Evaluation of the Integrated Care Communities 2 Programme (incorporating learning from the Integration Discovery Community)

Economy case studies

Annex report B to the Advancing Quality Alliance (AQuA)
June 2014
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Introduction

The Advancing Quality Alliance (AQuA) is a health care quality improvement body based in the North West of England. AQuA is funded by its members, who include Foundation Trusts, Mental Health Trusts, Local Authorities and Clinical Commissioning Groups (CCGs).

In April 2013 AQuA commissioned the Office for Public Management (OPM) to evaluate its Integrated Care Community 2 (ICC2) programme; the remit was subsequently expanded to incorporate learning from the Integration Discovery Community (IDC) programme.

This Annex report presents a set of 10 economy case studies drawing on insights captured during the three waves of data collection. It is intended to be read alongside the overall evaluation report.

IDC and ICC2 Programmes

The IDC programme commenced in November 2011 and was extended to run until 31 March 2014. The programme was jointly designed and delivered by AQuA and The King’s Fund, with the aim of supporting members in ‘discovering’ how the theory of integrated care can be applied in different economies. The programme commenced with eight participating economies; four remained engaged up to the end of the programme and formed part of this evaluation. The participating economies have co-developed AQuA’s System Integration Framework. These four IDC economies are Salford, Central Manchester, East Cheshire and Oldham.

The IDC programme was always intended to serve as a pilot for applying a concept to practice, and the participating economies helped to inform tool and programme development.

The ICC2 programme formed the second cohort, building on the work commenced by the IDC economies. This 18 month programme also ran until March 2014, and twelve economies successfully applied to take part. The ICC2 economies that remained engaged in the programme and took part in this evaluation (either throughout or at various stages) are: Liverpool, South Sefton Formby and Southport, Wigan, Warrington, Wirral, Vale Royal and South Cheshire, Stockport, East Lancashire and Pennine. In addition, Bolton re-engaged with the programme during the final few months, although they did not take part in this evaluation.

The economies did not receive funding from AQuA. All applications came from AQuA members, and all had different starting points, approaches and levels of progress.

There has intentionally been no previous formal evaluation of the IDC Cohort, and there has also been no formal audit of what The King’s Fund delivered by way of support to either the IDC or ICC2 economies.
Introduction to the case studies

This Annex report contains a set of 10 economy case studies (four IDC economies and six ICC2 economies). Each case study is themed around one or two of eight domains derived from AQuA’s System Integration Framework. These are: Leadership; Governance; Culture; Service User and Carer Engagement; Financial and Contractual Mechanisms; Information and IT; Workforce; and Service Redesign.

The case studies draw on insights gathered from three waves of data collected between May 2013 and April 2014. Data collection included semi-structured interviews and focus groups with economy leads / project managers and key stakeholders. Relevant documentation such as presentations, strategy documents and reports were provided by some economies and fed into the case studies. A full description of the evaluation methodology is outlined in the main evaluation report.

Caveats to the case studies

These case studies are intended to provide in-depth insight into the approach, activities, achievements, and key learning for each economy. However, as each case study is focused around one or two integration domains only, they should not be taken as a comprehensive overview of all activities undertaken.

Furthermore, the economies did not participate in the evaluation equally, and several did not engage at all during various different waves of data collection. This means that the volume and quality of data across the case studies varies. Readers should also note that we engaged with a range of stakeholders at different levels in different economies, including frontline staff, clinicians and senior executives and as such the case studies represent the perspective of interviewees which may not be shared by all within the economy.
Leadership

Summary

The Central Manchester economy serves a diverse population with a young age profile, high levels of deprivation, and low life expectancy. The partners in the economy had an established track record of working together at system level, and joined the Integrated Discovery Community (IDC) to complement and enhance their existing programme of work.

Central Manchester’s vision is to deliver an integrated model of care to support the most vulnerable members of the local community, so that no one is in a hospital that doesn’t need to be. There are several strands to the programme including multidisciplinary teams (MDTs), integrated care pathways and end of life care.

Central Manchester benefits from stable leadership, with previous experience of working together enabling leaders to build on existing trusting relationships. The next stage for the partnership is to build these relationships into a more structured and purposeful approach through Organisational Development (OD).

Each of the integration programmes have produced positive outcomes to date, and have therefore been supported by the partnership for wider roll out. One example is the multidisciplinary Practice Integrated Care Teams: 26 out of 35 practices in the economy are now using the developed model, with an aspiration for all practices to be engaged during the remainder of 2014.

The partners have learnt many valuable lessons along their journey. When developing partnerships among leaders, maintain good relationships and a cultivating a shared aim have been essential.

Background

The Central Manchester economy serves a diverse population. Compared to the rest of England, the population has a young age profile, high levels of deprivation, and lower life expectancy. There is a high prevalence of people living with chronic illness, which is a major contributor to the life expectancy gap between Manchester and England as a whole, and places high demand on primary, acute, community and urgent care services.

Prior to joining AQuA’s IDC, the partners in Central Manchester had an established track record of working together at system level, including the formation of a Clinical Integrated Care Board (CICB) in 2010. This Board leads a multi-agency integrated programme of work focusing on the redesign of planned and urgent care and the transformation of community services. In 2011 community services management transferred to the acute hospital, providing further opportunity to co-ordinate care across
The relationships and trust that the partners had developed in the course of this work created a strong platform from which to take forward their plans for integration.

In 2011 the economy joined the AQuA IDC in a partnership comprising of the Central Manchester University Hospitals NHS Foundation Trust (CMFT) the Central Manchester Clinical Commissioning Group (CCG), Manchester City Council, the Mental Health and Social Care Trust. The partnership hoped that joining the IDC would complement and enhance their existing programme of work, by drawing on the experiences and expertise of AQuA, The King’s Fund and other members of the Discovery Community.

Activities and Approach

Vision

Central Manchester’s vision is to deliver an integrated model of care to support the most vulnerable members of the local community, so that no one is in a hospital that doesn’t need to be. The programme initially focused on a cohort of patients aged 65 and over who were at highest risk of being admitted to hospital. However, as they progressed their approach expanded to look at the broader population of adults at high risk of admission, and children with complex needs.

The model for integrated services

The IDC model for integrated care consists of several programmes including:

| Practice Integrated Care Teams | A multi-disciplinary team (MDT) based around a general practice. The MDT meets regularly and builds up caseloads, calling on specialist input as and when required. Each patient develops his or her own personal care plan with the support of a keyworker. |
| Intermediate Care Assessment Team | A MDT provides assessments to people who have fallen in the community and puts in a package of intermediate care to keep them out of hospital wherever possible. Referrals are mainly received via the North West Ambulance Service (NWAS). |
| End of life care | A programme targeting end of life care in three residential homes, with the aim of supporting people to die in their preferred place. The programme offers training packages to residential care home staff to increase their knowledge of end of life care and facilitate end of life care planning. |
| Integrated care pathway for Chronic obstructive pulmonary disease (COPD) | Piloted in one general practice and then rolled out in two areas with high prevalence of COPD, the pathway applies a multidisciplinary case management approach to patients most at risk of deteriorating from COPD, creating individualised multi-disciplinary care plans. |
Risk stratification

The IDC takes a dual approach to identifying people who are at a high risk of admission to hospital by using both a risk stratification tool and referrals from community services, such as homelessness services and drug and alcohol teams:

“We realised that ‘high risk’ wasn’t a population group in itself, and within that there were population groups that were more identifiable such as people who are homeless, or drug and alcohol users.”

Developing partnerships

The partnership started with the CMFT, Central Manchester CCG, and Manchester City Council, and has since grown to include primary care, mental health, social care and NWAS. More recently the partners have been joined by the Carers Forum, in recognition of the role that carers play in supporting people in the community. There are further organisations that the partners hope to engage with in the future, such as local universities.

The economy has not applied any set approach or framework to the development of their partnership; rather relationships have developed organically through previous programmes of work.

“It’s absolutely been about developing relationships at different levels and then gluing them together around a shared purpose.”

The next stage for the partnership is to build these relationships into a more structured and purposeful approach. Organisational development (OD) sessions have been a useful tool to develop relationships within teams, focus thinking around shared aims, and reflect on organisational behaviours:

“The [OD] sessions as a team have been focusing on developing a wider ‘public sector’ focus, rather than just health and social care. Thinking about how we can bring in wider partners and create a bigger platform for that, linking to the north and the south.”

At this economy, having a strong leadership group with a good working dynamic has been critical to the success of their partnership working. While each individual represents their own organisational interests, they have fostered an environment where it is acceptable for disagreements to be discussed, meaning that “issues are aired, and not brushed under the carpet.”

Their experience has highlighted a number of ongoing challenges regarding the formation and maintenance of partnerships. Two factors have needed to be considered along the way:

1. The differing characteristics of partner organisations such as organisational size, scope (including the boundaries across which they operate), and
leadership personalities. Forming partnerships across a whole city is complex. The north, south and central systems in the economy are very different, and internally each organisation has multiple strategic agendas and leadership personalities. Work therefore has to be undertaken in each economy first before taking it forward in a city-wide model.

2. At times, the integration project will create pressure for leaders in managing both their own organisation’s needs and the common agenda across agencies. In commissioning for example, a saving in cost to a commissioner equates to a loss of income to one or more providers.

Achievements

Each of the integration programmes has produced positive outcomes and therefore been supported by the partnership for wider roll out. The outputs and outcomes achieved to date are presented below.

| Practice Integrated Care Teams | Having rolled out the Practice Integrated Care teams over 4 waves, 26 out of 35 practices in the economy are now using the developed model, with an aspiration for all practices to be engaged during 2014. |
| Intermediate Care Assessment Team | There have been 626 referrals and 443 assessments to date. The proportion of patients who ‘step up’ from the home into the community has increased from 30% to 40%. |
| End of life care | After one year within three residential care homes the number of people dying is hospital was reduced from 55% to 5%. There are plans to roll this programme out to all care homes in the area, and eventually to people living in private residences. |
| Integrated care pathway for COPD | Results from the pilot were positive with a high proportion of COPD exacerbations being managed in the community without triggering a hospital admission. Funding was secured to upscale the pilot to other localities. There are however challenges in interpreting results due to the seasonality of the condition. |

Although it is not possible to attribute to the work undertaken, an overview of impact data reveals that the economy now has the same level of emergency admissions as in 2008, having seen year on year growth previously. The economy programme is funded on a recurrent basis until a time when they can demonstrate a positive financial impact. They partners are currently in the stages of identifying a control group to enable them do this, although the changing regulations around patient data and balancing expense and methodological robustness have slowed down the process.
Since joining the AQuA IDC Programme, the partners now work with neighbouring economies to implement integrated care across the city-wide system.

**Key Learning**

1. **Don’t ignore the role of the voluntary sector and carers and their potential to enhance integrated care:** The partners are taking steps to better integrate with the third sector over the next five years in order to fully achieve the vision. They are also conscious that carers (both formal and informal) form the largest workforce supporting people at risk of admission, and therefore need to be engaged with and supported.

2. **Getting the buy-in from senior and clinical leaders has been key:** This has helped to prioritise the project within each organisation and create joint ownership and shared risk. It is vital that messages are communicated at all levels by “people who can articulate a very complex vision in a simple way”.

3. **Get the Health and Wellbeing Board (HWB) to take ownership of the project:** Having governance structures that sit underneath the HWB has been invaluable in pulling the system together in one direction, and ensuring strategic alignment.

4. **Even with clear reporting and oversight arrangements in place, governance is an ongoing programme of work:**

   “We can’t just say ‘we have done governance’ and tick it off, it’s about exploring what the relationships mean, have we got the right people, how do we develop strategy. So although [our governance arrangements are] very good, it’s not static.”

5. **Maintain good relationships and a shared aim:** At times, the integration project creates pressure for leaders in managing both their own organisation’s needs and the common agenda across agencies. A key learning point to emerge has been to allow sufficient time for leaders to understand one another’s organisational priorities, and how these relate to the shared vision.

6. **Outcomes set by commissioners, services designed by providers:** In this economy frontline staff were instrumental in designing and implementing the integrated services. In addition, the Practice Integrated Care Teams were rolled out in a staged approach to facilitate learning and re-design after each phase, enabling learning to feed into the broader programme of work.

7. **Keep the individual and their quality of life at the heart of the process:** Identifying and focusing on the benefit for the patient/resident/client (the terminology across organisations is different but a common understanding has been realised) has been a good approach. In the current climate, finance will
always be a focus, but focusing on the individual helps to ensure the quality of care remains at the heart of service re-design plans and activities.

8. **Where possible, try to keep things simple and focused on the needs of the patient:** For example, developing the IT system has been a long and complex process that has faced technological and organisational barriers to progress. On reflection, one partner felt that they may have overcomplicated the process:

“If we go back to just who needs information, and the needs of the patient and carer, we might have done it differently. That’s where the learning is going at the moment, thinking about it as the patient’s information, rather than the organisations.”

