approach will enable us to develop and test the evidence base for integrated care, as well as tailoring solutions at a neighbourhood level.

4.12 The following principles were used for the selection of the neighbourhoods:

- Contain a critical mass of older people
- History of early integration of health and social care services
- Relatively high demand / service use
- Complexity of need but not a demographic outlier
- Limited cross border flows (outside of Salford)

4.13 A 'loose / tight' philosophy has been followed, where the ICP's aims and improvement measures are tightly defined but there is significant flexibility, within neighbourhoods and integrated teams, as to how these are achieved.

5 Population Focus

5.1 One of the initial key debates within Salford was to determine the most appropriate scope and scale for integrating care. Too broad an approach would be unmanageable, whilst too narrow a focus would not deliver the scale of change required to bring material benefits. The early consensus was a system wide approach is required and that a disease specific approach would fail to recognise the holistic needs of individuals.

5.2 Although it was recognised that the other client groups could benefit from integrated care solutions, it was agreed that the principal focus should initially be on older people. The rationale for this is threefold:-

a. Older people account for a high use of health and social care services (and therefore cost), straddling the care and cure boundaries
b. Older people often have long term care needs (frequently associated with chronic health conditions) and therefore are likely to benefit from better care planning and coordination across health and social care
c. There is good evidence that integrated care for this client group can deliver better outcomes, improve experience and support cost containment

5.3 Salford has 35,240 people aged 65 or older registered with a GP Practice in Salford, which equates to nearly 14% of the total population. This is predicted to grow to 43,300, an increase of 28%, by 2030.

5.4 One of the reasons for selecting the two neighbourhoods for the initial 'tests of change' is that they account for a significant proportion of older people – nearly 40% of Salford's elderly population are registered with GP Practices in these neighbourhoods.

5.5 Building on the approach taken in Torbay, social marketing analysis has been undertaken of Salford's elderly population. This has brought together population, deprivation, hospitalisation and household classification (MOSAIC) data, providing a richer overall picture of the population and the characteristics of different 'segments':

- While Salford has a larger, younger population than Torbay the number of older people is roughly the same however their characteristics are very different.
- In a small area like Swinton, older people live in a variety of circumstances, there are more singles in flats with high levels of need, and more are reliant on the state. However there are also often more family members close by.
- In neighbouring Eccles & Worsley, there are more self-reliant couples, there is larger housing, the rate of hospitalisations is lower, and there is higher car ownership. However there is often less extended family close by.

5.6 One of the key messages from this work is the importance of tailoring solutions to meet the different needs of 'Sally Ford' and her family (Salford's equivalent of 'Mrs Smith').

Figure 6: Different Geographical Characteristics

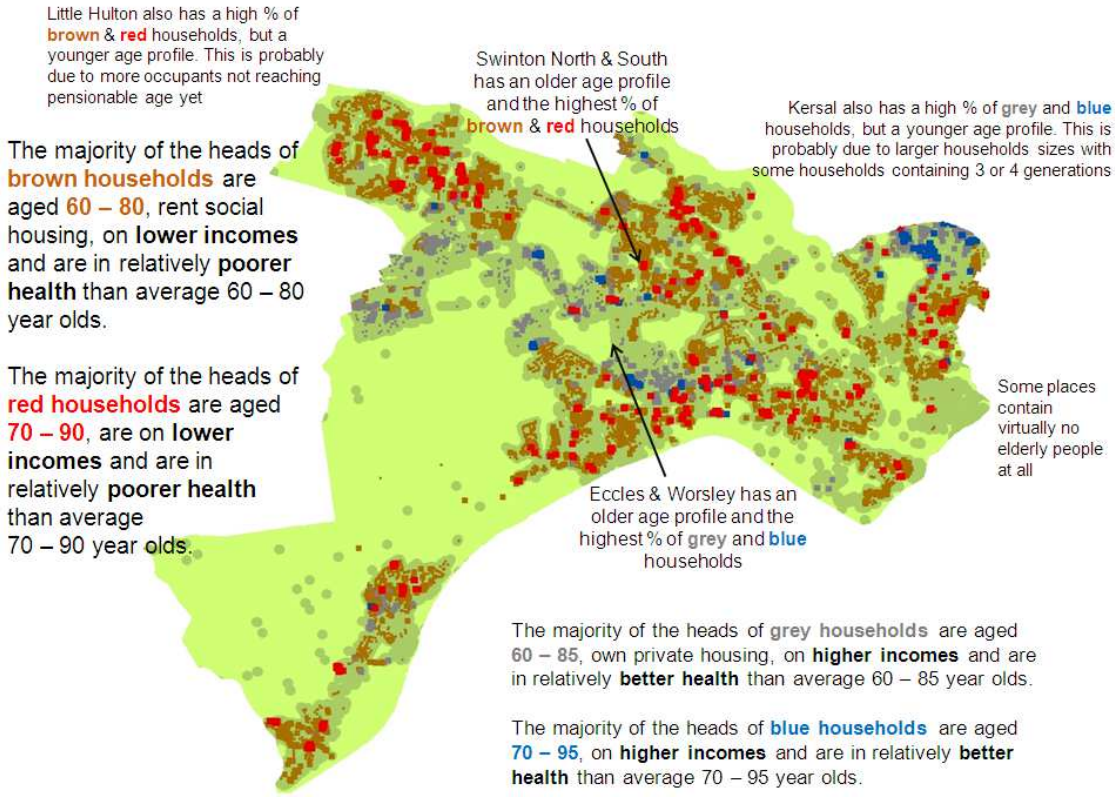
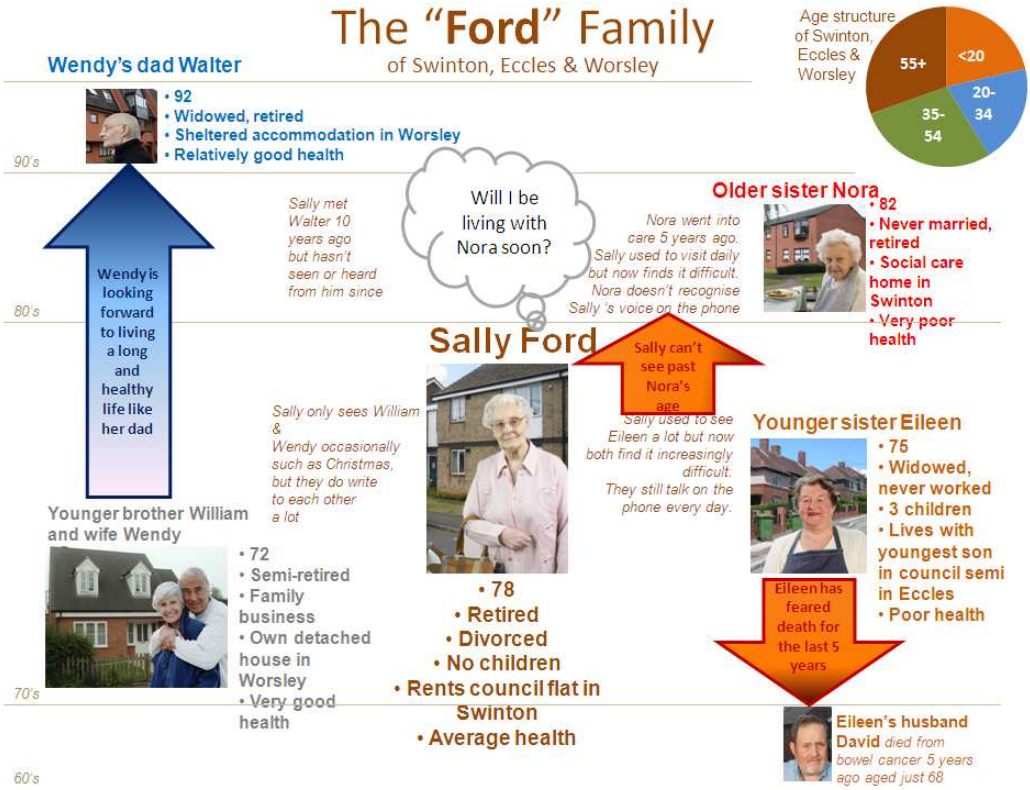


