Development of an Integrated Care Organisation
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Salford

One of 10 boroughs of Greater Manchester
- Population of 239,000
- Area of major growth economically and demographically
- Increasingly diverse population
- High level of deprivation in the City
- Diverse communities forming, established orthodox Jewish community

City of contrasts
- Predominately urban
- Areas of extreme wealth and extreme deprivation and poverty
- Extremes of health inequality
- Population growth, but unusual demographics
- Smoking, alcohol-related harm and lack of physical activity are key determining factors for poor health
Comparison with England

The diagram compares the distribution of residents across deprivation levels in England and Salford. The bars are color-coded:

- Blue: 1 - Most deprived
- Light Blue: 2
- Dark Blue: 3
- Light Grey: 4
- Light Blue: 5 - Least deprived

The percentage of residents is shown on the y-axis, ranging from 0% to 100%. The x-axis represents the categories 'England' and 'Salford.'
Salford Together - Background

Salford Together Partnership
- Strong partnership working
  - Salford CCG
  - Salford City Council
  - Salford Royal NHS Foundation Trust
  - Greater Manchester West Mental Health NHS Foundation Trust
  - General Practice
- Integrated Care Programme for 65+ population
- £112m Pooled Budget for 65+
- Governed by Alliance Contract
- Underpinned by 2014-18 Service and Financial plan (inc. BCF)

Key Features
- Co-terminus services
- Good relationships, alignment of effort & strategic intent
- Shared vision – population health improvement
- Potential to deliver more services in the community
- High need population groups requiring active case management
Joint Health and Social Care approach

- GM Devolution
- Financial context
- Salford’s Locality Plan
  - Starting Well
  - Living Well
  - Ageing Well
- NHS England Vanguard Status
- Alliance Board – Integrated Care for Older People
- Increasing focus on geographical neighbourhoods
- Increasing involvement of General Practice
Salford Locality Plan:
Our vision for a healthier future

Rationale, context, shared vision
- Integrated commissioning
- Co-production and social value
- IM&T
- Estates
- Workforce
- Innovation
- Public Engagement

The Life Course: Starting, living and ageing well
- Quality of care
- Transforming primary care
  - **Integrated care**
  - Hospital care
  - Long term conditions
  - Mental health

Governance, leadership, management

Transformation workstreams
- Enabling
- Better Care
- Prevention

Delivering
Improved outcomes and experience, with specific set of measures
Financial sustainability, tackling 2021 ‘do nothing’ gap

- Social movement for change
- Place-based working
- Best start in life
- Promoting healthy lifestyles
- Screening and early detection
- Wider determinants of health and wellbeing
Case for Change

• Status quo is unaffordable and unsustainable, outcomes poor
• Economic risks and benefits not equitably shared by partners

• Integrated care solutions are more cost-effective than the status quo
• Integrating care is essential to improving the health and wellbeing of the population
• Three categories of £ benefit
  – Reduction in admissions (hospital, care homes)
  – Removal of duplication and fragmentation
  – Reducing future demand

• £ benefits need be set against
  – Cost of new delivery models
  – Growth in population and associated demand
  – Existing savings plans
• Integrated care creates costs before it generates savings

• Shift focus from institutional settings
• Not a quick fix but the most credible and sustainable solution
• Support and mitigate adverse consequence of cost reductions

• New contractual and financial arrangements will be required
  (section 75 / Alliance Agreement / Prime provider)
• Effective integration of services and systems
• Highest quality, safest, most productive care system
Care Model – Older People

1. Local community assets enable people to remain independent, with greater confidence to manage their own care

2. Centre of Contact acts as an central health and social care hub, supporting Multi Disciplinary Groups, helping people to navigate services and support mechanisms, and coordinating telecare monitoring

3. Multi Disciplinary Groups provide targeted support to people who are most at risk and have a population focus on screening, primary prevention and signposting to community support

4. Care Homes standards

Promoting independence for adults and older people
- Better health and social care outcomes
- Improved experience for services users and carers
- Reduced health and social care costs
Integrated care enablers

- Population risk stratification and care standards
- Measureable joint outcomes
- Alliance Contract
- £112m pooled budget
- Service and Financial Plan 2014-18
- Academic Longitudinal evaluation
Building on Integrated Care Programme

- Issues and solutions are not unique to older people
- Significant growth in long term conditions – worst decile for related outcomes
- Greater scale required to deliver system-wide impact
- Upstream focus to secure population health benefit