9. **Build on what you already have, both in terms of infrastructure and relationships:** In this economy the historic work on governance helped the development of shared information agreements. The partners also found that building on their existing relationships and trust helped maintain the focus and progress of work.

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Case study 2: IDC Oldham’s Integrated Managed Care Model

Financial and Contractual Mechanisms

Summary

The economy recognised the need to improve the way care is delivered, particularly for children, the elderly and those living with long-term conditions, to improve patient outcomes and experience. At the same time, the partners in Oldham have come under pressure to substantially reduce NHS and local authority expenditure.

In response to this need for change, partners came together to deliver the Integrated Managed Care Model (IMCM) developed in 2010. The partners recognised a need to develop their organisational and financial frameworks to support further integration. A major part of this has been the development of an Alliance of providers underpinned by a Memorandum of Understanding (MoU). Expert legal support proved invaluable throughout this process for reassuring partners about risks and benefits.

A series of clinical changes have been implemented over the past 12 months including:
- The development of integrated health and social care teams
- More effective long term condition management within primary care
- The establishment of a falls service and alternative to transfer pilot
- The establishment of a memory service to support more effective management of dementia
- A multi-disciplinary care home model
- A review of discharge pathways.

Throughout this time, Oldham’s community services have also been re-specified and re-procured, and went live on the 1st April 2014.

Emerging evidence shows a decrease in A&E admissions and admissions to residential care, and an increase in deaths at home.

The partners have learnt much throughout this process; integrated care is a long term investment, not a quick fix solution and establishing the financial framework is crucial to the sustainability of integration.

Background

Oldham currently faces a number of challenges around the organisation and delivery of care. Some of these challenges are indicative of the wider economic context, while others are unique to the local population. As in other areas of the country, the economy is facing the dual pressures of increased demand for services and reduced budgets. As in many socioeconomically deprived areas, Oldham has high rates of A&E attendance. The area also has markedly high mortality rates - between 2008 and 2010, 876 residents under age-75 died from conditions amenable to healthcare; 38% more than expected in comparison with the rest of England.
There is notable inequality in healthcare outcomes across the locality, particularly in mortality rates for patients with long-term conditions. The economy recognised the need to improve the way care is delivered, particularly for the elderly and those living with long-term conditions, and to improve equity of access to healthcare. Yet at the same time, the partners in Oldham have come under pressure to substantially reduce expenditure.

In response to this need for change, in 2011 the CCG asked providers to come together in partnership to deliver the Integrated Managed Care Model (IMCM). The programme has focussed on the prevention and management of long-term conditions through primary prevention, early detection and diagnosis, and support for patients to self-manage their conditions and support carers. The longer term aims of the programme are to transform the delivery of urgent care through progressing integration, and reduce hospital admissions through early intervention and appropriate signposting. In order to support the development of the IMCM, in September 2011 Oldham joined the AQuA IDC Programme.

Activities and Approach

A major part of the IMCM has been the development of an Alliance of providers. In 2011, care providers in Oldham including acute, community and social care providers, as well as out of hours services came together to form an Alliance to drive forward health and social care integration. The Alliance worked together to develop joint workstreams covering urgent care, complex care, continuing care, children’s services, mental health, substance misuse and health improvement. Originally, the Alliance focused on the development of clinical pathways, with the workstreams largely driven by clinicians. However, the partners struggled with a lack of contractual framework and performance metrics to provide direction and cohesion to the process. The partners recognised a need to develop their contractual mechanisms to support further integration.

A key step in this process was the development of a Memorandum of Understanding (MoU) and a performance framework, for which the Alliance used their AQuA support days to obtain legal advice from law firm Wragge and Co. Agreeing the terms of the MoU proved challenging, as the different partners were concerned about the risks involved in pooling budgets and any compromises to their statutory accountability. However, with the help of legal advice from Wragge and Co and some organisational development support from the IDC Programme, the partners managed to agree on a performance framework and a governance structure for the Alliance. After six months of discussions and negotiations, the partners were happy with the performance framework, and signed the MoU.

The next step for the Alliance was to establish a formal Shadow Alliance contract. Again, agreeing the details of the contract presented challenges for the partners. As the Alliance arrangement involves working across organisational boundaries, it requires clear articulation of the risk and benefit share, which are still being worked through. Legal support from Wragge and Co again proved invaluable for reassuring partners.
about risks and benefits, and guiding the Alliance through the process of developing a contract.

The process was complicated by the CCG re-tendering for community services whilst the Shadow Alliance contract was being developed. This placed community and acute services in competition with one another for CCG contracts. Organisations became less willing to share information which may have placed them at a competitive disadvantage with one another.

However, with the aid of OD and legal support, the partners were able to agree to a performance framework based on hospital admission rates, social care use, patient experience and end of life care, and have developed an outline Shadow Alliance contract, which is expected to become operational imminently. Existing financial arrangements will remain in place for the duration of the Shadow Alliance contract, but providers will be monitored against the four agreed indicators. The contract also includes £500,000 of incentive payments, payable if the partners achieve the agreed KPIs. The Alliance partners will have the opportunity to distribute this money between themselves or to invest the resources in further developing the programme.

Although the contract is not yet operational, the Alliance model has already proved valuable in bolstering relationships across the care system. If the Shadow contract proves successful, a full Alliance contract is expected to be implemented from 2015-16.

Achievements

A major achievement has been the establishment of a MoU signed by all the partners, which has laid the groundwork for development of the Alliance contract. Most importantly has been the development of relationships between providers. The partnership working has led to better communication between services and sectors, and increased joined up working – which, the partners believe, is already having a demonstrable effect for service users.

Indicators are being monitored to assess the emerging clinical impact of the integration model, including reductions in admissions, reduced mortality and a reduction of placements in long term residential care. Early monitoring of these indicators suggests that the IMCM is having a positive impact on the delivery of care in the area.

In the first year of the programme:

- There was a 1.3% decrease in A&E admissions
- There was a 2.5% increase in deaths at home (an aim of the IMCM was to increase rates of people dying in their place of choice)
- There was a 4.4% reduction in permanent admission to care homes.

The Alliance model has already proved valuable in bolstering relationships across the urgent care system.
Key Learning

1. **Clinical leadership**: The most important aspect of this agenda has been the leadership from clinicians. The experience in Oldham highlights that the agenda needs to be led by clinicians and not managers, with improving patient experience at the heart of the ambition.

2. **The importance of building trusting relationships between different organisations**: It can be extremely challenging to bring together different organisations with different working cultures and accountability frameworks in an environment which involves a level of risk for all parties. It is important to allow sufficient time to cultivate relationships between partner organisations, even where there is past history of joined up working:

   “Don’t underestimate the amount of time it takes for partners to be comfortable with one another, to build up trust in each other and be open with each other.”

3. **It is vital to remain vigilant to issues which might derail fledgling relationships between organisations**: In this economy, re-tendering for community services in the middle of the Alliance contracting process made some parties wary of sharing information with potential competitors. It is important to anticipate these kinds of issues and put measures in place to mitigate them before they arise. Where possible, strategic planning should minimise the risk of potential issues clashing with key contractual and financial processes.

4. **The need for protected time to think and talk about integration**: Stakeholders reflected on the need to provide people with separate time and space to talk about integration:

   “People absolutely do need time and space to think about this stuff. It’s not the kind of thing that you come to at 5 o clock on a Thursday night at the end of your working day. You do need some proper time to think about it, and to think about those relationships associated with it.”

   It can sometimes be more productive to hold separate workshops focusing on integration, rather than tagging these discussions onto existing meetings. Workshop formats provide people with protected time and space to focus on the implications of integration without being distracted by their day-to-day responsibilities, and can allow people to discuss issues they might not feel confident in raising in their usual working environment.

5. **Silo working is often inefficient and repetitive**: If different working groups become too separate, they can lose awareness of what each other are doing, and end up ‘re-inventing the wheel.’ Shared meetings are important for making sure that different groups work together and avoid repetition.

Integrated care is probably not going to save money in the short term, but should result in more effective and efficient ways of meeting the growing care needs of the population in the future.
“When we started off with the Alliance we had a clinical group, a finance group, and a performance group. They all ended up talking about the same things, but in different silos. So it’s about making sure that those conversations about budget performance indicators and clinical pathways all happen at the same time with the right people in the room.”

6. Integrated care is a long term investment, not a quick fix solution: It is important to recognise that integrated care is probably not going to save money in the short term, but should result in more effective and efficient ways of meeting the growing care needs of the population in the future. This a difficult dilemma in the current economic climate.

7. Establishing the financial framework is crucial to the sustainability of integration: The financial and performance arrangements that underpin integrated care are vital in supporting joined up approaches. The financial and contractual mechanisms should be considered at an early stage, once the vision for integrated care has been agreed by the partners, as they take time to develop.
By 2030 the population of people over 65 in Salford is expected to rise to 34,542 – a 28% increase

**Background**

Like many areas, Salford faces a number of challenges around the organisation and delivery of health and social care. The age profile is projected to change dramatically over the next twenty years, and by 2030 the population of people over 65 in Salford is expected to rise to 34,542 – a 28% increase. This will lead to an increase in the numbers of people living with long term conditions.

At the same time Salford, like other areas, is under pressure to radically reduce NHS and local authority expenditure. Salford faces additional challenges due to the high levels of deprivation in the area. As in many deprived areas, uptake of screening services is low, poor lifestyle determinants such as smoking and obesity rates are high, and there is high usage of emergency and unscheduled care. Faced with the simultaneous pressures of increased need and reducing budgets, Salford recognised the need to deliver services in a more joined-up, efficient and preventative way, whilst also shifting as much care as possible away from hospital and nursing home settings to the community and peoples’ homes.

In 2011 Salford joined AQuA’s Integration Discovery Community (IDC) Programme, in order to develop their approach to sustainable integrated care. Salford City Council (SCC), Salford Clinical Commissioning Group (SCCG) and Salford Royal NHS Foundation Trust (SRFT) formed a partnership committed to integrating and improving the care of older people, by developing the Salford Integrated Care Programme (ICP) for Older People. The partners were later joined by Greater Manchester West Mental Health NHS Foundation Trust (GMWFT). Whilst older people remain the central focus of the partnership, the programme was seen as a basis for improving the care of other population groups as well.

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**Summary**

Salford’s Integrated Care Programme (ICP) seeks to transform the health and social care system, promoting greater independence for older people and delivering more integrated care. The intention is that every person should have their own multi-disciplinary shared care plan, accessible to all professionals involved in their care.

The partners have invested substantial time and resources upfront in developing a model which they believe will be effective and sustainable. The model is not yet at the stage of delivering concrete, measureable effects for service users. However, anecdotal evidence suggests that the direction of travel towards integration is already having a positive impact on Salford’s older population.

A number of key learning points have emerged from Salford’s experience, not least the importance of investing in preparation; engaging with stakeholders early on and allowing time to develop, test and refine a suitable model.
Salford benefitted from a history of joint working between health and social care partners. Integrated commissioning was already established, and there was a good working relationship between partners. This provided a strong basis for the ambitious programme of joint working and service redesign.

**Vision**

Salford’s ICP 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
- Reducing health and social care costs

Seven improvement measures have been agreed, with targets set for 2020 (outlined in the box below). The measures incorporate commitments contained within the three national outcome frameworks. Indicators were selected that primarily relate to older people, were consistent with the overall aims of the ICP and were difficult to address by a single organisation (i.e. where there was a prima facie case that the measure could be positively affected by integrated care solutions).

<table>
<thead>
<tr>
<th><strong>Emergency admissions and readmissions</strong></th>
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</thead>
<tbody>
<tr>
<td>— 19.7% reductions in NEL admissions (from 315 to 253 per 1000ppn)</td>
</tr>
<tr>
<td>— Reduce readmissions from baseline</td>
</tr>
<tr>
<td>— Cash-ability will be effected by a variety of factors</td>
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<table>
<thead>
<tr>
<th><strong>Permanent admissions to residential and nursing care</strong></th>
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<tbody>
<tr>
<td>— 26% reduction in care home admissions</td>
</tr>
<tr>
<td>— Savings directly cashable but need to be offset by cost of alternative care, especially increased domiciliary care</td>
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<table>
<thead>
<tr>
<th><strong>Quality of life, managing own condition, satisfaction</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>— Maintain or improve position in upper quartile for global measures</td>
</tr>
<tr>
<td>— Use a variety of individual reported outcome measures</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th><strong>Flu vaccine uptake for older people</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>— Increase uptake rates from 77% to 85%</td>
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<table>
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<tr>
<th><strong>Proportion of older people who are able to die at home</strong></th>
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</thead>
<tbody>
<tr>
<td>— Increase from 41% to 50%</td>
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</table>

Service planning and redesign has focussed on the experience of ‘Sally Ford’, a fictional older woman living in the area, and her extended family. Basing the redesign of services on Sally was important for maintaining a person-centred approach throughout the process.
The intention is that every person should have their own multi-disciplinary shared care plan, accessible to all professionals involved in their care. Care planning should be based on the segmentation of the population into four levels of need, with consistent standards of care.