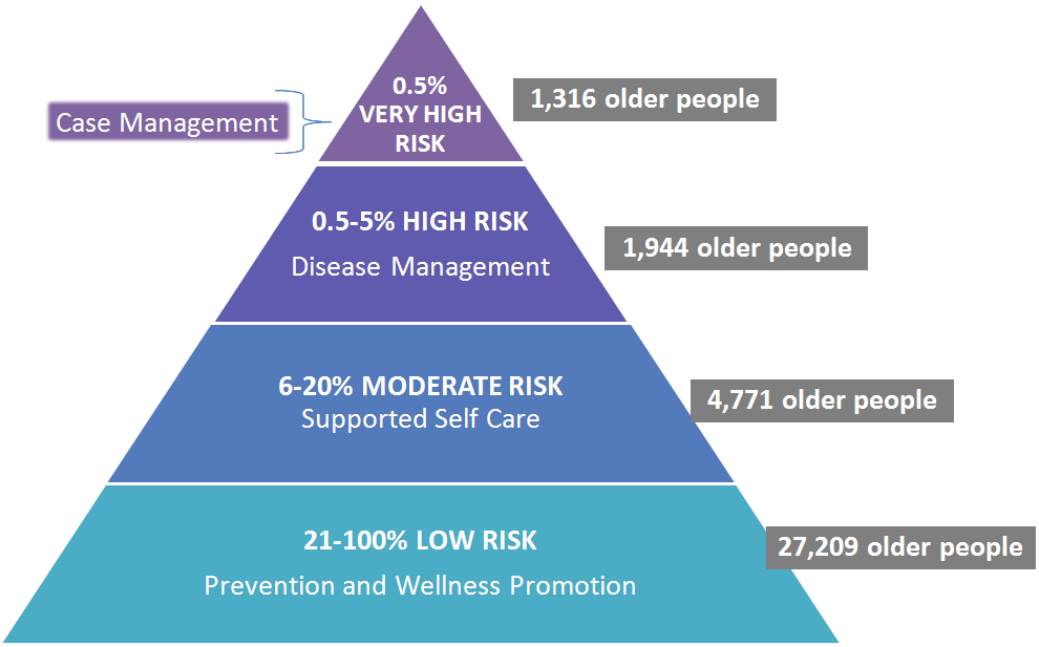
Figure 7: Sally Ford and the Ford Family



5.7 Salford is also using the Combined Predictive Model (CPM) to identify individuals who are most at risk of hospitalisation – and to ensure they receive targeted support (see figure 8 below and Appendix D for more detailed analysis of the two neighbourhoods).

5.8 Using CPM, 23% of Salford's 65+ population are identified as having very high to moderate risk. Thirty-seven per cent of Salford's admissions and 45% of readmissions relate to older people, with approximately 75% of this activity taking place at Salford Royal. Analysis of emergency admissions by age band shows that the greatest proportion of 65+ admissions relates to people aged 75-84.

Figure 8: Risk Stratification of Older People



5.9 One of the key principles underpinning the ICP, however, is to provide both targeted support to those who use (or are most likely to use) services and to ensure a focus on prevention and early identification in the wider population. Although stratification tools are helpful identifying at risk groups, Salford is seeking to provide appropriate support, where necessary, across the continuum of older people.

6 Salford's Integrated Care Model

6.1 Salford has developed a comprehensive and integrated model of care for older people. The scope encompasses health, social care and community resources. It is designed to promote holistic care, with a greater focus on prevention, planned and anticipatory care, reducing duplication and fragmentation.

6.2 Salford's model has three inter-related component parts, focussed around 'Sally Ford' and her family:

1. Promotion and increased use of **Local Community Assets** (e.g. carer support, self-management, community groups) to support increased independence and resilience for older people.
2. Development of a **City-wide Care Hub** to support navigation, monitoring and support; bringing together aspects of telephony and telecare support for older people
3. Establishment of **Multi-Disciplinary Groups** (i.e. structured, multi-disciplinary population based care) to support older people who are most at risk as well as a providing a broader focus on screening, primary prevention and signposting to community support.

6.3 The model has been informed by two related pieces of work:

- A review the national and international evidence base for integrated care – which identified a range of features of integrated care systems (figure 9)
- Two large local engagement events, attended by over 100 staff and stakeholders – which identified 10 key priorities for Salford (figure 10)

6.4 Although elements of Salford's model have been implemented in other areas, we believe the strength of Salford's approach is the breadth and comprehensive nature of the model (from community-based support for the broader population through to targeted interventions for individuals who are most at risk).

6.5 Whilst potential functions have been identified for each of three components of the model (see Appendix E), we have not sought to prescribe the way these will evolve or develop. Rather, we have provided an overall framework within which local teams in the two neighbourhoods can safely experiment and innovate.

Figure 9: Features identified in other Integrated Care Systems

Figure 10: Integrated Care Design Principles

	What	Issues
Population size	Core integrated team to cover c.30,000 to 50,000 (all age) population, with some specialist services at higher level – cluster of teams	Critical mass to support sufficient range of services and staff Reflect future demand
Team – configuration and location	Include health and social care staff Often, but not necessarily based on GP practices and supported by co-location	Can have shared management and pooled budgets Role and scope of 'care coordinators'
Geography	Best based on natural communities and patient flows	Recognise may not 'fit' with organisational boundaries
Information and Technology	Integrated records, decision support, patient monitoring and risk stratification (categorising people into groups according to need / risk)	Both to coordinate care and provide it
Spectrum of needs	Avoid excessive focus on highest acuity (hospitalisation) – balance with earlier intervention and prevention	E.g. represented by pyramid of need, Salford 'just enough care' model
Spectrum of services	Ensure include full range of health and social care, as well as Third sector and wider support	Initially share knowledge of what is already available
Engage and empower people	For older people to have greater control And for staff to further integrate services	E.g. deciding what services and when E.g. integrate supporting systems
Keep it Simple in Salford	Make the system understandable for people, customers and patients.	Priority to reduce hand-offs between elements in the system

6.6 Our 'litmus test' in developing, testing and refining this model will be the extent to which it can secure our improvement aims and measures, delivering tangible improvements for Sally Ford and her family.

Figure 11: What should be different for Sally Ford and her family

• **Greater independence**	✓ Able to live at home longer
• **Reduced isolation**	✓ Increased opportunities to participate in community groups and local activities
• **Confidence in managing own condition and care**	✓ Sign-off own care plan and agree who it should be shared with ✓ Support to monitor own health
• **Know who to contact when necessary**	✓ One main telephone contact number for advice and support
• **Increased community support, specialist care available when necessary**	✓ Access to a named individual to coordinate care and support
• **Support to plan for later stages in life**	✓ Agreed plan for last year in life

6.7 Salford is exploring ways in which we can incorporate 'social innovation' (social processes of innovation) into its approach. We are currently working with CVS North West and Unlimited Potential to identify and engage local and international social entrepreneurs through an innovation 'competition'. The focus is on finding new ways of reducing dependence and social isolation, and associated demand on statutory services.

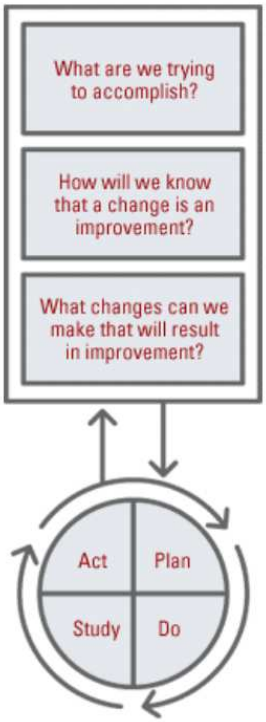
6.8 Salford is also part of a proposed European Union partnership to create 'senior friendly communities', turning the 'threat' of an ageing society into a 'positive opportunity'. A joint application has been submitted to the European Commission, covering 42 communities in 14 European Union member states (see Appendix F).

7 Change Methodology

7.1 Salford has adopted a 'Collaborative Improvement' approach for implementing change,[3] which is a simple yet powerful tool for accelerating improvement (see schematic).

7.2 Seven project groups have been established, each of which is taking forward elements of the integrated care model:

- Community Assets and Capability Building
- Integrated Care Hub / Contact Centre
- Neighbourhood Multi-Disciplinary Groups
  - Eccles, Barton & Winton (2 MDGs)
  - Swinton & Pendlebury (2 MDGs)
  - Care Home residents and housebound (1 MDG)



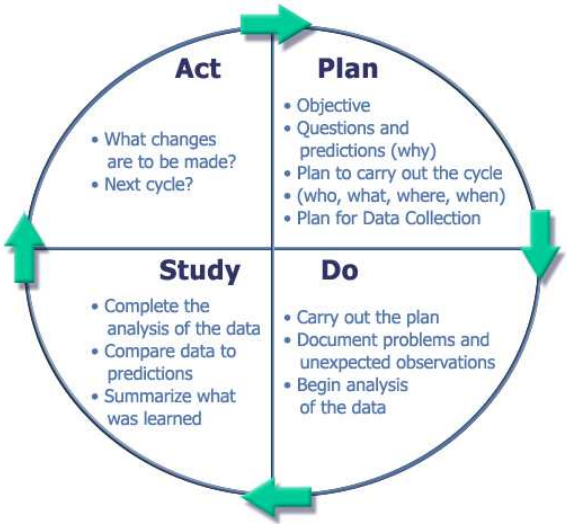
7.3 Each of the project groups is meeting on a fortnightly basis, supported by a Project Manager. Over 100 individuals are involved in the groups, with the Community Assets group having majority of its membership from the third sector and 'mature adults'.

7.4 The project groups come together at three Learning Workshops over the course of 10 months, to share ideas and plans for periods of improvement. The first Learning Workshop was held on 6 February, with the second and third scheduled for later this year.

7.5 The project groups have used a 'driver diagram' to break the aims of the ICP into primary drivers and associated actions (Appendix G), with the integrated care model being tested using small cycles of change known as PDSAs (Plan, Do, Study, Act).

Figure 12: PDSA Cycle for Learning & Improvement

[3] Langley GL, et al (2009*)* The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd edition). San Francisco: Jossey-Bass Publishers.