All Adult population
185,000

Long Term Conditions

Older people
35,000
## Three stage approach

<table>
<thead>
<tr>
<th>Stage</th>
<th>CORE COMPONENTS</th>
<th>STAGE 2 (2015-17)</th>
<th>STAGE 3 (2017 – )</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ICP for Older People</td>
<td>MDGs, Community Assets, Centre of Contact, Care Homes standards</td>
<td>• Extend core care model to adults</td>
<td>• Long term conditions redesign</td>
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<tr>
<td></td>
<td>Alliance Agreement and Pooled Budget</td>
<td>• Enhance adult strategies – mental health, carers</td>
<td>• Fully embedded neighbourhood model</td>
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<td></td>
<td></td>
<td>• Pilot locality model</td>
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<tr>
<td>2. ICP for Adults</td>
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<tr>
<td>3. Integrated Neighbourhood Model</td>
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### Key Enablers

- Alliance Agreement and Pooled Budget
- Revised system wide governance and accountability arrangements
- Extend Pooled Budget to Adults
- Provider Workforce Planning & Redesign
- Integrated Care Organisation
- Estates
- IM&T
- Capacity for Change
- Evaluation
- Communications and Engagement
Alignment with GM transformation

1. ICP for Older People
2. ICP for Adults
3. Integrated Neighbourhood Model

Alignment with GM ‘Local Care Organisation’ model

- Enable conditions to be managed at home and in the community
- Provide alternatives to A&E when crises occur
- Support effective discharge from hospital
- Help people return home and stay well

GM Devolution Transformation Workstreams

1. Radical upgrade in population health prevention
   - A move towards population health that supports GM residents to self-manage, innovate the model for prevention and pharmacies, and focuses the future vision of cardiovascular disease and diabetes.

2. Transforming community-based care & support
   - A new model of care delivery for home that includes scalable evidence-based models for integrated primary, acute, community, mental health and social care. Key features will be: hospital-based intervention, the population most in need delivered by a clinical and occupational therapy team, together with streamlined clinical pathways in order to reduce the demand placed on acute hospitals.

3. Standardising acute & specialist care
   - The creation of “single shared centres” for acute services and specialist services to deliver improvements in patient outcomes and productivity, through the establishment of consistent and best practice specifications that decreases variation in care, enabled by the standardisation of information management and technology.

4. Standardising clinical support and back office services
   - The local and national delivery of clinical support and back office services at scale across GM, including the establishment of coordination centres to help navigate GM residents through our complex system to the right services.

5. Enabling better care
   - The creation of innovative organisational forms, new ways of commissioning, contracting and payment design and standardised information management and technology to incentivise ways of working across GM, so that our ambitious aims can be realised.
Care Model development for Adults

Central Themes
- Engagement, activation and asset building
- Risk stratification, assessment, care coordination and navigation
- Enhanced Care
- Enabling Changes

Life Course Model
- Live well (18-64)
- Age Well (65+)

Citizen and staff engagement
- Deeply engaged neighbourhoods, supported to be self caring through community assets, well being plans and health and social care advice and navigation
  - Proactive personalised MDT support and care navigation
  - Improved access to and response from services
- Needs some help / needs more help
  - Urgent care / crisis response and reablement
  - Case management, planned transitions crisis response
- Needs a lot of help

System
- Workforce redesign
- Population health management
- Salford integrated record
- Assistive technology
- Quality and safety focus

Structure
- Integrated commissioning
- Integrated Care organisation
- Integrated provision
- GP provider neighbours

Enablers

Adult population stratification
Co-ordination and Navigation
## Population Segmentation