**Figure 1: Sally and the Ford Family**

Basing the redesign of services on Sally was important for maintaining a person-centred approach throughout the process.

**Figure 2: Segmentation, care planning and standards**
Each of these levels of need will have a different level of associated care planning. A clear set of standards is to be developed for different elements of the health and social care system, potentially underpinned by a CQUIN style incentive scheme.

**Activities and approach**

The partners were keen that the re-design process should be co-produced through engagement with the stakeholders and agencies which would be affected by integrated care. Organisational and staff engagement commenced with two large engagement events during October 2012, each attended by over one hundred people from across the local health, social care, voluntary and independent sectors.

The first event presented the case for change and the evidence base for integrating care. It also offered a platform to reflect on the current health and social care landscape.

*Figure 3: Key messages from engagement*

<table>
<thead>
<tr>
<th>Current Services / Support</th>
<th>Keep and Build</th>
<th>Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deep, broad range of health, social care and other support</td>
<td>Commitment, trust and ‘can do’ attitude – strong relationships</td>
<td>Support better knowledge and easier access to components</td>
</tr>
<tr>
<td>Lack of knowledge about services and support – within the system!</td>
<td>Connections e.g. with Third Sector</td>
<td>Strengthen coordination roles, single point of contact</td>
</tr>
<tr>
<td>Co-location does not equal integration</td>
<td>Good elements across the system – many specific examples cited</td>
<td>Clarity on pathways</td>
</tr>
<tr>
<td>Poor coordination leaves people baffled and potentially lost to follow up or lacking support</td>
<td>Range of services – general to specialist</td>
<td>Focus on older peoples’ experience – shift attention to prevention / avoid crisis</td>
</tr>
<tr>
<td>Multiple IT issues and opportunities</td>
<td>Integrated health and social care teams – build upon, reach into how services are organised</td>
<td>Supporting staff – in large scale change</td>
</tr>
</tbody>
</table>

The second engagement event built on the first – reflecting back on the initial discussions, but also looking towards potential solutions. This was informed by a review of integrated care in other health and social care systems.
From this second partner engagement event the outline of the redesigned model of care began to emerge. This is based on three major initiatives:

1. The promotion, utilisation and growth of Community Assets. This involves both a bottom-up approach of supporting local community groups to develop their services, and also commissioning some additional services from the third sector. The aim is to support older people to maintain their independence, prevent social isolation, and enable older people to maintain active and productive roles within their local communities.

2. The development of a Centre of Contact, through which older people and their carers could access support and advice about the services available to them. This service is primarily telephone and web-based, but will also have a degree of physical presence with drop-in facilities in community Gateway Centres. The service has two tiers – the first to provide general signposting and advice, the second to provide more specialist support to people with more complex needs. There are also plans to roll-out a text service called ‘Flo’, which will support people with long term conditions to help them to take their own vital signs, and prompt them around self-care. The aim is to help service users to navigate the complex health and social care landscape, and to enable people to better manage their own care.
3. The development of **neighbourhood based Multi-Disciplinary Groups** (MDGs). These groups are made up of professionals from across the health and social care economy coming together on a fortnightly basis to identify individuals at risk, undertake multidisciplinary case reviews, and agree multi-agency care plans. This component is designed to support anticipatory care planning and avoid the fragmentation of care.

Once an outline of the model had been developed, it was agreed that this would be ‘tested’ in two of Salford’s neighbourhoods – Swinton and Eccles. A breakthrough series collaborative was adopted, with a ‘driver diagram’ (theory of change) and cycles of change (plan, do, study, act) used to test impact and refine the model.

*Figure 5: Salford’s driver diagram*

Following the collaborative phase, the partners conducted an interim review and developed a refined version of the model. Salford is rolling this out on a phased basis during 2014-15. Although partners feel confident that they have developed a model of integrated care that works, it is recognised that the model will need to evolve and adapt to changing requirements.

**Achievements**

The partners have been wary of attempting to ‘run before they could walk’, and have invested substantial time and resources upfront in developing a model which they believe will be effective and sustainable. As a result, the model is not yet at the stage of delivering concrete, measureable impacts for service users. However, anecdotal
The integration agenda in Salford is now deeply embedded in the priorities of all the major partners. Evidence suggests that the direction of travel towards integration is already having a positive impact on Salford’s older population.

Salford has been committed to co-producing the service redesign model, and the stakeholders involved are committed to the model. The integration agenda in Salford is now deeply embedded in the priorities of all the major partners and associated professionals:

“It is inconceivable for us to go backwards at this point. It is part of the Health and Wellbeing Strategy, it’s reflected in the priorities of all the partners. It’s embedded – it is going to happen.”

The partners are working with the University of Manchester to carry out an evaluation of the impact of the programme. This involves assessing impact on the improvement measures. In addition, they are also measuring experiential impacts of the programme on older people and their carers, recruiting and tracking a cohort of 3,000 older people.

Key Learning

1. **Maintaining an inclusive engagement approach is crucial to service redesign:** Having key partners engaged from the inception of the programme ensured they bought in to the concept from the outset. The two large-scale stakeholder engagement events proved invaluable – both for shaping the model, and also for providing a platform for collaboration and a sense of joint ownership from all the relevant organisations:

   “I think the whole approach of bringing people together at these large learning workshops has been really positive.”

2. **Allow time to develop, test and refine a suitable model for the local area:** Although this involves putting more time and resources in upfront, it means that as the project moves into its implementation phase, the model developed is more likely to be effective, sustainable and appropriate for the needs of the area. Implementation may have been swifter if the economy had taken a model of integration ‘off the shelf’, but the partners remained committed to developing a model sensitive to the needs of their local communities, and feel that this commitment has paid off.

3. **Manage expectations regarding efficiency savings arising as a result of integrated care:** Financial savings are unlikely to be realised in the short term, and it is important to recognise that investments may need to be made upfront in order to make longer terms savings:

   “You can’t approach this with a short term view. There are expectations that you’re going to see financial efficiency savings straight away. But it’s a big programme of work stretching to 2020, you need to invest before you get the benefits.”
4. **Spending time on organisational development can be a valuable investment:** Cultural differences existed between the partners, and so they invested time and resources to resolve these differences, and brought in some external organisational development (OD) support. This allowed staff at different levels and sectors to reflect on organisational behaviours, how they worked together as a team, and what people’s different professional needs were.

   “Expecting [the partners] to just behave as a cohesive team... that doesn’t just happen naturally. So having that OD support was really important.”

5. **Translate and explain language which people might not be familiar with:** There were some differences in the language used by different sectors: for example, the language of PDSAs was very familiar to staff from SRFT, but much less so for general practice. The partners recognised the importance of actively cultivating cultural as well as practical integration and developing shared understanding of key terminology and processes.

6. **It is important to provide staff with protected time for developing integration:** The time and commitment required from staff for integration to work should not be underestimated, and it cannot simply be tagged on to people’s day jobs.

   “If you’re just asking people to take it up on top of their day jobs, it’s probably nigh-on impossible.”

7. **It is crucial to secure the commitment of all stakeholders at the outset:** Although the ICP got off to a relatively slow start, the partners agreed that taking this time to engage with all the stakeholders and ensure that people understood and were committed to the case for change, was crucial for developing strong foundations for the project.

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Case study 4: IDC East Cheshire’s Integrated Care Programme

Workforce

Summary

The population needs of this economy are changing rapidly with a growing population aged over-65 and people living with more complex care needs. In response, a longstanding partnership has developed within East Cheshire to facilitate the better integration of health and social care. When the partners joined the Integration Discovery Community (IDC), they particularly focused on transforming the workforce and engaging staff as a key element in supporting and enabling the whole-system change required.

The early stages of looking to transform the workforce encompassed a range of projects aimed at building trust and joint working between teams in the partnership. The programme included training and development, recruitment and HR processes, and communications and engagement. Key achievements include the piloting of newly created integrated roles; a commitment to jointly running a government pre-employment scheme for people experiencing long term unemployment; and a shared programme of leadership training and development.

Much has been learned throughout the development and implementation of this ‘first phase’ programme about the challenges of inter-organisational working. This case study particularly illustrates the importance of engaging with the workforce from the outset (including engagement with recognised trade unions); communicating the programme effectively; and designing services in co-production with front line staff and their leaders.

Background

The economy serves a relatively healthy population, although there are large differences in health outcomes between local areas. The population needs are changing with a rapidly growing population aged over-65 and people living with more complex care needs. Faced with the increasing demand on health and social care services, the partners estimate a shortfall in health funding locally of between £12-15 million each year for the next five years.

A partnership comprising the Clinical Commissioning Group (CCG), two NHS trusts, the local authority and general practitioners formed to facilitate the integration of health and social care. The partners have a track record of working together, and an overarching programme of work has been developed to oversee the system-wide change and align integrated care projects across the economy.

In 2011 the partnership joined aQuA’s IDC Programme and focused on a Transforming Workforce in Partnership project. This project aimed to facilitate transformational change across the workforce, and engage staff to support and enable the whole-system change.
underway. This case study focuses on the early stages of workforce-focused activities which sit within the wider integrated care and cultural transformation programme.

Activities

Senior representatives from each partner organisation met as a workforce workstream operating alongside other projects within the wider integrated care programme to support, for example, the integrated neighbourhood teams, service model re-design, and IT and information sharing.

The workforce workstream agreed a programme of projects designed to promote joint training and development, HR processes and communications and engagement. Frontline staff and their managers formed the key focus of these projects, specifically those working in community and local settings. Specific activities undertaken are outlined in the table below:

| Training and development | — A mapping exercise of current training across the partnership was undertaken to develop a shared learning and development prospectus for a set of common core programmes  
| | — Considering the particular management training and development needs associated with integrated working |
| Recruitment and HR | — Linked / shared job vacancy bulletins  
| | — Developing a shared pool of assessors to support recruitment & selection processes  
| | — Developing a programme for a shared HR graduate position  
| | — In partnership with Job Centre Plus and Skills for Health, agreeing to offer a joint pre-employment scheme for people experiencing long term unemployment  
| | — Working to develop a foot-print wide workforce map |
| Communications & engagement | — Developing a shared and accessible narrative for staff to support integrated working. For example, a video was developed for use in all partner organisations’ employee induction programmes  
| | — Introduction of regular news letters  
| | — Establishing a programme website  
| | — Running quarterly ‘update and lessons arising’ sessions for trade union officers and the wider professional HR community. |

The overall integrated care programme has gathered significant momentum since its development stage, and in September 2013 the governing body accepted the Strategic Outline Case for a new care system within the economy. Activities are now being
undertaken as part of a pre-consultation phase that will see the programme through to an expected formal public consultation period in summer 2014.

As part of a restructuring of the programme governance arrangements, the workforce workstream has now been reconfigured to have a sharper focus on cultural transformation across the local health and social care workforce as the pace of the integration programme accelerates and the process of developing a business case for large scale change progresses. Programme leaders fully recognise that:

“We need to get the thousands of people working in health and social care locally thinking about what we need to change, how we should best do it and the importance of everyone needing to change their behaviours if high quality health and social care services are to be sustained in the long term.”

Achievements

Key achievements under the workforce workstream to date include:

— With the support of Skills for Health, a partnership between the economy and Age UK has led to the creation of a pilot Wellbeing Coordinator role. The Wellbeing Coordinator will work with older people to support them to adopt a healthier lifestyle and to navigate services, with an aim to reduce GP visits and hospital admissions.

— A HR Graduate Trainee joined the economy in 2012, working across the CCG, the council and the two NHS trusts.

— A management training programme and action learning set has been launched to identify the skills and behaviours needed to work in an integrated way. The results of this will inform the content of a partnership wide development programme for ‘leaders’ of integrated teams.

— Two of the partners have committed to jointly running a government pre-employment scheme for people experiencing long term employment. Seventeen places will initially be made available on this scheme.

— Joint briefings have brought together local trade unions and partner organisations. This has facilitated an open and transparent relationship with the unions, ensuring ‘no surprises’ as future challenges emerge as the process of transformation begins to have direct impacts on staff.

Key Learning

1. ‘Real champions’ will help drive the programme forward in the early stages: The partners benefitted from people in both senior and junior roles who were prepared to carry the programme forward:

“If you don’t have people who are prepared to do that, it’s too easy at the beginning stages to come across a barrier and stop.”

2. Maintain a focus on integration at the system wide level: Integrated care is about system change not just organisational change; however every organisation must ensure that its internal functions are fully integrated as well.
3. **Develop a common vision across partners:** Having a shared vision from the outset is important – as is being persistent in communicating that to staff. The partners learnt that engaging small groups at a time was a good way of building understanding.

4. **Having effective governance arrangements in place provides accountability and helps keep partners focused on the shared purpose:** Preventing partners from reverting to their silo working was described as akin to “keeping frogs in a wheelbarrow”. Having the right structures in place kept people around the table and focused on their common aim.