7.6 Salford's Haelo Centre has been commissioned to provide quality improvement support to the Programme[4], including:

- Capability building for Project Teams / Project Managers
- Technical advice and support (e.g. improvement tools, measurement)
- Support for Learning Workshops
- Data collection and project reporting

7.7 External OD support has also been commissioned, providing developmental coaching for Project Managers and team development for the Project Groups (to address potential relational and inter-professional barriers).

[4] Haelo is a new health improvement organisation connecting the 'thinkers' with the 'doers', with a focus on innovation in improvements across three key areas: Safety; Measurement; and Large Scale Change. Haelo is based in Salford, but works with partners across Greater Manchester, the North West, England and the world. See www.haelo.nhs.uk/

8 Financial and Contracting Arrangements

8.1 The combined turnover of the partners is in excess of £800 million, of which circa £270 million relates to the delivery of health and social care services within Salford.[5]

8.2 Approximately £100 million is spent on health and social care for older people each year, however this understates the true cost to the public sector as it excludes primary care (where expenditure cannot easily be attributed to age cohorts) and other areas of public expenditure (for example, housing and benefits).

Figure 13: Anticipated Expenditure in 2013/14 (£ millions)

	TOTAL turnover	Relating to Salford		Existing CIPs for 2013/14		
		ALL AGES	H&SC 65+	Total	Salford	Salford 65+
Salford Royal	420.0	128.0	48.3	19.0	6.4	2.4
Salford City Council	233.7	233.7	n/a	23.5	23.5	n/a
of which H&SC	113.4	113.4	29.9	10.7	10.7	4.1
Greater Manchester West	157.4	28.9	6.9	5.0	0.7	0.3
Other acute	n/a	n/a	14.4	n/a	n/a	n/a
General Practice	not yet identified	not yet identified	not yet identified	not yet identified	not yet identified	not yet identified
TOTAL	811.1	390.6	99.4	47.5	30.6	6.8
TOTAL (H&SC only)	**690.8**	**270.3**	**99.4**	**34.7**	**17.8**	**6.8**

Notes:

1. Salford CCG's budget allocation for 2013/14 is £321m.
2. SRFT total turnover (£420m) is for all services (specialist, acute and community, R&D and education) irrespective of commissioner. Salford All Ages and 65+ income is for community and acute services (but both exclude specialist commissioned services and third party income).
3. SCC total turnover (£233m) is net of income from specific grants, fees etc. However the Health & Social Care income is gross, i.e. it includes fees from clients and NHS income.
4. GMW total turnover (£157m) is for specialist and district services (the latter includes Bolton and Trafford, as well as Salford). The income figure for Salford is for district MH services (i.e. excludes specialist MH services) and does not include City Council commissioned services.
5. Information has not yet been collated for General Practice or primary care prescribing.

8.3 In the current climate of austerity it is anticipated that the statutory partners will need to save nearly £48 million per annum for the foreseeable future. This equates to

[5] Both SRFT and GMW also serve wider populations. This figure only includes SCC expenditure for health and social care for older people, i.e. it excludes children services and other council services.

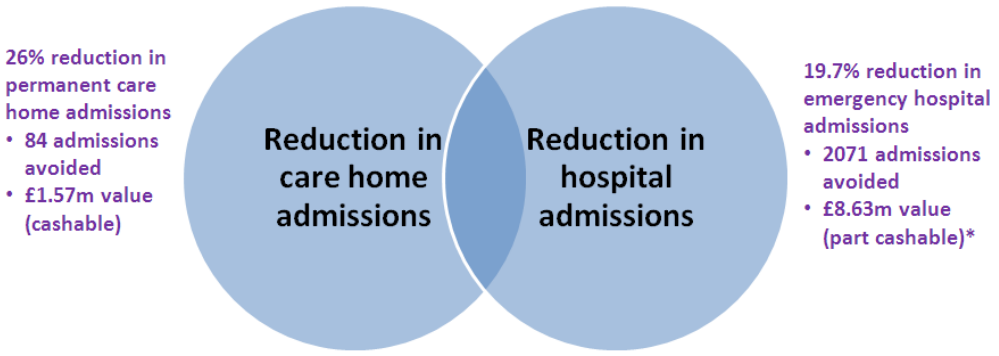
approximately £18 million on health and social care expenditure in Salford, of which nearly £7 million relates to older people. However, this does not take account of the significant growth in the 65+ population; which suggests much greater savings may be required to release resources to deal with future demand.

8.4 Although the evidence base is currently under-developed, it is our belief that integrated care solutions are more cost-effective than the status quo and that three types of financial benefit can be delivered:

- Reduction in admissions (hospital, care homes)
- Removal of duplication and fragmentation (reducing unit costs)
- Reducing future demand (reducing lifecycle costs)

8.5 Salford is still at an early stage in assessing the scale of financial benefits that could be delivered, however the combined value (to commissioners) of the planned reduction in admissions to care homes and secondary care is in excess of £10 million.

Figure 14: Expenditure Associated with Care Homes and Hospital Admissions



8.6 Of course, this is not a short term endeavour – and the evidence suggested that it may be 2-3 years before integrated care solutions are delivering sustained benefits.

8.7 It is recognised that the relationship between activity and costs tends not to be linear (figure 15, overleaf) and therefore not all savings will be 'cashable'. The costs of the new delivery model will also need to be offset against the savings – whilst we have started to 'map' potential categories of cost and savings (Appendix H) these have not yet been quantified as part of a Cost-Benefit Analysis (CBA).

8.8 In the short term, the ICP will assist the Local Authority and the NHS to achieve existing budget savings, such as identifying alternative packages of care to support people in the community as an alternative to residential care. If successful, this element will assist in the delivery of the existing budget target of £850k, set by the City Council for 2013/14.

8.9 It has been agreed to implement new contracting arrangements to support risk and benefit sharing and to remove perverse incentives from the system. This is likely to take

to the form of an 'Alliance' contract, incorporating the four statutory partners (CCG, SCC, SRFT, GMW) potentially commencing in 2014/15.

Figure 15: Behaviour of Provider Costs

Behavior of the Various Cost Layers in the Health and social care system

Cost Layer	Effects of Reduction in Use	Examples
Layer 1: truly variable costs of patient care	The item is not consumed, does not need to be replaced, and is available for later use.	Supplies, medications
Layer 2: semivariable costs of patient care	The item is not consumed, but the ability to repurpose the item is limited by time. Costs of providing the service may be reduced with sufficient reduction in volume.	Direct hourly nursing, respiratory therapists, physical therapists
Layer 3: semifixed costs of patient care	The item is not consumed, but the obligation to continue to pay for the item does not change.	Equipment, operating-room time, physician salaries, ancillary services
Layer 4: fixed costs not associated with patient care	Resource consumption is not altered in the short run but may be altered in the next operating cycle.	Billing, organizational overhead, finance

Releasable over time

8.10 Some external support has been commissioned through the King's Fund to develop a Memorandum of Understanding (MOU), as a staging post to implementation of the new contractual arrangements. The MOU will set out the scope of the new contract, key principles and commercial terms.

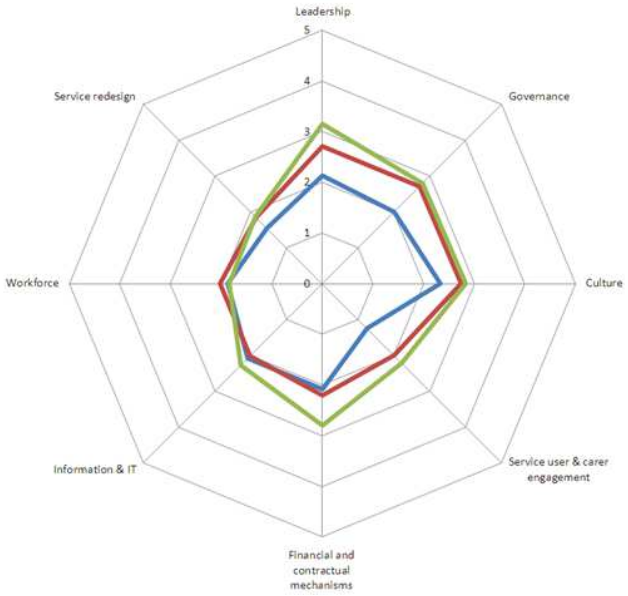
8.11 Interim contractual arrangements have been agreed for 2013/14, with work being undertaken to align current financial incentives.

9 Review and Evaluation

9.1 The Integrated Care Board undertakes regular, 6 monthly reviews of progress within Programme, checking progress against agreed milestones and using AQuA Integration Framework to assess whether core integration 'domains' are being progressed.

Figure 16: AQuA Integration Framework

	Apr-12	Oct-12	May-13
Leadership	2.13	2.71	3.08
Governance	2.00	2.71	2.81
Culture	2.33	2.74	2.92
Engagement	1.25	2.00	2.28
Financial & contractual	2.08	2.21	2.80
Information & IT	2.08	2.03	2.17
Workforce	1.88	2.03	1.84
Service redesign	1.54	1.84	1.84



9.2 In addition, the Board has agreed to use the end of each phase of the programme as a 'decision-point' – an opportunity to formally check progress with partners and to identify any issues that may require review within each organisation (including where decisions fall outside the delegated authority of the Board).