<table>
<thead>
<tr>
<th>Adult population 180,000</th>
<th>Initial segmentation</th>
<th>Vanguard Programme</th>
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</thead>
<tbody>
<tr>
<td><strong>Level 1</strong></td>
<td><strong>Supported self care</strong>&lt;br&gt;- Neighbourhood-based&lt;br&gt;- Engagement&lt;br&gt;- Community assets&lt;br&gt;- Health and social care advice</td>
<td><strong>Engagement, Activation and Asset Building</strong>&lt;br&gt;- Strategic engagement plan&lt;br&gt;- Co-production of care plans and care pathways&lt;br&gt;- Social marketing&lt;br&gt;- Community assets</td>
</tr>
<tr>
<td>Able adults&lt;br&gt;60-70%</td>
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<td><strong>Level 2</strong></td>
<td><strong>Enhanced care and support</strong>&lt;br&gt;- Proactive multi-disciplinary planning and support in neighbourhoods&lt;br&gt;- Co-production of care pathways and care plans&lt;br&gt;- Improved and personalised access and care navigation&lt;br&gt;- Urgent care</td>
<td><strong>Risk Stratification, Assessment, Care coordination and Navigation</strong>&lt;br&gt;- Risk stratification&lt;br&gt;- Multi-agency triage and vulnerable person protocol&lt;br&gt;- Centre of Contact, Multi-disciplinary groups, key workers&lt;br&gt;- Connectivity – electronic person-held records, care homes</td>
</tr>
<tr>
<td>Adults needing some help</td>
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<tr>
<td><strong>Level 3</strong></td>
<td><strong>Vulnerable adults</strong>&lt;br&gt;- Integrated protocol to support vulnerable adults&lt;br&gt;- Multi-agency identification of triggers&lt;br&gt;- Proactive engagement and case management&lt;br&gt;- Planned transition&lt;br&gt;- Rapid support</td>
<td><strong>Enhanced Care</strong>&lt;br&gt;- Proactive multidisciplinary support&lt;br&gt;- Improved access to services&lt;br&gt;- Urgent care</td>
</tr>
<tr>
<td>Adults needing more help&lt;br&gt;30-40%</td>
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<tr>
<td><strong>Level 4</strong></td>
<td></td>
<td><strong>Enabling Changes</strong>&lt;br&gt;- Strategic workforce plan&lt;br&gt;- Salford Integrated plan&lt;br&gt;- Salford Integrated Record&lt;br&gt;- Population health management&lt;br&gt;- Quality Improvement&lt;br&gt;- Leadership and capacity</td>
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Integrated commissioning

Integrated health and social care commissioning and system governance

• Joint governance - SCCG and SCC members
• Aligned framework of standards for provision – Salford Standard
• Joint commissioning and contracting with Integrated Care Organisation
• Pooled budget for adult services – c. £246m (to be confirmed at Full Business Case)
Proposed joint governance structure

Integrated Care System Governance Infrastructure

SRFT Board of Directors
- GMW Board of Directors

Salford Health and Wellbeing Board
- Oversee Locality Plan
- Oversee Integrated Care System

Salford Council – City Mayor & Cabinet
- Sets high level strategy & outcomes
- Approves contribution to pooled fund
- Approves Section 75/Contract
- Retains statutory responsibility
- Receives assurance reports

NHS Salford CCG Governing Body
- Sets high level strategy & outcomes
- Approves contribution to pooled fund
- Approves Section 75/Contract
- Retains statutory responsibility
- Receives assurance reports

Advisory Board for Integrated Care
- ICS and ICO Adult Health and Care
- Engagement of ICO and ICS stakeholders
- Advisory in relation to:
  - Service strategy
  - Service design
  - Annual Programme Plan
- Decision making in relation to:
  - Vanguard
  - Other elements on a case by case basis that are agreed by each of the four partner organisations

Integrated Adult Health and Care Commissioning Joint Committee
- Adult Health and Care Pool including ICO
- Commissioner Group (City Council & CCG)
- Membership to include GPs and SCC Members
- Service & Financial Plan (Commissioning Plan Integrated Care System & ICO)
- Decision Making Body (Up to £1m) in relation to:
  - Service strategy
  - Service design
  - Annual Programme Plan
  - Market Management
- Management of System & Performance

Service Development and Finance Group
- Officer Group (Commissioner only)
- Review of Business Cases

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Moving from ICP to ICO

Context
- Good relationships, strong alignment of effort and strategic intent
- Shared vision – population health improvement by promoting personal independence and community resilience
- Evidence based model
- Deliver more services in the community
- High need population groups requiring active case management

Current position
- Strategic Outline Case (November 2014)
- Outline Business Case (December 2015)
- Full Business Case agreed April 2016 and ICO implementation July 2016

ICO Benefits
- Full range of services within a single management arrangement – more effective, efficient and coordinated care
- Collaborative environment without the need for new organisational forms
- Aligns interests of commissioners and providers, removing organisational and professional ‘silos’ that contribute to fragmented and sub-optimal care
- Collective ownership of opportunities and responsibilities; any ‘gain’ or ‘pain’ is linked to performance overall
- Supports a focus on outcomes and incentivises better management of population demand
Integrated Care Organisation

- NHS Foundation Trust as integrating ‘vehicle’
- ICO as prime provider – delivery and subcontracting responsibility for community health, acute care, social care, mental health services
  - c. £134m primary, community and acute services (SRFT)
  - c. £84m adult social care services (SCC)
  - c. £29m adult and older adult mental health services (GMW)
- Single health and social care contract – NHS Standard Contract
- Platform to test and further develop integration – primary care, capitation models
Key Enablers

- Population risk stratification in neighbourhoods
- Salford Integrated Record - primary, community, acute and mental health and social care
- Strategic Workforce Plan - addressing system workforce deficits and supporting new ways of working
- Cultural support and transformational capacity