5. **Recognise that developing an integrated culture between organisations will take time:** Familiarity between people working in different organisations was a key enabler for facilitating integrated working. Over a long period of time (over a year) they talked and grew to understand one another’s perspectives and organisational priorities.

   “People now have an ease with each other that wasn’t there originally.”

6. **Build engagement with partners where it exists and use this as a starting point from which to encourage others:** Where it was not possible to gain the commitment of all partners for one project, they began by implementing the project with just two partners in order to build confidence in the work:

   “The important thing is that all partners know about the programme and have the opportunity to be involved.”

7. **Co-design the programme with frontline staff and managers and respond to their feedback:** Operational staff are generally able to clearly see the benefits to be had from working in a more integrated way. Equally they are able to identify barriers to maximising those benefits. Senior leaders must be able to address these to ensure continued credibility and secure the ongoing commitment of frontline managers and staff.

8. **Explore the underlying reasons why some stakeholders appear disengaged and address them - just telling people they need to do the work will not gain a sustained commitment:** For example, the economy found that when stakeholders in partner organisations undertook this programme of work on top of their day job, it limited the extent to which they could commit. Furthermore, if messages have not filtered down from chief executives, then stakeholders may fail to see integration as a priority:

   “[You need to] put yourself in their shoes, why is it difficult for them to come to these meetings, why is it not a priority for them? You have to make it seem real for people.”

9. **Prepare the workforce and stakeholders to expect that the pace of change will be frustrating at times:** Implementing whole-system change will take many years to achieve and the work can at times “feel as though you are taking three
paces forward and two paces back.” Building in training can make the workforce more resilient and prepared that they might be working on something for several months before they can see tangible results.

10. Early engagement with trade unions can pre-empt workforce related challenges down the line: Trade unions are kept informed through regular briefing sessions. The feedback the partners received was very positive; although the unions expressed some anxiety around how the potential changes might impact on the workforce, they were pleased to be involved and consulted with from an early stage.

“It’s sowing seeds, it’s saying to them that ‘we are not talking about changing terms and conditions yet, what we are talking about is getting people to work together in the same building’ and reassuring them that [the union] will help people through those changes.”

The partners have created a transparent environment where trade unions are kept informed and given a key point of contact with whom they can raise issues or concerns. Furthermore, removing any mystery around the plans for integration enables the unions to respond to their members’ concerns from an informed position.

11. Measuring progress is important for understanding how far you have moved towards an integrated workforce culture, and how much further you have to go: Measuring changes in workforce culture has been a challenge highlighted by this economy and others. The partners are planning to implement a simple survey tool to gain insights into how much the workforce understand about the overall aims and vision of the programme. This tool will be administered before a period of intense engagement activities to determine a baseline, and again afterwards to capture evidence of progress.
Case study 5: ICC2 East Lancashire’s Intermediate Care Allocation Team (ICAT) Programme

Service Redesign

Summary

When joining the Integrated Care Community 2 (ICC2) Programme, the partners in East Lancashire chose to focus on the transformation of health and social care intermediate care services. As analysis of existing data and service user stories revealed that current services were fragmented, duplicated and inconsistent in their operating models.

The Intermediate Care Allocation Team (ICAT) Programme was developed with an overarching aim “to place adults who require intermediate (short term community care) into the right care, at the right place, at the right time.” ICAT is an interdisciplinary team of social work, occupational therapy and nursing services, with an overview of intermediate care across the economy. Alongside ICAT, a multi-agency initial assessment / screening tool has been trialed to reduce assessment duplication and provide an early indication of what services a person may need.

In its first year of operation ICAT can boast a number of achievements:

— The service actioned the majority of referrals within two hours and gave people access to an integrated assessment plan
— The service saved at least one further assessment per service user
— ICAT enabled people to go straight into a reablement package at their point of discharge
— ICAT ensured a number of people received care in a community setting who would have otherwise been placed in more expensive care packages such as community hospitals, residential care and residential rehabilitation.

The East Lancashire experience shows that placing the individual at the heart of the service can help to break down silo culture working between agencies, and facilitate a more integrated approach from acute to community pathways.

Background

The East Lancashire economy covers five boroughs containing a mixture of urban and rural communities. While the economy ranks as average on the Index of Multiple Deprivation Score (2010), the internal picture is more varied; the deprivation scores of individual districts range from Burnley (11) to Ribble Valley (290).

Lancashire County Council, the East Lancashire Hospital NHS Trust and the East Lancashire CCG came together with a commitment and desire for effective joint working to deliver integrated care across East Lancashire. In 2012 the East Lancashire partnership joined AQuA’s ICC2 Programme, hoping to build on their previous experience of delivering and commissioning integrated care.
“We wanted to learn from other health economies and also learn through the structured approach of the ICC2 programme.”

East Lancashire chose to focus on the transformation of health and social care intermediate care services. Analysis of existing data and service user stories revealed that current services were fragmented, duplicated and inconsistent in their operating models. The patient/servicer user journey was confused and disjointed and there was scope for outcomes to be greatly improved. For the economy, this led to wasted resources and overreliance on more expensive rehabilitation / residential care stays.

**Activities and approach**

*The service model*

ICAT is an interdisciplinary team of social work, occupational therapy and nursing staff with an overview of intermediate care across the economy. Patients and service users are identified through a number of referring groups including GPs, therapists, acute providers, social care and- as the programme developed- community pharmacists.

Alongside ICAT, a multi-agency initial assessment / screening tool has been trialed to reduce assessment duplication and provide an early indication of what services a person may need. This ensures reablement goals are identified and begun as early as possible. When a person is ready to be transferred into an intermediate care service at home or in a community setting, they have already had early conversations about the right intermediate care package for them.

The ICAT team plans to move into one locality, supported by an integrated IT system so that all records regarding an individual’s care are accessible to the range of professionals supporting them. In the meantime, patient consent is key to sharing information and all relevant databases are available to ICAT workers; in particular ISISS is used as the main system across health and social care. The development of the IT system has been slightly slower than first anticipated, due to technical and organisational challenges. Work undertaken to develop data sharing agreements has highlighted the differing cultures regarding risk and data sharing between partners.

Building in time to reflect on the ICAT model has been integral to the economy’s approach, a key example of which has been the mobilisation of a Service Development Group. The Service Development Group comprises a group of practitioners that meet on a monthly basis to discuss challenges of the service on a case by case basis. This enables issues to be addressed as and when they arise, negating the need for the escalation of easily resolvable issues to the senior management level. As such:

“The service managers across the referring groups are still in control of the process and the development of that process, because they have developed trust in each other and have peer to peer conversations, before things escalate into a whole system issue.”
ICAT is supported by clear governance and reporting arrangements, ensuring that progress is monitored and owned by both operational and strategic groups. Key learning around individual cases and the service model is fed back through the management meetings, while the ICAT project team sets strategy, monitors and reports on broader trends and key indicators. ICAT also reports through the East Lancashire Trust and Lancashire County Council operational governance systems, as well as through the CCG clinical governance board groups.

As part of the next steps for East Lancashire, the ICAT programme is expanding into a larger piece of integration work around Transfer of Care. ICAT will become part of the Transfer of Care ‘hub’ - a single point of access service that will bring together a number of teams, expanding across acute and community transfer of care. Future ambitions include using ICAT as a single ‘one stop shop’ or coordination point for access and overview of other intermediate care services commissioned by multiple agencies.

“ICAT is our pilot with integration in East Lancashire; we are learning a lot from what we have put into it, and hope to transfer that learning across the health economy.”

**Achievements**

In 2013/14 ICAT cost the East Lancashire Health economy £280,000 including £30,000 of set up costs. It received over 1000 referrals in 2013/14 with 61% of referrals being from a home setting. Thirty-percent of referrals are now being made by GPs and 1% of referrals are made from A&E/ Urgent Care/ MAU to ICAT before an acute admission is made. Referral numbers are expected to rise as single point of access pathways are developed.

Approximately 60% of the service users / patients referred to ICAT require no further assessment and have a service commissioned as a result of the assessment information given by the referrer within a few hours. In addition to this, ICAT changed or added additional services to the referrer’s original recommended pathway for over 50% of people referred. Whilst the majority of referrals are for patients / service users over 65 (89%), the team is seeing a growing number of referrals from people under 65 as the services expands to GPs.

In its first year of operation, ICAT:

- Actioned the majority of referrals within two hours and gave people access to an integrated assessment plan
- Saved at least 1.2 further assessments (and sometimes more) per service user / patient
- Avoided interim care packages where possible and supported people to go straight into a reablement package at their point of discharge. The economy has evidence that 60% of people in East Lancashire do not need long term funded support after receiving reablement, and the earlier this is received the better the outcomes achieved
- Ensured a number of people received care in a community setting who would have otherwise been placed in more expensive care packages

Where people used to wait for three weeks for reablement services, they now wait just over five days
such as community hospitals, residential care and residential rehabilitation. The partners have also begun to work more closely with the voluntary sector to ensure support is provided around lower level needs including befriending services, community groups and hospital aftercare services. They are seeing evidence to suggest this has avoided longer term care or more expensive packages.

- Supported a number of referrers who did not know the East Lancashire system to allocate a person into the right care. This is particularly apparent amongst temporary/locum professionals.

Due to the work undertaken in East Lancashire, people are now able to access reablement/residential rehabilitation services much more quickly; where people used to wait for three weeks for reablement services, they now wait just over five days. ICAT has contributed to this by coordinating allocation for residential rehabilitation. It is able to challenge reablement waiting times/links to interim packages and educates referring groups around the aim of reablement services.

A key achievement for East Lancashire is that different services are working together as a team and with a shared purpose to improve the quality of care for individuals. In doing so, they have overcome a number of barriers including changing people’s attitudes to the way that acute and community services are resourced at times of pressure.

The ICAT pilot has highlighted important issues in the system that need to be resolved before it can be rolled out on a wider level. By identifying and addressing issues surrounding culture, team working and sharing resources, the programme team members are confident that the wider model developed is likely to be effective and sustainable.

**Case study: example service user**

Following a home visit, Dr S referred his patient ‘Mrs A’ to ICAT in January 2014. Mrs A was diagnosed with a urinary tract infection, and was becoming increasingly confused and struggling to complete normal tasks (such as feed herself). Mrs A was non-weightbearing (she was previously able to mobilise with supervision and a frame); she had become incontinent (prior to this she was able to engage in a regular toileting regime and remain clean and dry); and her nutritional status was becoming compromised due to lack of appetite. Mrs A was highly resistant to essential personal care that her daughter normally provided her with. Medical history included a diagnosis of dementia.

Dr S telephoned the ICAT Professional with the above assessment information and requested urgent support. Whilst on the phone ICAT gave immediate feedback that Crisis Support would be commissioned the same day following further consultation with Mrs A’s daughter.

As a multi-disciplinary team, further ICAT assessment screening took place. The nurse on the team considered that the District Nurses were the most appropriate service to provide support with pressure relief, continence and to complete an assessment with a view to considering a referral to the dietician. The Nurse on the team made the referral to the local Integrated Community Team. The District Nurses prioritised the referral and
Key Learning

1. **Placing the individual at the heart of the service can help to break down silo culture working between agencies:** East Lancashire has deployed a number of strategies to keep outcomes for individuals at the heart of service delivery. This includes:
   a. Introducing management performance indicators that measure the service’s *overall outcomes* as opposed to individual *team outcomes*
   b. Leadership training and development that emphasise the importance of sharing resources
   c. Using service user stories and case studies to evidence that the integrated care model really does lead to better user outcomes.

2. **Integration takes time to realise savings but creates a greater number of benefits:** The ICAT pilot has achieved savings and importantly revealed that the partners can reduce assessments and speed up care mobilisation, and achieve a greater capacity to meet the needs of the growing number of people. The partners are beginning to understand where a shortage of alternative provision is causing a number of people to be placed in more expensive packages of care, and how decision making can be improved with a better “real time” overview of available intermediate care provision.

3. **Measures of success may need to be adapted to reflect the wider context:** The partners have used a measure that captures whether the model has been able to redirect people away from residential care and maintain independence. However, with an aging population the number of people entering residential
care is likely to rise until the whole system change is realised. East Lancashire are now planning to monitor figures on whether the average age of people entering care has gone up, i.e. whether entry into care has been delayed.

4. **What can be considered a positive clinical outcome may not always have a positive impact on the user experience; remain open to unexpected outcomes and adapt the model accordingly:** East Lancashire have speeded up the mobilisation of packages of care, meaning that some patients have been able to leave hospital sooner as a result. However, for some patients this transition has almost been ‘too quick’, as illustrated in the example below:

“If someone has never had a package of care before and finds themselves in a crisis situation, and it is proposed that they need a package of care at home, it can be too much to take in for them and their carers. Introducing a package of care is a change in way of life, so when we have mobilised it in two hours, there have been issues around patient sensitivity and giving them time to reflect and make their own decisions.”