9.3 In terms of evaluating the impact of the ICP, Salford has partnered with the University of Manchester and CLAHRC,[6] with an initial interim evaluation scheduled to be conducted between January and March 2014.

9.4 A joint bid has also been submitted to the National Institute of Health Research (NIHR),[7] to undertake a five year evaluation of Salford's ICP – 'Comprehensive Longitudinal Assessment of Salford Integrated Care' (CLASSIC).

9.5 The proposed evaluation framework is a variant of the cohort multiple randomised controlled trial, where a large cohort of older people are recruited and followed systematically over time, with subgroups used to evaluate different interventions.

[6] CLAHRC: Collaboration for Leadership in Applied Health Research and Care in Greater Manchester www.clahrc-gm.nihr.ac.uk

[7] www.**nihr**.ac.uk/

9.6 If the bid is successful, the plan is to undertake evaluation at four levels:

- Population level: effect on overall population experience, self-management and outcomes over time
- Cluster level: implementation of some aspects of the ICP will be tested first in a smaller number of practices or neighbourhoods in a 'staged' manner
- Individual level: there will be potential to allocate individuals to certain components of the ICP to allow a rigorous estimate of the contribution of individual components
- External comparators: comparisons with sites and cohorts outside Salford

9.7 A summary of the NIHR bid is included as Appendix I

10 Enablers, Risks and Support

10.1 Integrating care for older people will require significant changes in the way services are commissioned and delivered. It will require changes in the way our workforce operates and in the use of information and technology. Most important, however, will be how we engage with older people and local communities – and how they respond to a reformed care system.

10.2 Implementing our new integrated model of care will depend upon a number of key enablers. These include:

- Cost-benefit analysis of the new delivery model, including an assessment of the likely impact of changes within what is a complex, dynamic system
- Development of more sophisticated approaches to risk stratification, including factors that are likely precipitate admission to a care home
- Creation of Shared Care Record for older people, building on the Salford Integrated Record and the Council's Single Customer Account
- Robust data sharing arrangements, recognising data protection restrictions
- Effective implementation of new contractual and payment arrangements that support 'pain and gain' sharing

10.3 The nature and scale of the changes being introduced inevitably means that there are risks, some of which relate to factors which are only partially in our control.

Figure 17: Risks and Mitigation

Key Risks	Proposed Mitigation
▪ Distributed nature of General Practice (48 distinct entities) and separate commissioning arrangements (via NHS England) create additional complexity in securing GP engagement and support	▪ Engagement via CCG membership model and neighbourhood structure ▪ Partnership approach with the LMC and individual GP Practices ▪ Engagement with NHS England to align commissioning arrangements ▪ Potential options for engagement through federated GP provider models
▪ New ways of working, new staff roles and (in some areas) reduction in the size of the workforce, may result in resistance to change	▪ Close working with staff and early engagement with Trade Unions ▪ Promotion of changes by staff involved in the neighbourhood tests of change ▪ Commitment to 'natural wastage' and to redeploy staff (across the partner agencies) wherever possible

Key Risks	Proposed Mitigation
▪ Delivering more care closer to home is likely to require a growth in workforce capacity in primary and community services. The capacity required has not been quantified and there is likely to be a time lag in securing any expansion of the workforce	▪ Remodelling the existing workforce, including outreach models for consultants and nurse specialists ▪ Workforce planning to identify where a growth in existing or new roles is required
▪ Out-of-hospital care is likely to place increased demand on the community estate and may necessitate some consolidation of premises (for which there are constraints)	▪ Identification of potential increased demand on the community estate ▪ Mapping of existing estate, potential constraints and opportunities
▪ Proposed formal evaluation is contingent on external funding from the NIHR	▪ Active engagement with the NIHR ▪ Evaluation of alternative research options and other funding routes
▪ The new model will require active engagement from older people and the wider community, to play an increased role in their own care, which will require a shift in attitudes and behaviour	▪ Sustained engagement, through the Citizens Reference Group, with natural communities and in conjunction with third sector partners ▪ Explore the potential for a dedicated social marketing campaign
▪ Partnership approach between the statutory agencies could be deemed to restrict patient choice or be anticompetitive by regulators	▪ Professional advice and early engagement with the regulators ▪ Potential partnership approach to overcoming regulatory obstacles if Greater Manchester is successful in securing 'pioneer' status

10.4 Salford has established effective programme management arrangements, with a central Programme Office hosted by SRFT. This provides a coordinating function, on behalf of partner organisations, ensuring that workstreams are aligned and managed.

10.5 SCC is in the process of creating an Integrated Commissioning Hub, which will enable the Council and partners to better join-up resources and activities. This will be supported by an 'Engine Room', bringing together IM&T, HR, Finance and other functions. The Engine Room will play a key role in supporting learning and shared approaches across the PSR areas.

10.6 It is also likely that there will be opportunities to collaborate on specific issues across Greater Manchester. This could include areas such information sharing and risk stratification, where the Greater Manchester Commissioning Support Unit will play a key role. There will also be complex issues, such as developing new contractual models, where it may be sensible to jointly commission external advice.

10.7 Securing 'pioneer' status for Greater Manchester could also play a critical role in helping to address some of the 'wicked' issues that too often impede integrated care. In

particular, Salford would be keen to explore new contractual arrangements and ways of overcoming potential regulatory barriers.

11 Next Steps

11.1 The following table summarises the priorities and associated milestones for the next six months of the Programme.

Priorities	Milestones and Timescales	Responsibility
1. Further test, embed and refine the integrated care model	▪ Social innovation competition during June 2013 ▪ Progress review at Learning Workshops on 12 June and 9 October 2013, with a focus on transferable learning ▪ Interim 6 monthly review of the Programme to be held by the ICB on 18 June ▪ Assessment of impact of neighbourhood tests of change phase, during January - March 2014	Steering Group and Care Standards Subgroup
2. Increase staff and public engagement and commence engagement with Trade Unions	▪ Staff and public communications plan to be produced in June 2013 ▪ Explore options for social marketing campaign ▪ Integrated Engagement event to be held with older people on 17 June 2013 ▪ Partnership approach to engagement with Trade Union to be agreed	Communications, Engagement & HR Subgroup and Citizens Reference Group
3. Agree the specification and commence implementation of a Summary Shared Care Record	▪ Refinement of minimum dataset at Learning Workshop on 12 June 2013 ▪ Initial Project Initiation Document to be completed by July 2013 ▪ Specification to be completed by August 2013 ▪ Interim options to be agreed and implemented	IT & Data Sharing Subgroup
4. Finalise the specification for the interim review and agree 'plan B' if NIHR bid is not successful	▪ Research Associate to commence in post in June 2013 and Information Officer in July-August 2013 ▪ Run charts for improvement measures to be finalised in June-July 2013 ▪ Plan B options to be considered by Evaluation Subgroup in June 2013, with recommendations to the ICB in July 2013 ▪ Outcome of NIHR bid to advised by August 2013	Evaluation Subgroup and Information Subgroup

Priorities	Milestones and Timescales	Responsibility
5. Finalise the financial targets for the ICP and assess the fiscal benefits of the model	▪ Further consideration of the financial targets in July 2013 ▪ Development of initial CBA during July-August 2013 ▪ Finalisation of CBA and associated targets in September 2013	Finance Subgroup
6. Develop a roll-out and sustainability plan for extending the approach city-wide	▪ Options for roll-out to be considered by the Integrated Care Board in July 2013 ▪ Engagement with GPs and other stakeholders ▪ Review of roll-out plan as part of end of phase 2 review in November 2013 ▪ Development of estate and workforce plan	Steering Group, Communications, Engagement & HR Subgroup and ICB
7. Establish an MOU for the implementation of an Alliance contract / Joint Venture arrangement for 2014/15	▪ Alliance contract briefing and options paper to be consider by each of the partner organisations during June-July 2013 ▪ Output to be considered by ICB in July-August 2013 ▪ Draft MOU to be finalised ▪ MOU to be considered by each of the partner organisations during August-September 2013, seeking formal approval and delegated authority to commence contract development	Finance Subgroup and Steering Group