The partners have learnt that in such circumstances professionals need to be sensitive to individual needs, and may need to build some reflection and recovery time into the transfer of care process and decisions around allocation. It is beneficial for discussions to include family members so that they can support the service user to make these decisions.

5. **Having a dedicated Intermediate Care Programme Lead, lead GP commissioner and ICAT Operational Manager has helped to drive the programme forward:** Having dedicated resources has brought numerous benefits to this work in East Lancashire. Having one GP commissioning lead and a programme lead provides an overarching view of all the separate components, whilst the operational manager focuses on their specific area. Unique to this programme, is that the programme lead and the operational manager are employed by Lancashire County Council and hosted by the East Lancashire Hospital Trust – importantly this enables relationships to develop securing buy in to the referral process, and facilitating integration at an operational level for both IT and governance systems:

“We’ve realised that the pilot in East Lancashire has been successful because we have had the dedicated resources to push it through. The challenge now is to grow and mainstream these services.”

6. **Be proactive in bringing in referrals:** Knowledge and support for the programme was relatively slow spreading throughout the economy. With the benefit of hindsight, and if given the opportunity to run the programme again, East Lancashire would have built in a more proactive approach to education earlier on in the programme - going out into the community and working with professionals to actively bring referrals into the service.
7. Working further with partners from across health and social care providers, the voluntary sector and the social housing sector is key to successful wellbeing/personalised care: Early evidence from referrals indicates that transfer of care partnership developments are key to providing patients and service users with the opportunity to achieve wellbeing/personalised care decisions and outcomes.

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Case study 6: ICC2 South Sefton’s Virtual Ward Programme

Governance

Summary

The partners at South Sefton developed the Virtual Ward project in response to the increasingly frail, elderly population with complex needs, as well as the pressure to reduce high acute care admissions and costs. This case study focuses on South Sefton’s governance arrangements underpinning the Virtual Ward project.

Governance is provided via the bi-monthly Steering Group, bi-monthly governance group and fortnightly Operations Group, supported by task and finish workshops as required (for example, regarding information sharing). Six implementation groups are involved in operational planning and turning the vision into a reality. While a risk monitoring system reviewing all emerging and long-standing risks at the Operations Group meetings.

Achievements to date include the establishment of a shared vision for the Virtual Ward programme across the partners, and rolling out the Virtual Ward approach to 150,000 local residents across the four localities.

There are a number of learning points to emerge from the South Sefton experience, including the importance of ensuring there are clear roles and responsibilities across the partners.

Background

South Sefton is a largely urban area to the north of Liverpool, encompassing Bootle, Crosby, Seaforth and Litherland, and Maghull. South Sefton launched their Virtual Ward System in 2013, with a focus on maintaining the happy independence of frail and elderly people and those with long term conditions.

The Virtual Ward project is being led by South Sefton Clinical Commissioning Group (CCG), working in partnership with Sefton Council, Liverpool Community Health, University Hospital Aintree, Sefton Council for Voluntary Services, Merseycare, Merseyside Commissioning Support Unit, and PSS. The partners developed the Virtual Ward project in response to the increasingly frail, elderly population with complex needs, as well as the pressure to reduce high acute care admissions and costs.

“Virtual Ward is our attempt to be more proactive and integrated. It’s a good model – but that’s not to say it has all been easy.”

South Sefton was part of AQuA’s ICC2 Programme, although the partners developed their approach largely independently of the programme. This case study focuses on South Sefton’s governance arrangements underpinning the Virtual Ward project.
Activities and approach

There are four key aspects to the Virtual Ward project, all supporting the vision of developing a community-based admission avoidance system:

1. Integration of community health and social care via coordinated partnership working; developing a common commissioning plan between the CCG and Sefton Council; and joint care planning, with more face to face contact with service users.

2. Improving disease prevention amongst patients with long term conditions, including predictive risk stratification, early intervention and management, improved screening for dementia, and proactive use of assistive technologies.

3. A single point of access and common referral pathway, an integrated electronic care record, and a cross-system patient alert for key workers.

4. A self-care approach, with greater patient and carer involvement in decision making, individual advanced care planning, patient centred goal setting, and improved education.

The Virtual Ward is resourced by a multi-professional team using a common care record. Administration support is provided by a Ward Manager and Ward Clerk, and patients are discharged after a maximum of 12 weeks of intervention. The four localities in South Sefton all began running fortnightly MDTs in August 2013.

The ward is ‘virtual’ because the patients are cared for in their own homes. Each Virtual Ward mirrors the GP locality structure within South Sefton CCG, each covering approximately 40,000 patients, six GP practices and based from one community location.

Referrals into the Virtual Ward

Referrals to the virtual ward lead to patients being accepted as any of the following: a singular referral (whereby only one professional is involved in their care); an integrated referral (whereby more than one professional provides patient care); or thirdly as a proactive patient (whereby the patient engages specifically in a proactive programme of care).

There are four referral routes into the system: referral by a GP; identification by the risk stratification tool; referral via specialist / intermediate community care teams; or via the acute trust. A single point of access into the system has been developed for all referral routes.
Diagram: Referral routes into the Virtual Ward

Governance arrangements

Governance is provided via the bi-monthly Steering Group, bi-monthly Governance group and fortnightly Operations Group, supported by task and finish workshops as required (for example, regarding information sharing). The Steering Group operates at a strategic level and invitees include two representatives from each key partner. The Operations Group involves stakeholders who are directly involved in the Virtual Ward, as well as others whose work may be affected by the project.

Six implementation groups are involved in operational planning and turning the vision into a reality. They include clinicians of a variety of disciplines, senior managers and frontline staff. The implementation teams have been gradually rolled out, reflecting the phasing of the Virtual Ward project, with the first being pro-active nursing, followed by reablement, IM&T/ support, care planning, communications and urgent care.

Whilst they are part of the Virtual Ward, a patient’s medical governance remains the responsibility of their GP, unless the patient is being seen by the Community Geriatrician under the Urgent Care Team - whereby the medical responsibility lies with the Community Geriatrician for a time limited period. Outside of medical governance, the

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1 Diagram taken from Chamberlain, P (Dr). South Sefton Virtual Ward Project Strategic Outline, South Sefton CCG, August 2012, page38
Virtual Ward Manager is responsible for organising the patient’s care as discussed during the MDT meeting.

The partners in South Sefton have established a risk monitoring system for the programme, reviewing all emerging and long-standing risks at the Operations Group meetings. Each GP practice is sent a discharge notification on each virtual ward patient, and each practice is visited monthly by the Community Matron, to discuss new patients to include in the Virtual Ward and referrals into specialist care.

**Feedback and stakeholder engagement**

Stakeholders are invited to regularly reflect on progress and key learning emerging from the Virtual Ward programme. Specific engagement activities are also being undertaken at key points, to identify potential improvements to the programme. For example, all general practices are currently being visited by Operations Group members to obtain GP feedback on the processes and how the Virtual Ward programme should develop over the coming months.

**Achievements**

Achievements so far include:

- Establishing a shared vision for the Virtual Ward programme across the partners
- Partners working to an agreed model of care and standardised processes, with local flexibility where appropriate
- Rolling out the Virtual Ward approach to 150,000 local residents across the four localities
- Identifying an appropriate, interoperable IT solution to facilitate data sharing across partners
- Improved relationships between the partner organisations, at both strategic and operational levels
- Anecdotally, staff report improved morale and job satisfaction. Informal feedback from patients indicates that they are receiving more streamlined support and that they welcome the changes to integrate their care.

The Virtual Ward programme is progressing as planned and is expected to lead to reduced unplanned and emergency admissions to acute care, as well as reduced numbers of people entering long-term residential care homes. The partners will be monitoring progress towards these outcomes over the coming months.

Longer term, there are plans to capture evidence of service user experiences and case study examples of impact.
Key learning

1. **Ensure there are clear roles and responsibilities across the partners**: South Sefton have benefitted from having clear accountability and reporting arrangements in place from the outset, with the vision for the programme and how it would be operationalised being outlined in the Virtual Ward Project Strategic Outline.

2. **Have an individual responsible for co-ordinating risk and mitigation updates from all workstreams**: Risks and mitigating actions are reviewed at the fortnightly Operations Group meetings, with the governance arrangements enabling risks to be escalated as required.

3. **Ensure there is clinical input into the model**: GPs (and other health and social care professionals) will need to take ownership of the approach, and consequently it is important that the programme meets their requirements from the outset. Engaging clinical leaders from project inception, accompanied by a programme of ongoing clinical engagement activities (for example, face to face visits to meet with all GPs who are part of the programme) has helped to ensure that the South Sefton model meets clinicians’ needs.

4. **Focus on the vision and outcomes sought**: Partners involved in the South Sefton project reflected that it is important to shift the focus and language away from ‘input and interventions’ towards ‘outcomes and visions’, to engage stakeholders and ensure the project remains patient-focused.

5. **Provide guidance and clear criteria, but also feedback on unsuccessful referrals**: Having cases referred into the MDT but subsequently rejected for inclusion into the Virtual Ward has led to concerns that GPs and other partners may disengage from the process, as they perceive it as not meeting their own and their patients’ needs. It is important that these referrals are addressed via other means, and that GPs or others who made the referral receive feedback on why it was rejected.

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This ICC2 economy faces a number of health and social care challenges in the coming years, in particular relating to the increasing needs of an aging population. The economy is a relatively new town with a large retired population. The current proportion of the population over 65 is expected to increase by 60% by 2030; the population over 80 is set to rise by 20%. As well as anticipating the needs of frail elderly, the economy also recognised that a large proportion of their retired population are in good physical health and will remain active for many years. It is therefore important to consider what the future needs of this population may be, and how to best promote health and wellbeing so they can stay active and independent into old age.

The economy has extensive experience of cross organisational working, including their work as a pilot site for the government’s Local Integrated Services programme looking specifically at joint working to support vulnerable families. They have a joint health and social care integrated commissioning team and a number of integrated services in adult social care, intermediate care and reablement. Operating under the HWB is an Integrated Commissioning Governance Board whose purpose is to promote integrated working across organisations, to deliver sustainable care.

The Council in partnership with the CCG were motivated to join AQuA’s ICC2 Programme to accelerate their integration work, firmly believing that integration is the only way of meeting the future population needs whilst making financial savings. In particular, the partners hoped to gain from the programme’s structured approach, whilst learning from the experience of others:

**Summary**

Warrington’s older population is growing and will require health and social care services that support the needs of both the frail elderly and those who are active and in good physical health. This pilot project aims to improve outcomes for isolated older people, enable them to live independently in their own home for longer and reduce admissions to hospital.

A small cohort of housebound housing trust tenants were identified and offered a choice of two check-ups; a domiciliary medicines use review, and/or a health and wellbeing check. The medicine reviews and the wellbeing checks highlighted a number of issues that could have had a significant impact on the health and wellbeing of the user had they not been identified. For example, some older people were found to be using outdated medicines and creams, or required basic home repairs and adaptations for a safe home environment.

A number of key learning points have emerged from Warrington’s experience, not least the value of engaging with partners outside of health and social care, such as the community and voluntary sector and housing trusts.

The current proportion of the population over 65 is expected to increase by 60% by 2030; the population over 80 is set to rise by 20%.
“We were initially attracted [to the ICC2 programme] by AQuA’s focus around the integrated care domains. We thought that [with regards to] any barriers we uncovered under those domains, hopefully other areas would have the solutions.”

### Activities and approach

### Vision

The project aims to improve outcomes for isolated older people, enable them to live independently in their own home for longer, and reduce admissions to hospital. The project was piloted in two geographical districts - areas characterised by high instances of smoking, obesity and poor levels of wellbeing. This reflects the programme’s wider definition of ‘healthy aging’, to encompass healthy eating and other lifestyle factors, home safety and social isolation.

### The service model

Focusing on older people who were housebound, two housing trusts helped to identify a small cohort of suitable tenants for participation in the pilot. Those identified were offered a choice of two check-ups; a domiciliary medicines use review, and/or a health and wellbeing check. Medicine reviews were delivered by pharmacists in the home with the aim of ensuring the client understood how their medicines should be used, and why they should be taken. The health and wellbeing check was delivered by the local Home Improvement Agency (HIA).

A health and wellbeing checklist questionnaire was developed for use by the HIA for referring older people into low level services. The comprehensive checklist covers wellbeing, accident prevention, crime, safety, finance, food preparation, depression, and isolation and inclusion. The review also checked for small home improvements and adaptations needed, including adaptations to improve the environment for those living with dementia.

Following the publication of the results from the pilot (discussed in more detail in the achievements section below), the partnership formed a cross-organisational operational group to develop a wider offer to isolated older people. This includes taking a more proactive approach to referrals by working with two local GPs to identify a wider clientele who might benefit from the service. They are also identifying community venues that can host a range of interventions and activities; alongside medicine reviews and health and wellbeing checks, clients will have access to physical checks and fitness classes, for example.