Appendix A

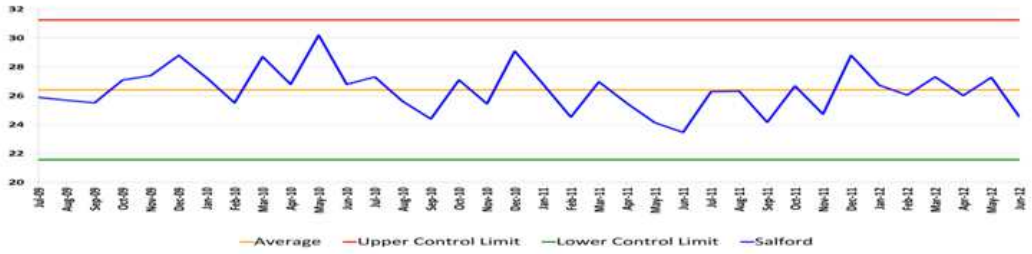
ABRIEVATIONS AND ACRONYMS

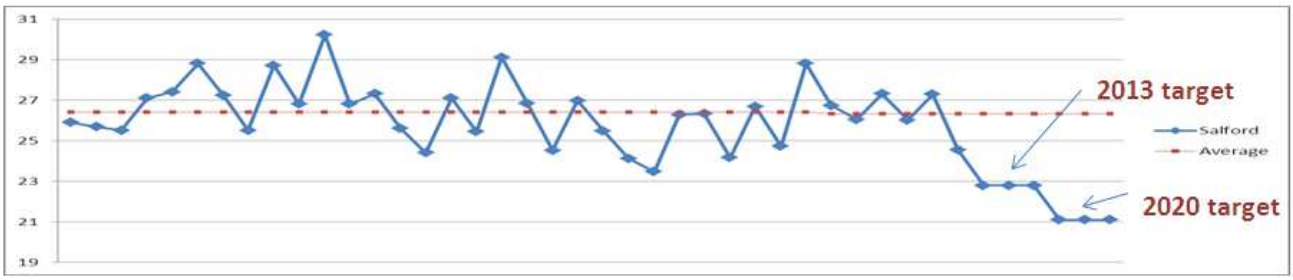
AGMA	Association of Greater Manchester Authorities
AQuA	Advancing Quality Alliance
CIP	Cost Improvement Programme
CLAHRC	Collaboration for Leadership in Applied Health Research and Care in Greater Manchester
CBA	Cost-Benefit Analysis
CPM	Combined Predictive Model
GM	Greater Manchester
GMW	Greater Manchester West Mental Health NHS Foundation Trust
H&SC	Health & Social Care
H&WBB	Health & Wellbeing Board
ICB	Salford's Integrated Care Board
ICP	Salford's Integrated Care Programme for Older People
MDG	Multi-Disciplinary Group
MOU	Memorandum of Understanding
NIHR	National Institute for Health Research
NW	North West region
PDSA	Plan, Do, Study, Act
PSR	Public Service Reform
Salford CCG	Salford Clinical Commissioning Group
Salford LMC	Salford Local Medical Committee
SCC	Salford City Council
SHIFT	Salford Health Investment for Tomorrow (a previous whole-system programme focussed on shifting care from the hospital to the community)
SRFT	Salford Royal NHS Foundation Trust

Appendix B

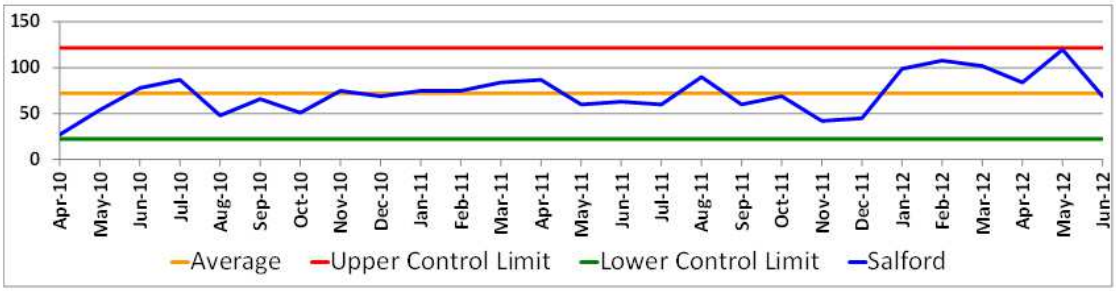
IMPROVEMENT TARGETS: TIME-SERIES AND BENCHMARK DATA

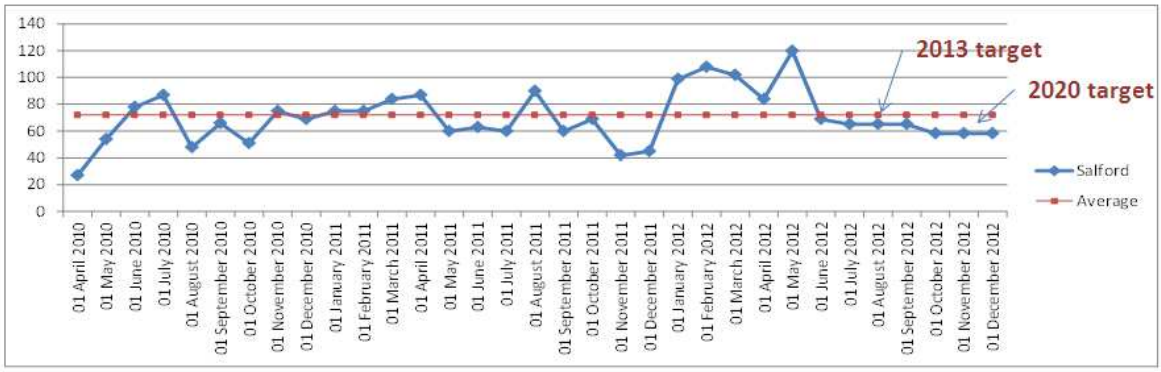
1. Baseline performance and improvement targets for emergency admissions to hospital



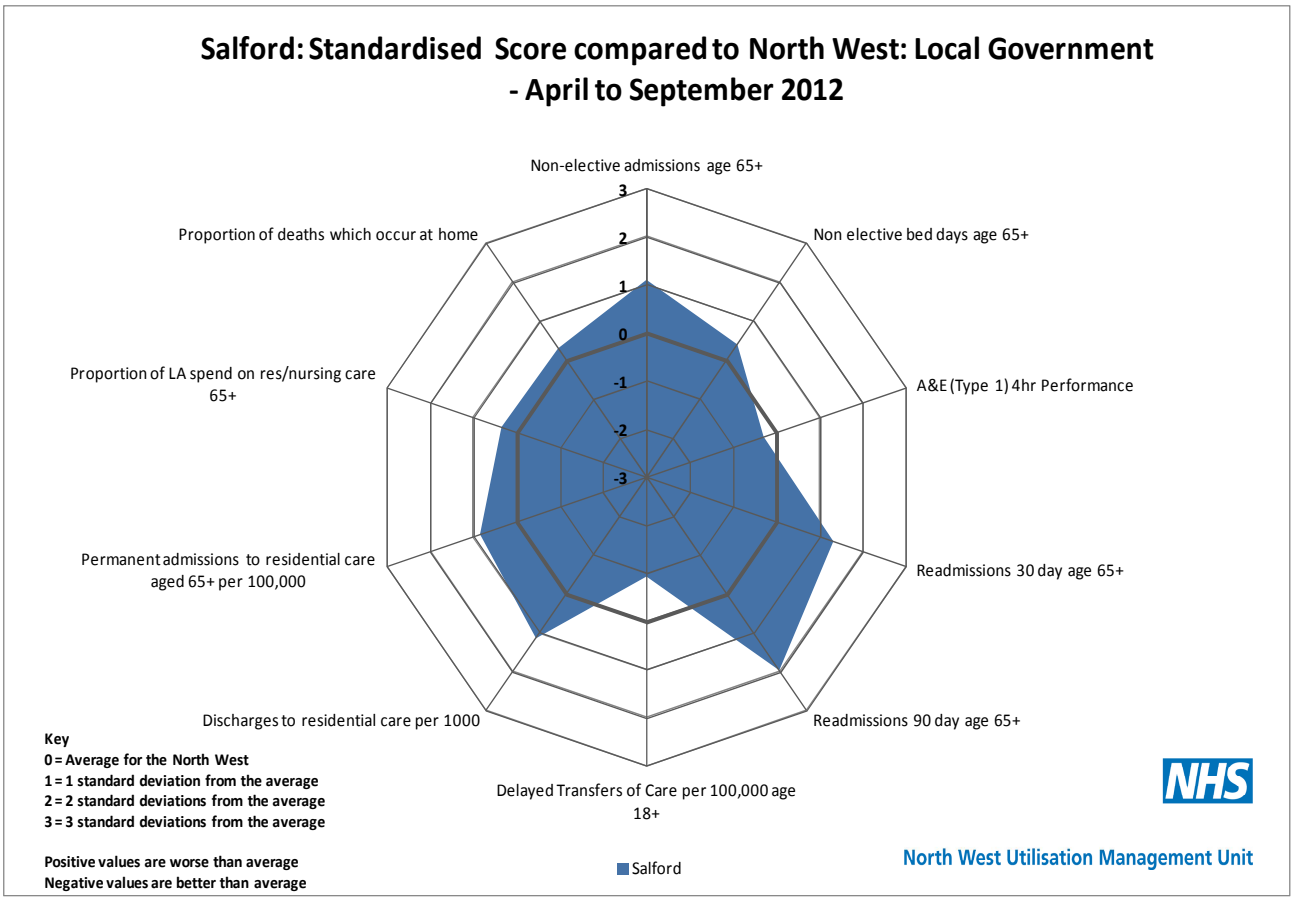


2. Baseline performance and improvement targets for admissions to care homes



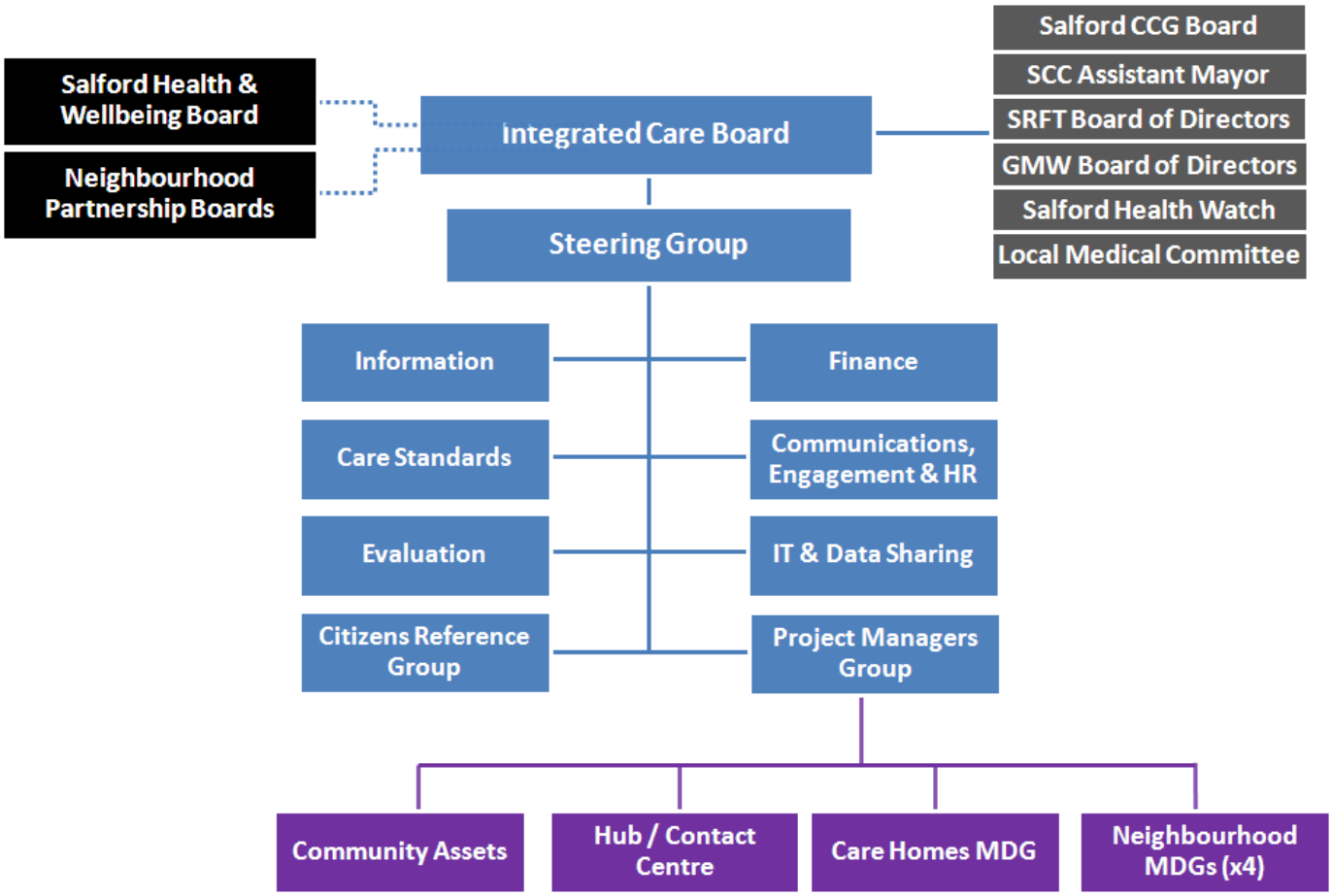


3. North West ADASS / AQuA Scorecard



Appendix C

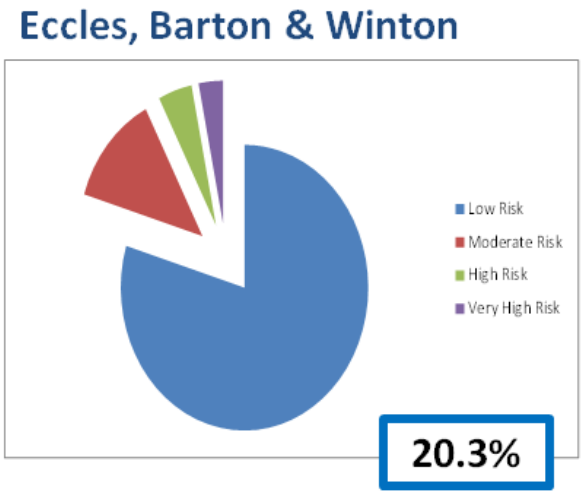
GOVERNANCE AND PROGRAMME STRUCTURE

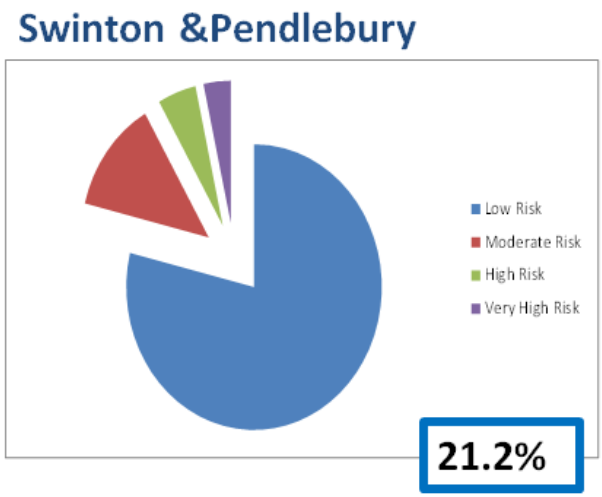


Appendix D

NEIGHBOURHOOD RISK STRATIFICATION

Age Band	Low Risk	Moderate Risk	High Risk	Very High Risk	Grand Total
Eccles Barton & Winton	4518	719	250	180	5667
	79.7%	12.7%	4.4%	3.2%	100%
Swinton & Pendlebury	6384	1040	394	279	8097
	78.84%	12.84%	4.87%	3.45%	100%

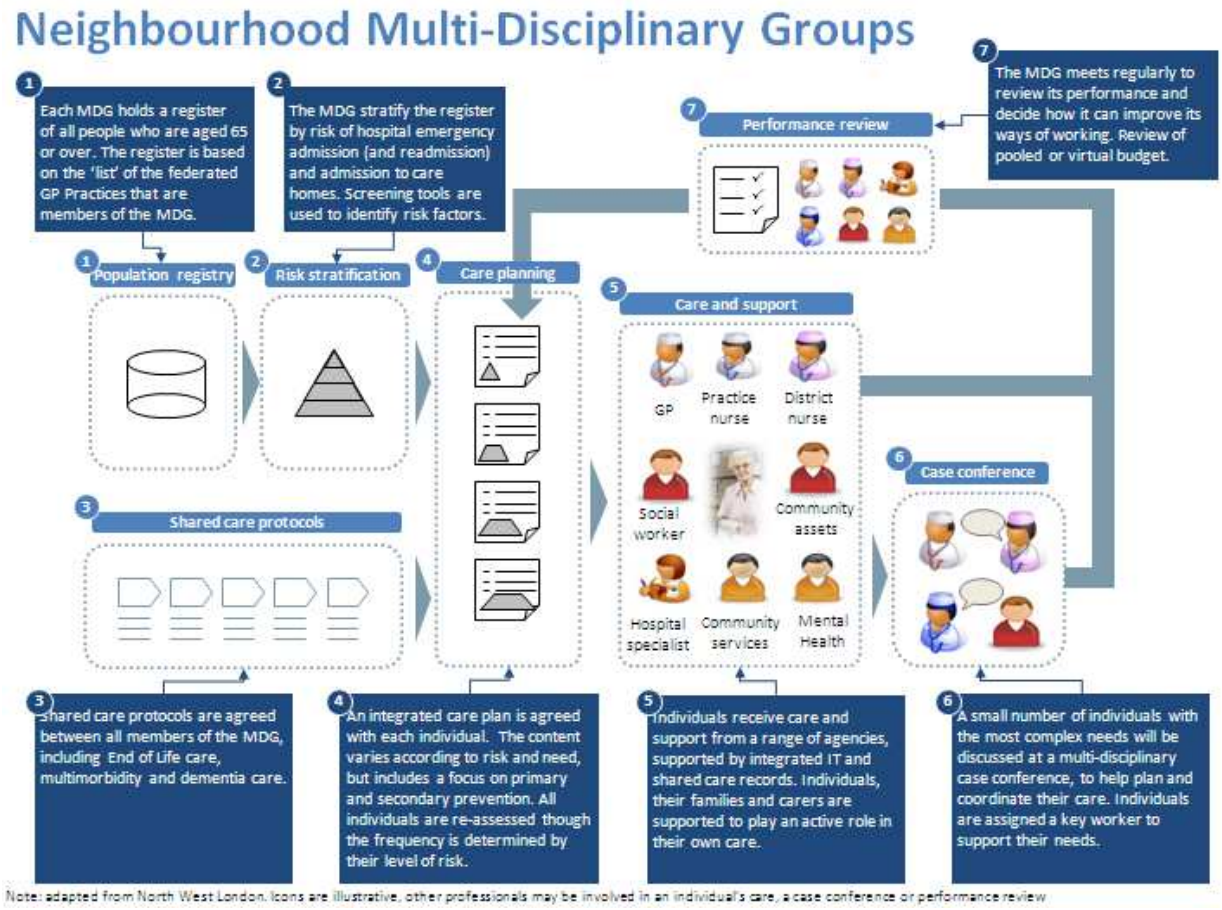




Appendix E

SALFORD'S INTEGRATED CARE MODEL

City-wide Care Hub (single point of access)