### Engaging with older communities

The economy benefits from several well established and active mechanisms for understanding and engaging with older communities including: the Older People’s Partnership; the Older People’s Engagement Group (OPEG); and Older People’s Champions. These groups have been instrumental in engaging older people in the
Piloting the health and wellbeing questionnaire ensured that this tool was fit for purpose before scaling up the project to a wider client base.

Piloting the health and wellbeing questionnaire proved important, ensuring that this tool was fit for purpose before scaling up the project to a wider client base. The OPEG supported the partnership to identify a group of older people to test the tool to ensure it was accessible. Now the partners are confident in the content they are exploring the potential for developing the questionnaire into an app for use on tablet devices.

Further engagement work is being planned to expand the project to a wider and potentially more vulnerable and isolated cohort of older people. The partners are working with a community-based organisation that undertakes outreach work with hard to reach populations. They will focus on listening and gaining a better understanding about older people’s lifestyles and the implications for health and wellbeing. The partners plan to use a variety of tools including focus groups, social media, neighbourhood boards and community groups.

The economy have found that capturing the experience of the older person, for example through the use of video and case studies, can prove powerful for gaining support for the project from senior leaders and politicians.

Achievements

A total of 70 older people were invited to undergo a review as part of the pilot process, of which 17 undertook a medicine review and 26 undertook a health and wellbeing check. The medicine reviews highlighted a number of issues that could have had a significant impact on the health and wellbeing of the user, had they not been identified. These included:

- Participants being unable to open the medicine bottle cap without assistance and hence failing to take their medication
- One person had stopped taking their medication on account of the taste, being unaware that the tablets could be taken with water
- A number of people were using out-dated medicines and creams. One older person was using an out of date ointment on a gangrenous leg that had deteriorated since prescription
- Examples of people stockpiling medicines acquired mainly through repeat prescriptions.

The health and wellbeing check also revealed a number of issues for referral to other services, including:

- Of the 26 who received a check, 13 people required minor home repairs
- 8 people required minor aids and adaptations to their home
- 3 people were found to have overloaded pug sockets
Loneliness and isolation were an issue for a large number of participants, affecting their wellbeing by making them feel depressed, and leading to them being less able to manage their health.

It is difficult to translate these findings into measurable savings for the economy, for example through reductions in admissions to hospital or residential care. However, evidence suggests that small repairs, adaptations and security improvements can impact by reducing falls, preventing burglaries and reducing hospital admissions. Furthermore, in some cases the immediate benefits for both the older person and the economy are clear, such as in the case of the person with a gangrenous leg who could potentially have needed an amputation had their condition deteriorated further.

With the evidence collated from this pilot, the programme leaders have been able to take their findings to various bodies including the HWB and gain support for the work they have done so far.

Key learning

1. **Start small, test, and learn:** The economy implemented a Plan, Do, Study, Act (PDSA) model of service improvement. They plan to roll out the project through six cycles that include the identification of best practice; implementing a small pilot; mapping resources; and developing outcome measures and delivery models. This approach aids reflection and development of the model at each stage. For example, the partners found that older people were more successfully engaged when approached face to face rather than by telephone. By capturing learning they can continually improve their approach.

2. **Develop outcome measures that are real for the user:** The economy partners are developing their outcome measures at a later stage of their programme, rather than at the outset. This enables them to draw on feedback from participants and the emerging findings from the pilot, to ensure they are measuring meaningful outcomes.

3. **Draw on the capacity of partners outside of health and social care, such as the community and voluntary sector and housing trusts:** The Golden Gates Housing and Your Housing Group and the HIA have made significant contributions to the success of the project. Drawing on the capacity of highly trained voluntary sector individuals enables the project to do more within tight budgets.

The partners are now looking to expand on their work with the housing trust, including creating dementia friendly environments. This has resulted in the housing trust offering a Project Manager for 18 months to get one of the initiatives off the ground.
“From our conversations with housing associations we have been able to work at a low level with them and built up trust, which has now enabled us to have a range of new conversations.”

4. **Persistence and patience may be necessary when trying to engage partner agency leaders in the project:** At the early stage of the project Warrington experienced some challenges in engaging leaders in the project, they took an approach where they kept people informed of their activities and successes to build engagement:

   “Where I get engagement I go with it. When they are not engaging I keep offering them the opportunity to be engaged and be kept up to date.”

5. **Invest in gaining GP buy-in:** Now that GPs are championing the project it has brought additional energy to the work:

   “By opening it up to other providers, now we are saying this is not a local authority project anymore, it’s a partnership project.”

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Summary

This integrated care programme was developed in response to the need to reduce readmissions to hospital and patients’ length of stay, whilst ensuring the right care is provided at the right place and the right time.

Wigan chose an Integrated Neighbourhood Team (INT) model, clustering the 65 general practices into 16 INTs within three separate localities. Each locality was appointed a Clinical Facilitator to support their INTs. Each INT organises multi-disciplinary team meetings (MDTs), which meet eight times per year to review the care of patients identified by the risk stratification tool.

The programme achievements include the successful engagement of partners in the economy, including care homes and 64 of the 65 GP practices in the area. There is also anecdotal evidence of reduced duplication and more streamlined pathways for patients, with the Care Facilitators raising awareness of the different pathways available.

Through project implementation the economy has learnt the importance of engaging key partners from the outset. Alongside partner agency involvement, it is vital to ensure that patient and carer voices are heard by involving patient representatives in key decision making activities.

Background

“We’ve been able to implement this at scale and pace... the platform, station and approach road are all on fire, so we don’t have 4-5 years to get it going.”

The Integrated Care work in this economy involves a partnership between the NHS Foundation Trust, the Community Healthcare Trust, the Clinical Commissioning Group (CCG), the Council, and the Mental Health Trust. The project builds on previous partnership working in the area, and was designed to establish good quality community services, streamlining care from acute to community settings.

The partners recognised the need to reduce readmissions to hospital and patients’ length of stay, whilst ensuring the right care is provided at the right place and the right time. The programme aimed to reduce waste and duplication, and give people with long term conditions greater control over their care.

“Integration was already entrenched among the partners, which has made a big difference.”
Activities and approach

The 65 general practices in the economy were clustered into 16 INTs, within three separate localities. Each locality was appointed a Clinical Facilitator to support their INTs.

Each INT organises MDTs, which meet eight times per year to review the care of patients identified by the risk stratification tool. The project leads developed a standard operating procedure, based on the approach employed in Central Manchester (as highlighted by AQuA as a good practice example from the Integration Discovery Community Programme). The three Clinical Facilitators carried out extensive early engagement work with GPs, to explain the programme to them and how the INTs and MDTs would work.

“After 48 hours of [the risk stratification tool] being available on practice desks, over 30% of practices had accessed the data.”

Integrated Neighbourhood Teams and Multi-Disciplinary Team meetings

All 16 INTs commenced in April 2013, meeting monthly and supported by a weekly implementation group at programme level.

GPs meet with their District Nurse to identify patients at the highest risk of re-admission based on their risk stratification score. They then determine which patients would benefit from a MDT review. The MDT meets two weeks after the risk-stratification meeting, with the referral form and patient information provided to participants. The MDT discusses the best way of managing the patient’s care given their hospital admissions and care needs over recent months.

There are local variations in how the meetings run, but in general each practice has a one-hour timeslot to discuss their patients, and several practices attend each MDT at different times. This arrangement enables the District Nurses and community health and social care staff to meet with all relevant practices on one day.

Staff and stakeholder engagement

Staff and GPs working as part of the INTs have completed an online survey regarding their experiences. In addition, 23% of practices took part in a semi-structured face-to-face interview to explore their views in greater depth.

Feedback reveals that general practice staff and GPs welcome the INTs and MDTs, reporting:

- Improved communication amongst partners
- That having standardised operating procedures and paperwork eases their workload
- That the risk stratification tool enables them to identify key patients requiring coordinated care
Benefitting from the protected time offered by the MDTs to discuss patients:

“The INT process is simple – practices do it often anyway, but we’ve formalised it and standardised the process across them all... A lot of GPs have welcomed that. They like the systemisation and structure.”

GPs requested greater clarity about the role of specialists in the MDTs, and as a result of the engagement findings the allocation of Community Matrons is being reviewed, to provide greater equity of service across practices.

“The Clinical Facilitators have been great in keeping the contact with the patient, getting feedback etc. GPs don’t necessarily know what services are out there, so the Community Facilitators have helped by providing that knowledge.”

Achievements

The partners in the economy are well engaged in the programme, including care homes and 64 of the 65 GP practices in the area. There is anecdotal evidence of reduced duplication and more streamlined pathways for patients, with the Care Facilitators raising awareness of the different pathways available.

“The DES is in place, which is great and we have got the [MDT] meetings in place, but essentially the GPs can see the value in it, which helps to drive it. They have become more engaged with their Community Matrons – before [this programme] they were operating without them.”

The partners monitor progress and impact via a monthly dashboard, against which several KPIs and outcomes are reported on, including length of stay and emergency / unplanned admissions. One year’s worth of baseline data was mapped prior to the intervention commencing, and a cohort is being monitored at individual patient level, to map their experience from the point of intervention to 12-18 months later.

During the first ten months of the INTs being operational there were 175 MDT meetings, with 1500 referrals from GPs to INTs. The programme of work has continued to make positive impacts, as reported by programme leads:

— Approximately 4,100 patients have been risk stratified and over 950 case management plans have been developed as a result.
— Between April 2013 and January 2014 there was a 48% reduction in non-elective admissions, A&E has seen as 43% reduction, and outpatient attendances have seen a 17% reduction, compared to the same period in 2012 for the cohort of patients with a risk score of between 30% and 90%.
— For the whole population, the health economy saw a reduction in overall A&E attendances of 5%, non-elective admissions of 14% and out-patient attendances of 2%.

The partners set themselves a target of generating £4million of savings during 2013-4 by shifting care out of acute settings and into the community. The latest figures indicate that
they remain on track to achieve this target, and the next step is to realise these savings by reducing the resources in acute settings to correspond with the reduced demand.

Case studies are currently being developed to explore the impact of integrated care on patients, and LTC6a and LTC6b are being used to assess the impact of the case management approach on patient experiences. Risk stratification scores are also being tracked after patients have been case managed and discharged.

*Next steps*

The work on INTs will make a significant contribution to the implementation of the Avoiding Unplanned Admissions Enhanced Service, where the total number of case management plans needs to increase to circa 6,500 per annum.

Work is also taking place to improve information data flows. The partners have purchased the MIG (Medical Interoperability Gateway) which will enable health and social care to view (but not amend) a patient’s care record. A number of electronic templates have also been developed which have streamlined the process from primary care into the INTs.

“It isn’t a massive change in terms of how data is inputted – it just means it can be accessed remotely. So people can sit in the INT meetings and check whether a patient has a care plan or not – if it’s not on the system then it won’t have been done. It’ll help the Case Manager hold people to account.”

**Key learning**

1. **Engage key partners from the outset:** The economy engaged GPs, commissioners and providers as partners in the programme from the outset, involving them in shaping the vision and project plan. This has proved vital in securing engagement in the MDTs by 64 of the 65 local practices, and is likely to help to sustain the approach over the longer term, as partners feel a sense of ownership for the programme.

2. **Involve patients in co-producing your approach:** Alongside partner agency involvement, it is vital to ensure that patient and carer voices are heard from the outset. Involve patient representatives in key decision making activities.

3. **Have a clear vision with room for local flexibility:** It is important to set out a clear vision, whilst being flexible in how this is achieved:

   “You have to take people with you, being clear on the project but flexible enough to understand what needs to be compromised to get you to where you need to go. Have the confidence to be clear about what you want and be confident about what you want to deliver. Set out the vision, bring people with you and be resilient.”

It can be easier to engage GPs and other partners in work which is seen as a national priority, and which draws on learning and evidence from elsewhere.
4. **Emphasise how the programme contributes to national priorities:** The partners found that it can be easier to engage GPs and other partners in work which is seen as a national priority, and which draws on learning and evidence from elsewhere:

“National work has kudos with GPs. It’s more work for GPs to do, with no additional resource, but they have recognised the logic in doing it and the benefits to patient care. We’re using the national experience in the demonstrator sites to engage them.”

5. **Establish effective governance and reporting arrangements:** Weekly meetings between the key individuals and partners involved, including the CCG, the Community Healthcare provider, the Mental Health Trust and the programme communications team have helped to drive activity forward and maintain progress. In addition, establishing a standard operating procedure and basic INT processes and documentation has helped to ease the burden on practitioners and ensure some consistency across the localities.

6. **Draw on available support where relevant:** The economy benefitted from learning from peers but also from experts working in the field. The partners developed a clearer vision and made quicker progress as a result of the AQuA ICC2 Programme.