Note: adapted from North West London. Icons are illustrative, other professionals may be involved in an individual's care, a case conference or performance review

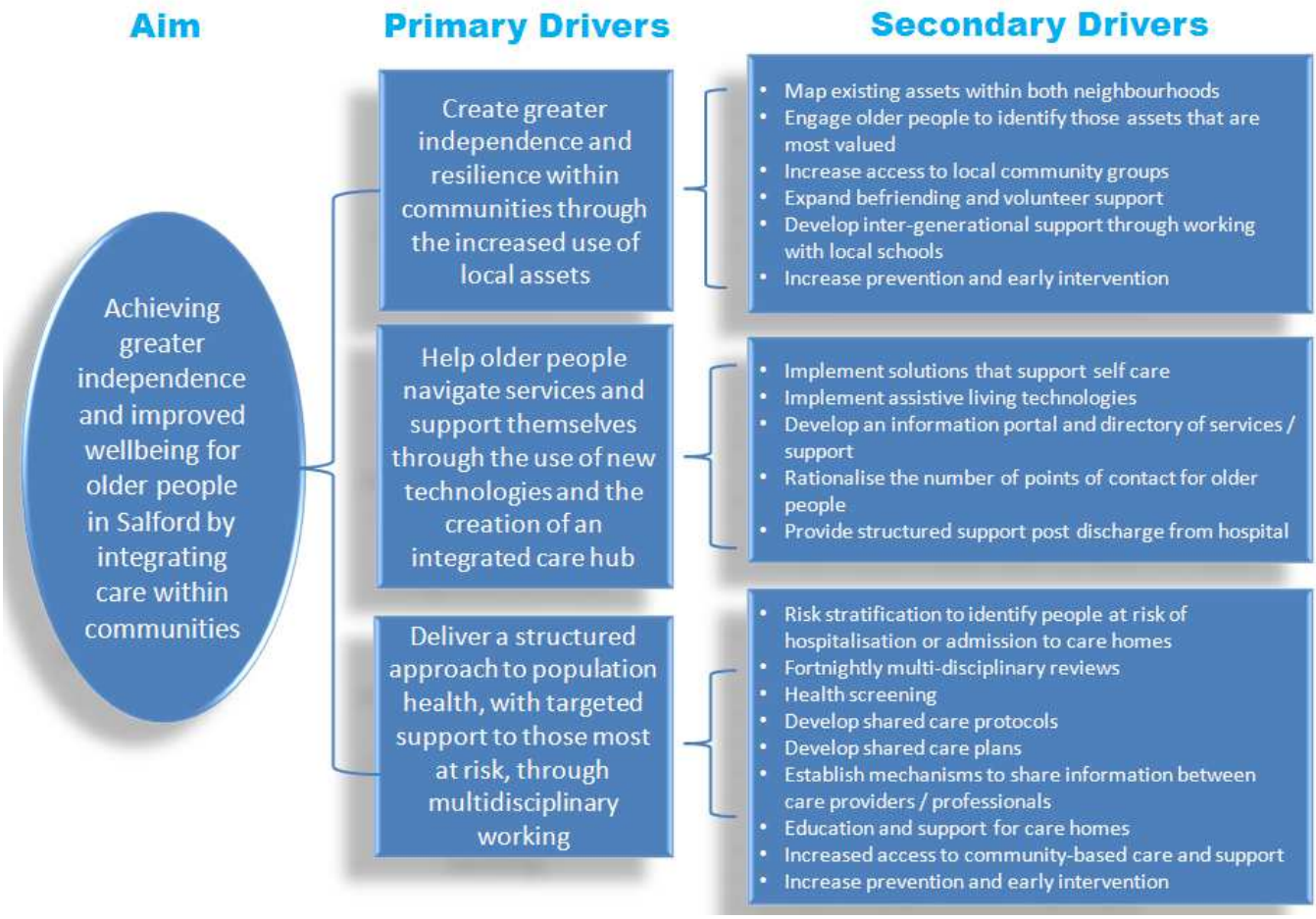
Appendix F

SENIOR FRIENDLY COMMUNITIES PROJECT

1. Salford has agreed to participate in a proposed European Union 'Senior Friendly Community' (SFC) project, as part of an international Project Consortium. The project is in response to a European Commission call for research initiatives that address chronic diseases and promote healthy ageing.
2. The ambition is to turn the 'threat' associated with ageing (increasing elderly population, associated burden of disease and cost) into a positive feature for society, creating socially inclusive communities that promote a healthy lifestyle and reintegrate older people into society. There are some similarities to the concept of dementia friendly communities and age friendly environments.
3. If approved by the European Commission, the SFC project will start in January 2014 and run for three years. The purpose of the project is to identify, develop and test best practice – applying this within the participating communities – and then develop guidelines for other EU member states.
4. The Project Consortium is being led by EuPrevent; a public health organisation in the 'Meuse-Rhine Euregion' which has responsibility for the five neighbouring regions/provinces that border Belgium, Germany and the Netherlands.
5. The project includes 42 separate communities in 14 EU countries: Austria, Belgium, Czech Republic, Estonia, Germany, Greece, Hungary, Ireland, Italy, Lithuania, Netherlands, Poland, Spain and the UK. The three communities in the UK are Salford, Liverpool and Cambridge.
6. The project has seven work packages: (1) Coordination of the project; (2) dissemination of learning from the project; (3) Evaluation of the project; (4) Mapping and analysing good practice; (5) Developing best practice indicators and guidelines; (6) local community pilots; and (7) fine tuning, conceptualisation and sustainability.
7. EuPrevent will lead work packages 1-3, with the University of Maastricht supporting packages 4-5. Salford has provisionally agreed to lead work package 6, supporting and facilitating the local community pilots. It is proposed that this is undertaken by Salford's Haelo Centre (formerly the Centre for Health and Healthcare Improvement).
8. In addition to coordinating the EU community pilots, Salford would participate as a community in its own right, with this work aligned to the Integrated Care Programme for Older People and, in particular, the local assets workstream. This will enable Salford to learn from, share and develop best practice with other EU member states.
9. The project includes funding to cover the direct costs of participating (e.g. attending EU workshops) and the costs associated with leading work package 6 (for which some dedicated posts will be required). It is anticipated that the European Commission will make its decision in June 2013, as to whether the SFC project is approved.

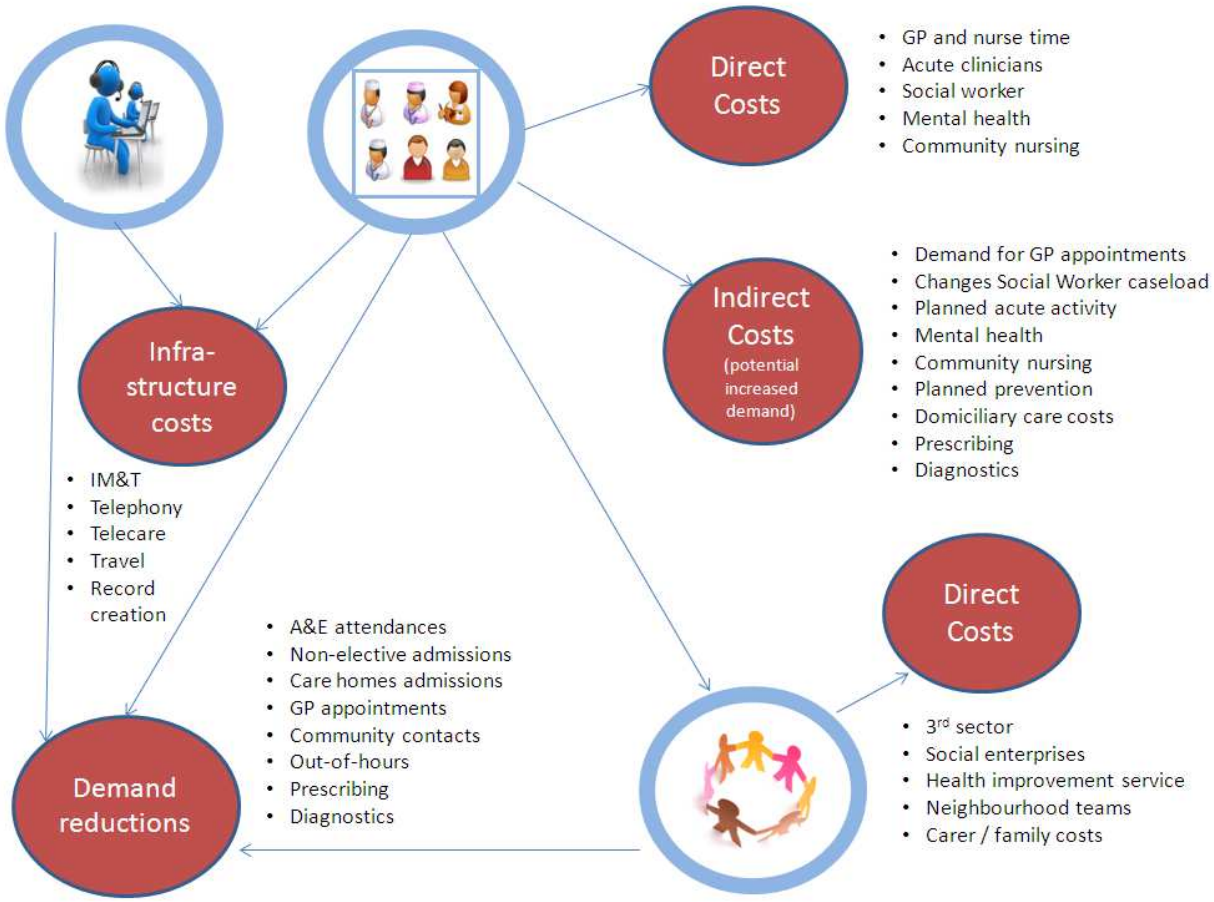
Appendix G

DRIVER DIAGRAM FOR COLLABORATIVE



Appendix H

INITIAL MAPPING OF POTENTIAL COSTS AND SAVINGS



Appendix I

NIHR CLASSIC BID

Summary of Research

The Salford Integrated Care Programme (ICP) is a large scale transformational project to improve care for older people with long-term conditions and social care needs in Salford. SICP will deliver improved care through 3 core mechanisms:

- Improved access to community resources and targeted support for self-management
- Better integration of care through multidisciplinary health and social care groups providing structured, population based care.
- Introduction of an 'Integrated contact centre' to support navigation and self-management

The Comprehensive Longitudinal Assessment of Salford Integrated Care (CLASSIC) is an evaluation framework designed to provide a rigorous test of the ability of the ICP to deliver:

- Improved user/carer experience
- Improved well-being and quality of life
- Reduced costs of care and improvements in cost effectiveness

Design

The evaluation framework we are adopting to assess the impact of the SICP is a variant of the cohort multiple randomised controlled trial. In this design, a large cohort is recruited and followed systematically over time, with subgroups of the cohort used to evaluate different interventions.[1]

CLASSIC will recruit a cohort of older people (65+) with long term conditions (N=4000) in Salford prior to introduction of the SICP, sampling patients with varying numbers and types of long-term conditions to ensure representation of older people at all levels of the Kaiser pyramid, and including people with varying social care needs.

Participants will be followed up every 6 months over the lifetime of the project, using brief measures of service experience, self-management, health and social care outcomes and health and social care utilisation. Measures will be linked to routine data in the Salford Integrated Record (a combined GP and hospital data set) to provide data on clinical parameters, medication use, and interactions with NHS and social care services.

We will also conduct in depth qualitative work in the cohort to support our research themes (see below). Cohort members will provide consent to be contacted about other CLASSIC sub-studies. Establishing the cohort will facilitate recruitment by allowing proactive contact with older people.

Evaluation in the cohort

We plan four types of evaluation in CLASSIC:

- population level (to assess the effect of the SICP on overall population experience, self-management and outcomes over time);

- cluster level (implementation of some aspects of the SICP will be tested first in a smaller number of practices or neighbourhoods in a 'staged' manner)
- individual level (there will be potential to allocate individuals to certain components of the SICP, such as 'health coaching' (i.e. proactive telephone support for self-management), to allow a rigorous estimate of the contribution of individual components
- external comparators: there will be additional comparisons with sites and cohorts outside Salford, as part of a large package of evaluation, using routinely available data on service experience, health care utilisation, and mortality

Core research themes

As well as the overall assessment of effectiveness and cost effectiveness of the SICP described above, we have identified 4 core research themes. These will provide a focus for generaliseable findings with enduring policy significance for the wider NHS and public sector, enhancing value for money. They reflect major strengths of the University of Manchester research team.

- *'The engaged population' (self-management)*

A core focus of the SICP is using self-management to improve outcomes and reduce costs. However, the NHS has faced challenges in turning the potential benefits of self-management into demonstrable gains.

We will use our extensive experience of the delivery and evaluation of self-management interventions[2-6] to explore the ability of the SICP to deliver change in self-management through multiple mechanisms (community resources, health coaching, and appropriate information technology).

- '*Hearts and minds' (integrating care for physical and mental health)*

Depression is prevalent in older people with long-term conditions and the combination of long-term conditions and depression is a critical driver of outcomes in this population.[7]

We will draw on our expertise in the design and evaluation of self-management interventions for mental health[8,9] and on collaborative, multidisciplinary care models to enhance care for depression and distress in people with long term conditions,[10-12] building on work done in the Greater Manchester CLARHC.

- *'Future care' (e-health)*

One of the contextual factors supporting the SICP and CLASSIC is the existence of the Salford Integrated Record, which provides staff with access to information from GP and hospital systems, and provides researchers with a comprehensive database.

We will explore the ability of information systems to support better integration of care, to monitor safety, and to provide feedback on implementation of the SICP. Such feedback has been identified as a key driver of success of large scale transformational efforts.[13] We will take a system-wide informatics perspective.[14]

- *'Drivers of change' (commissioning and incentives)*

Commissioning through clinical commissioning groups is a key driver of service change[15] and CLASSIC will explore how the new groups respond to the SICP. The team has experience in the analysis of commissioning (www.prucomm.ac.uk/).

Alignment of financial incentives with quality improvement is key and the team has evaluated incentives for quality including QOF,[16] Advancing Quality, CQUIN and Best Practice Tariffs.[17] We will examine how the SICP alters incentives, either unintentionally (e.g. budget sharing) or intentionally (e.g. through payment schemes). After the initial assessment and implementation stage, the Board of the SICP have expressed enthusiasm for piloting new incentive schemes as a way of encouraging spread and sustainability.

Reference List

1 Relton C, et al. Rethinking pragmatic randomised controlled trials: introducing the 'cohort multiple randomised controlled trial' design. *BMJ* 2013;**340**:

2 Blickem C, et al. A randomised controlled trial of the clinical and cost-effectiveness of BRIGHT (Bringing Information and Guided Help Together) intervention for the self-management support of people with stage 3 chronic kidney disease in primary care: trial protocol. *Trials* 2013;**14**:28

3 Kennedy A, et al. The effectiveness and cost effectiveness of a national lay led self care support programme for patients with long-term conditions: a pragmatic randomised controlled trial. *J Epidemiol Community Health* 2007;**61**:254-261.

4 Bower P, et al. A cluster randomised controlled trial of the clinical and cost-effectiveness of a 'whole systems' model of self-management support for the management of long- term conditions in primary care: trial protocol. *Implementation Science* 2012;**7**:7

5 Burt J, et al. Prevalence and benefits of care plans and care planning for people with long-term conditions in England. *Journal of Health Services Research & Policy* 2012;**17**:64-71.

6 Sanders C, et al. Exploring barriers to participation and adoption of telehealth and telecare within the Whole System Demonstrator trial: a qualitative study. *BMC Health Services Research* 2012;**12**:220

7 Moussavi S, et al. Depression, chronic diseases, and decrements in health: results from the World Health Surveys. *Lancet* 2007;**370**:851-858.

8 Gellatly J, et al. What makes self-help interventions effective in the management of depressive symptoms? Meta-analysis and meta-regression. *Psychol Med* 2007;**37**:1217-1228.

9 Lovell K, et al. Developing guided self-help for depression using the Medical Research Council complex interventions framework: a description of the modelling phase and results of an exploratory randomised controlled trial. *BMC Psychiatry* 2008;**8**:

10 Coventry P, et al. Collaborative Interventions for Circulation and Depression (COINCIDE): study protocol for a cluster randomized controlled trial of collaborative care for depression in people with diabetes and/or coronary heart disease. *Trials* 2012;**13**:139

11 Archer J, et al. Collaborative care for depression and anxiety problems. *Cochrane Database of Systematic Reviews* 2012;Issue 10. Art. No.: CD006525. DOI: 10.1002/14651858.CD006525.pub2:

12 Richards D, et al. Collaborative Depression Trial (CADET): multi-centre RCT of collaborative care for depression - study protocol. *BMC Health Services Research* 2009;**9**:188

13 Best A, et al. Large scale transformation in health care: a realist review. *Milbank Quarterly* 2012;**90**:421-456.

14 Buchan I. Informatics for Healthcare Systems. In: K Walshe, J Smith, eds. *Healthcare Management*. London: Open University Press, 2011;

15 Checkland K, et al. Commissioning in the English National Health Service: What's the Problem? *Journal of Social Policy* 2012;**41**:533-550.

16 Campbell S, et al. Effects of pay for performance on the quality of primary care in England. *N Engl J Med* 2009;**361**:368-378.

17 Sutton M, et al. Reduced mortality with hospital pay for performance in England. *N Engl J Med* 2012;**367**:1821-1828.