7. **Consider the admin requirements:** The economy recruited three Care Facilitators to help implement the process in each locality, ensuring that clinical staff were not distracted with the admin and remained able to focus on decision making and patient care.
Summary

Wirral have implemented an integrated care programme in anticipation of an aging population and a substantial increase in the numbers of people living with long term conditions. The aim of Wirral’s approach is to coordinate the care of patients with multiple long-term conditions, supporting patients through the early identification of those at greatest risk of hospital admission and enhancing self-management.

Sharing information regarding a patient’s care will be a central component of their integrated working. Wirral are developing a single referral gateway, a single assessment and a single care planning document that can be shared between agencies.

To date, eight integrated teams have been successfully implemented and are meeting daily in four locations across the economy. Plans are also underway to bring together an integrated therapies team spread over two bases, an intermediate care team, a hospital team, an integrated out of hours service and a single community gateway.

Wirral have learnt that effective integration is dependent on buy-in from frontline staff working within the integrated teams. Having a dedicated Programme Manager and investing upfront in communication and workforce engagement were shown to be important enablers for effective team working.

Background

The economy has a relatively high older population compared to the national average. This older population is growing; between 2011 and 2021 the number of people aged over 65 is predicted to rise by 17.4% and the number of over 85 year olds is set to increase by 29.9%. The economy also has a large number of people living in economic deprivation. As long term conditions are more prevalent with age and deprivation, the economy is therefore anticipating a substantial increase in the numbers of people living with long term conditions.

Experience and service user feedback also highlights that patients with long term conditions and the elderly often receive care which is not well coordinated. As a result, people are subject to multiple assessments and care plans, and sometimes do not know where to turn for advice, guidance and support. Having spent time considering the evidence base around integrated models of care (for example, Torbay, Kirklees, and Brighton and Hove), the partners in the economy became confident that integrated multi-disciplinary team (MDT) working has the potential to reduce the numbers of people unnecessarily being admitted to hospital and long term residential care.

There is a long history of integrated working in the economy between primary and secondary care, community services and the voluntary sector. In 2012 a partnership consisting of the CCG; the Council; the NHS Teaching Hospital; the Community Trust;
and the NHS Foundation Trust joined AQuA’s Integrated Care Communities 2 (ICC2) Programme.

“We recognised that we need to work smarter and more efficiently and deliver integration. Being successful [in joining the ICC2] meant that we were able to access more support.”

Activities and approach

Vision

The economy aims to coordinate the care of patients with multiple long-term conditions. Specifically it aims to support patients through early identification of those at greatest risk of hospital admission (risk stratification), provide enhanced self-management, and ultimately enable people to be supported at home for as long as appropriate.

Service model

This model has two key elements: integrated care co-ordination teams (ICCT) (implemented October 2013 - March 2014) and a single integrated referral gateway (planned implementation in 2014).

1. ICCTs offer multi-disciplinary care, providing a rapid response to meet both the immediate and long term needs of patients. They operate an inclusive service with no limits regarding condition or need including support for elderly patients, patients with long term conditions, patients with mental health needs and patients with learning disabilities. Service users are referred through a number of channels including GPs, acute trusts, community services, social services, or direct referrals via patients, carers, family or neighbours.

2. The integrated gateway, still in the developmental stage, aims to be a single point of contact for all health and social care referrals. At the gateway, call centre operatives working with health and social care professionals will assess each case using a single referral form and screening tool. From here the customer can be referred to the most appropriate care (e.g. urgent, ICCT or single professional). All referrals will be assigned a named care co-ordinator.

IT and information sharing

The aim for the economy is to have a single referral gateway, a single assessment and a single care planning document that can be shared between agencies. Sharing information is a challenge as the partner organisations operate on different systems, and some agencies such as social care are in the process of changing systems.

The economy has explored a number of different options that would facilitate information sharing across partners. Having looked at the learning from other areas they have decided on a system called Single View; a system which has successfully been used to share records within the youth justice sector.
They have now secured sign up from all the agencies to develop one Single View system and hope to implement this fully in summer 2014. Single View will act as a lens for all professionals working with an individual to see their single assessment, therefore supporting the coordination process:

“The methodology we are using here will enable practitioners to see whether someone has had a package of care, what they are getting on a daily basis and whether that’s working. That’s critical to know when you are planning your own intervention.”

**Risk stratification tool**

When fully implemented, the risk stratification tool is planned to be a key part of the integrated service model. It will enable the early identification of people most at risk of admission into hospital and invite them to be supported by a care coordinator. Prior to commencing their work, the economy has considered the evidence base from other areas using similar tools to help them decide between developing a purpose built model, or applying an existing model to their system.

Designing the right model has been a challenging aspect of the process. The selected risk stratification tool is not compatible for use with local authority data, which could potentially limit the scope of its future use if, for example, the partners wish to identify risk factors associated with entering long term residential care, which is an important programme aim.

To date, the risk stratification tool has been demonstrated in two general practices. These pilots will help to identify the most appropriate threshold for identifying people for intervention. The threshold will be decided in collaboration with GPs by running risk stratification reports and identifying the point at which they begin to identify unknown patients. GPs will play a crucial role from then on, in running the reports, sense-checking the list of names generated, and contacting patients.

The partners are now planning a consultation process with patients over the sharing of their data with the team. Conscious of the recent media coverage surrounding the sharing of patient data, they will ensure all data policies are in place and that patients are approached in a sensitive and transparent manner, to enable them to make an informed decision as to whether to take part.

**Achievements**

To date, eight integrated teams have been successfully implemented and are meeting daily in four locations across the economy. Plans are also underway to bring together an integrated therapies team spread over two bases, an intermediate care team, a hospital team, an integrated out of hours service and a single community gateway.

While it is too soon to identify outcomes for service users who have been through the new system, the economy has made some significant process achievements in
developing their service model and a collaborative culture at both strategic and operational levels:

— Successfully securing the buy-in from senior leaders and clinicians. This includes all partners signing up to implementing the Single View system from summer 2014
— Maintaining collaboration between all partners within a context of financial strain and increasing demands
— Frontline practitioners from different organisations are working well together to provide coordinated care for patients and service users
— The workforce is engaged in and supportive of the changes; this is credited to the partners’ significant investment in workforce engagement. The content of the workshops covered the culture of the teams, effectiveness of working relationships, vision, what the MDT would cover, what would be the role of the MDT Coordinators, how to share risk, and how to escalate problems
— The culture between the leaders is now more collaborative, with better communication and more streamlined processes:

“Our culture has come on a long way. At the beginning it wasn’t in our heads that it was an issue. I don’t know if we knew what ‘culture’ was then, but now we know.”

**Key Learning**

1. **Quality communications are key for securing workforce engagement:** Communicating information about the programme has been critical for gaining workforce support. While integrated care can sound like common sense at board level, on the ground it can provoke fears over job roles. The partners report that frontline staff can see integration as something additional to their day job, rather than something integral that could potentially ease their workload.

2. **Get staff from different agencies working together in the same place:** Colocation and daily meetings facilitate collaborative working and information sharing among professionals:

   “When staff sit down together, for example Social Workers and District Nurses, they will both recognise they are filling out forms and doing similar work, and when they are sitting in a room together they gel much quicker.”

3. **Invest time in developing an integrated culture between different frontline staff:** The integrated teams are currently sharing information through daily meetings. They are focusing on setting a collaborative culture for these meetings by getting professionals talking to one another and knowing each other. By building these foundations now, it means that when future systems require the teams to share information virtually they will have already developed the relationships and trust to support this.
4. **Having a common screening tool can help to align different professionals:** Developing a common screening tool requires buy-in across the partner organisations. However, once it has been agreed, it can facilitate joint working and an integrated culture.

5. **Provide a dedicated Programme Manager who makes themselves available to the frontline workforce:** In this economy members of the MDTs can bring their issues to the Programme Manager and give feedback around what is and isn’t currently working. For example, it has come to light that professionals are finding it challenging to find the time for integration work on top of their day jobs. In response they are now trying to build meetings on the back of existing ones to make the most constructive use of everyone’s time.

6. **Engage with trade unions from an early stage:** The partners have found that communicating with trade union representatives facilitates open and transparent relationships. This can ease anxieties regarding the impact of integration on the workforce.

7. **Co-design the service with front line professionals:** The economy takes an approach whereby the partners seek feedback on what is working and what isn’t working around implementation. For example, work is currently underway to develop their common screening tool. When they tested the tool with professionals it highlighted that more work needs to be done to make the content relevant and clearly presented. However, testing the tool also highlighted that work needs to be done around the ways that different practitioners are applying the tool:

“The screening tool [aims to] identify the areas that are relevant but practitioners are thinking in their social care mentality that you need to fill everything in…they are finding themselves getting bogged down in that.”

8. **Keep the service user at the centre:** The partners found that maintaining a focus on the outcomes for the patient/service user will help to break down cultural barriers between organisations:

“You have to work with them to say that there are differences [between organisations] but you can work through those, there are also quite a lot of things that are the same, you have to focus on the patient.”

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Case Study 10: ICC2 Liverpool’s Clinical Integrated Care Model

Culture

Summary

In Liverpool, financial cuts combined with increasing demand for services will inevitably impact upon populations with health and wellbeing needs, and potentially create gaps in service provision. Furthermore, by 2017 the largest acute provider will be rebuilt significantly reducing its bed base; creating further, urgent need to improve community care for those with long term conditions.

The partners in Liverpool are committed to transforming services for people with long term conditions. They are implementing integrated care through a three pillar approach of risk stratification, multi-agency multi-disciplinary team (MDT) working, and emphasis on self-care and education. By April 2014 the partners had implemented their model in all 18 neighbourhoods (with each neighbourhood serving patient populations of between 20,000-40,000 people).

Integrated care has been well embedded across the city, and programme evaluations show seemingly positive changes in emergency admissions and readmissions and effective MDT working. Furthermore the programme has made significant contributions to developing the self-care agenda across the city.

Many key learning points have emerged from this work, such as the importance of building on existing infrastructure and relationships, and remaining flexible to programme changes.

Background

The residents of Liverpool typically die earlier than those in most other parts of England. The area is faced with multiple challenges that place ever increasing demands on local health and social care services. Liverpool is an area of high deprivation; unemployment rates are currently 8.9% in Liverpool Walton ward (with 12.3% of men not working) and, for example, 5490 members of the Riverside population claim incapacity benefits.

Liverpool City Council is managing budget cuts of 52% over a three year period. The resultant changes will inevitably impact upon populations with health and wellbeing needs, and potentially create gaps in service provision. Specific additional impetus for change is provided in Liverpool, as the largest acute provider with whom Liverpool City Council contracts, the Royal Liverpool University Hospital, will be rebuilt by 2017 significantly reducing its bed base. This creates further, urgent need to improve community care for those with long term conditions.

Integrated Care is one approach to enhancing quality of life for people with long term conditions. In 2012 Liverpool joined the AQuA Integrated Care Communities 2 (ICC2) Programme in partnership with Liverpool Community Health NHS Trust, Mersey Care NHS Trust, Liverpool Clinical Commissioning Group (LCCG), Liverpool City Council (LCC), Secondary Care Trusts (with representation from Royal Liverpool & Broadgreen
and Aintree Hospital Trusts), local community services, health trainers and patient groups. The hope is that by changing the way that health and social care services work together – creating a seamless and integrated service – people can take more control over their own health and as a result, experience improved health and wellbeing outcomes.

Activities and approach

Vision

The LCCG-led Integrated Care Steering Group is committed to working together to transform health and social care services for people with long term conditions in Liverpool.

Objectives of the Integrated Care Programme are to:
- Define the Integrated Care model at neighbourhood level; across primary, secondary, social and community provision
- Identify health and social resources at neighbourhood level
- Engage communities in defining the model of care
- Commission the agreed model for health and social care.

Investment in this programme aims to make significant cost savings, based on evidence from similar initiatives implemented elsewhere in the UK and in Liverpool.

The model for integrated services

Integrated Care in Liverpool is built upon the Department of Health (Sir John Oldham) model, the three pillars of which are risk stratification, multi-agency multi-disciplinary working, and emphasis on self-care and education.

Integrated care is targeted at patients identified through the risk stratification tool, and also those who have long term conditions and are requested for inclusion by a member of the Integrated Care neighbourhood team (MDT).

Current data from the risk stratification tool shows that there are approximately 1,700 patients in Liverpool (0.35% of the population) with a 70% or more risk of unplanned admission to hospital. This rises to approximately 5000 patients (1%) with a risk score of 50% or more.

By April 2014 Liverpool CCG was implementing the Integrated Care Programme in all 18 neighbourhoods (neighbourhoods in Liverpool are clusters of GP practices, covering patient populations of between 20,000-40,000 people). Liverpool’s model for integrated care consists of several activities and processes including:
A MDT based in each neighbourhood, (consisting of on average 4-6 GP practices) that meet regularly to discuss patients and develop personalised care plans.

Each team currently has 1 representative from the following areas: GP, Community Matron, Medicines Management, Social Care, Mental Health, Health Trainer and an Administrator/Coordinator. Teams also bring in District Nurse team leads and Practice Nurses based on local need. Specialists are also drawn in on a neighbourhood basis – for example, in areas of high drug and alcohol use, a specific MDT is held quarterly with experts from local drug and alcohol services.

Each patient develops his or her own personal care plan with the support of a keyworker. Around 50% of patients require further interventions that are carried out by MDTs.

<table>
<thead>
<tr>
<th>Population Risk Stratification</th>
<th>Tool used to identify those at high risk of admission into hospital for inclusion in this programme.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Care and Prevention Agenda</td>
<td>The IC Programme was the initial driver for the self-care agenda in Liverpool in recognition that greater outcomes could be achieved if the approach to self-care was agreed on a wider footprint. As such, the IC programme influenced the early HLP agenda to ensure that a joint approach across health and social care was taken to self-care. Through HLP, the IC programme is working with the Health and Wellbeing Board (HWB) and they continue to develop the self-care and prevention agenda together. Different groups under the HWB work on different areas in the community including prevention; physical activity; and work on diabetes, respiratory, and healthy ageing.</td>
</tr>
<tr>
<td>Patient engagement</td>
<td>Significant pieces of insight work have been undertaken, enabling the co-design of programme outcomes with patients and carers. This work has been designed around the National Voices patient narrative for integrated care and has sought to prioritise the ‘I’ statement outcomes for the local population. A questionnaire has been designed to help capture the subsequent important information from patients. The IC Steering Group liaises with patient groups at the local level, and patient membership in the steering group is under establishment. The steering group acknowledge the importance of patient engagement in the process and agree that more needs to be done.</td>
</tr>
</tbody>
</table>
**Strategic Drivers**

**The Healthy Liverpool Programme (HLP):** The HLP is Liverpool CCG’s 5-year strategy. It focuses on areas of priority for local change so as to better tackle challenges; priorities include healthy ageing, neighbourhood working and better management of long term conditions. The Integrated Care Programme is aligned and embedded within the HLP, in particular within the aforementioned priority areas. The long-running IC Steering Group pre-dated HLP and is currently outlining the approach to transition into wider neighbourhood working structures, ensuring integrated care becomes ‘business as usual’ rather than a stand-alone programme. The HLP reports into both Liverpool CCG’s Governing Body and the Liverpool HWB.

**Developing partnerships between organisations**

The Integrated Care Model is being implemented at the neighbourhood level across Liverpool, and has relied on the effective development of partnerships. Partnership working has been an organic process, building on existing relationships and structures wherever possible. Prior to this programme, Liverpool was split into 18 neighbourhoods; each containing a cluster of 4-6 GP practices with 20,000–40,000 patients in total. This same neighbourhood structure is being used for the IC Programme.

These GP neighbourhoods were already working together with nurses and other providers; this gave a framework for communication and engagement. As such, MDT meetings were arranged so that they slotted in with these neighbourhood forums. These MDTs focus on identifying people in each neighbourhood with the most complex needs, in order to undertake care planning and problem solving activities with those individuals.

By building on this pre-existing neighbourhood framework, the foundations for effective communication and partnership were already strong.

“The neighbourhood set up is a helpful framework, as our ground teams were well established and already part of pre-existing networks.”

Liverpool has not applied a fixed approach or framework to the development of their partnerships; rather relationships have developed through continuous, one-to-one communication at all levels:

“It has absolutely been an ongoing process of relentless engagement and communication.”

Integral to the process of developing partnerships has been clear communication between the Steering Group and all levels of senior, middle and lower management in partner organisations. This includes engaging executive managers who are the decision makers, whilst also ensuring that dialogue occurs with middle managers and frontline staff:

“If you only speak to one group it will not work, you need complete organisational commitment at all levels. Only then will it be part of the working agenda throughout.”
“You cannot underestimate the necessity of speaking to all organisations and stakeholders at multiple levels.”

Whilst some partners were keen from the outset, there were also some initial difficulties bringing on more cautious and risk averse partners. To overcome this initial reluctance, extensive one-to-one meetings with chief executives and senior management were organised. Furthermore, organisations were kept informed and involved in all new developments. Subsequently all partners are now on board and represented at MDTs.

**GP Champions**

The way neighbourhoods and GPs have been engaged has also been crucial to programme success. The process has been GP-led which has been an integral ingredient to its success. Each GP neighbourhood was given £10,000 in their first year of the programme, to assist in setting up MDTs and begin the implementation of an integrated care model. The IC Steering Group has also provided support to each neighbourhood to establish a GP Champion in a leadership role, to ensure both the implementation of integrated care locally and attendance at the MDTs.

**Forward Planning and Insight**

In addition, Liverpool Community Health NHS Trust’s leadership team had also begun working on integrated care models; as a result, key leaders in the team had already started thinking about the meaning of integrated care and initiated discussions and approaches with other team members. When first bringing different organisations together to be part of the programme and the Steering Group, much planning was involved to ensure the buy-in of representative stakeholders. The pre-existing links and relationships built with key stakeholders and organisations by the Liverpool team helped kick-start the process.

**Scaling Up**

Initially the programme was rolled out only to 7 ‘phase 1’ neighbourhoods. By December 2013 (3 months earlier than planned), all 18 neighbourhoods had gone live and had mobilised their integrated care teams; all are now all undertaking MDT work. As more neighbourhoods joined, learning MDTs were organised. These were larger workshop events, so people could see what the Integrated Care Programme was doing and to allow each neighbourhood to review their progress. These learning MDTs also proved valuable for neighbourhoods that were not yet part of the programme, to explore how integrated care might effectively be implemented in their locality. The process has been very inclusive, with regular learning MDTs being organised in a systematic way, enabling representatives from each neighbourhood to come together and share learning:

“We’ve really changed people’s relationships and knowledge of each other’s services.”

**Achievements**

Integrated care has been embedded across the city, with emerging outcomes including:
Teams appreciate that they can achieve more by working together than separately.

**Outcomes evaluation report**
A formal evaluation cycle is established that looks retrospectively at the same period 12 months before; as such to date, an evaluation has been conducted on the very small cohort of 52 patients. Seemingly positive changes in emergency admissions and readmissions have been recorded. However, the number of patients is too small to draw any real conclusions. The next evaluation report is due to be issued in May 2014, which will encompass a larger cumulative cohort (approx. 150+ patients) and this evaluation cycle will continue to grow throughout the year.

**Evaluation with IC programme staff**
The ‘ITMA’ tool has been used to evaluate staff perceptions of integration. Responses from the first 40 staff (additional responses are still being gathered) have revealed that there is strong agreement that;

- Teams are working towards clear aims and objectives and appreciate that they can achieve more by working together than separately
- Team members ask for and receive help from one another

The ITMA tool has also helped to diagnose areas for continual improvement; examples include more team training and development, further improved electronic systems/information sharing and the need for continual support from within their own respective organisations.

**Patient & Carer involvement, engagement & insight**
The programme is based on extensive input from patients and carers in its design. A patient experience questionnaire has now been developed on the basis of the responses from over 300 people with long term conditions and their carers. Those experiencing integrated care will be contacted independently and their experiences gathered at the start and part way through their journey for evaluation and continual review of the programme. A systemised approach to administering the questionnaire had been established, although the timescale for each patient will vary.

**Liverpool’s Better Care Fund (BCF)**
Liverpool’s BCF plan has been jointly developed across health and social care commissioners and takes integrated care into account throughout, given its emphasis on ensuring a transformation in integrated health and social care. Stage 1 plans for Liverpool’s Better Care Fund have been approved by the Liverpool HWB.

**Integrated care rolled out across Liverpool**
All 18 neighbourhoods in Liverpool are now implementing integrated care. At the time of writing, 417 patients have been discussed in 97 MDTs city wide. Furthermore, over half of these patients have also been reviewed at least once in an MDT. All providers have been cooperative, collaborative and supportive of this process. Furthermore,
the programme has seen relationships vastly improve with various partners, notably the local Council.

The programme has been delivered within the total budget earmarked, as a result of every partner organisation delivering the MDTs using people’s substantive roles. This is expected to help to sustain the approach, by ensuring delivery is conceived as a transformation of people’s day jobs, rather than an additional burden;

“The whole thing at the moment has all been done on good will, because people know it’s the right thing to do. We’ve delivered the work through culture [change].”

**Next steps**

1. To date, there is a small amount of Liverpool-based evidence regarding the impact integrated care can have for patients. However more evidence will continue to be gathered on a larger scale, in order to define patient and organisational benefits with accuracy. The next evaluation report will analyse extensive data on the health and social care outcomes of over 150 patients involved in the programme to date, and this number will continue to grow in future reporting cycles. Following this review, the business case for sustaining the programme will be developed, clearly outlining the anticipated outcomes.

2. The partners aim to have integrated care established as ‘normal business’ by the end of March 2015. This will involve further integrating integrated care into the HLP at the neighbourhood level and aligning parts of the IC Programme into existing processes. For example, looking at how to align risk stratification with the ‘forget me not’ cards that are sent out by GPs to older people to self-risk score themselves. Alignment of this sort will allow MDTs to target integrated care capacity at the healthy ageing population. The partners aim to have effective teams in place that can assess and create care plans for the 5000 patients who are at 50% (and above) risk of unplanned admission.

3. Feedback from GPs in areas where the programme is working less successfully indicates that some individuals experience difficulties in bringing cases to a MDT meeting in sufficient time to make a difference. The reactive rapid assessment process therefore requires refinement. This will involve more coordination between the individual programmes operating under the HLP (including Integrated Care, the Neighbourhood Working project and Healthy Ageing project). The next step is to improve each neighbourhood’s ability to react quickly and effectively to urgent cases.

4. The partners are keen to maintain momentum. The IC Steering Group will meet monthly to further develop the model.

5. Further work will be carried out to engage patients and carers at every level of the programme. Analysis of data from the experience-based questionnaires will
take place on an ongoing basis and learning used to inform development of the programme.

Key learning

1. **Engaging the right leaders (decision makers and clinicians) at the outset is key:** This has helped to prioritise the programme within each organisation and create joint ownership and shared risk. GP involvement has been integral and the process has been very much clinically led, with the programme being co-designed with frontline professionals.

2. **Maintaining good relationships and building a shared vision with all stakeholders has been important:** Continuous communication allowed the Steering Group to capitalise on shared concerns and challenges. For example, most partners shared a sense of impending doom due to budget cuts and understood the need to change health and social care services. The Steering Group used this to bring everyone together and create a unified plan and vision.

3. **Build on existing infrastructure and relationships:** The programme was developed in a pragmatic way, using the 18 neighbourhood structure already in place and existing strong GP relationships. To begin with the programme did not involve all 18 neighbourhoods (which consist of approximately 450,000 people and 94 GP practices) as this would have been over-ambitious. It was important to start small, demonstrate benefits and learn from mistakes, and then bring the rest of the neighbourhoods on board.

4. **Be conscious of the impact on health inequalities:** Efforts are being made to ensure that health inequalities are not widened, are addressed appropriately and are handled with a pragmatic approach. Early analysis has shown that the ratio of high risk patients to weighted population is relatively balanced across the city; where it is not, multiples of the above core team members may be recommended for inclusion in a neighbourhood’s core team. This will be continually evaluated as data is captured.

5. **Be flexible and prepared to adapt the programme timeline and strategy:** Initially, the inclusion of all neighbourhoods in the programme was planned to happen slowly. However, when the national government introduced the Direct Enhanced Service (DES) for GPs to get involved in Integrated Care, most practices wanted to get involved right way. The initiative was introduced with an ‘all or nothing’ approach which actually produced some serious challenges. The programme had to support those practices that wanted to get involved earlier than planned. It meant the process of bringing all 18 neighbourhoods into the programme did not allow for timely and tailored engagement. The DES did bring new GP partners willingly onto the programme but many were not ready or as fully committed to the programme as existing partners. Although learning MDTs (larger workshop events) were organised in response to this, these new partners did not go through the same iterative narrative process.
6. **Having a compelling narrative is integral:** AQuA were clear that there was a need for a persona example when promoting the programme and trying to get stakeholders on board. Liverpool have used a well known persona called ‘Our Terry’ that had been created by the LCCG. Their 5 year HLP plan was built on this character and they have in fact further developed a whole family of personas. The Liverpool IC Programme found using a persona to be a useful method of grounding and landing ideas with stakeholders. It is important to use a persona that speaks to your target audience. Liverpool found that 28% of their IC patients in the over 70% risk pool were between the ages of 40 and 59. They therefore did not use an elderly persona like other areas, but a middle-aged man that a large proportion of their target demographic could relate to.

7. **A dedicated Programme Manager is essential:** A Programme Manager is needed because the clinicians alone cannot ensure the programme is implemented successfully. It is important that the responsibilities are not a bolt on to someone’s job and that they are able to focus on doing the necessary groundwork. The LCCG recognised that if they wanted the programme to work, they had to resource it.

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