Executive Summary

Integrated Care Model for Oldham

AGMA Informal Leaders Meeting 28th June
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Integrated Care Model for Oldham

<table>
<thead>
<tr>
<th>Overall Aim and context</th>
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<tbody>
<tr>
<td>1. Integration is not new to Oldham as partners have worked together over many years developing integrated partnerships, commissioning arrangements and service delivery.</td>
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<td>2. A Local definition of integration based on discussions to date, has been suggested as:</td>
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“The approach by which by total patients needs are coordinated, the interventions are connected, the pathway of care is seamless and the contributions of professionals, services and organisations are regulated for quality, performance and adherence to optimal customer quality standards …delivered by properly structured care, delivered by professionals who care and are motivated to work to the highest standards”

| 3. This needs to be delivered via a jointly developed local system of public service delivery based on a solid and common platform. |
| 4. It is accepted that there are some areas of good practice however there is still no system wide approach. The past year has seen the beginnings of such an approach and there has been some success in bringing together key stakeholders to redesign co-ordinated pathways both into and out of hospital. However, much remains to be done, and whilst there is some understanding of making best use of ‘the Oldham pound’, there has been no significant agreement to transfer monies across systems to achieve better outcomes. |
| 5. The Integrated Care Model going forward, which will deliver the required system changes for Oldham, is being based on a two pronged approach: |

- A place based approach to Public Service Reform which recognises the broader determinants of health and those cross cutting factors which affect service demand (initially being prototyped around the wards of St Mary’s and Coldhurst and associated GP cluster)

- A whole system approach to urgent care and longer term conditions (as the Health and Social Care element of PSR) based on an alliance contracting model and shared risks and benefits

| 6. The Integration Plan therefore looks at both these elements under the respective headings, recognising that delivering a coordinated approach to Urgent Care/Long Term conditions is a fundamental part of realising the wider PSR ambition. |
| 7. Whilst the focus does need to remain on reducing demands on the health and social care system with more community based alternatives, the solutions require a fundamental shift in |
behaviour and culture to harness a whole-systems approach that goes far beyond traditional health and social care responses.

8. The model explained in subsequent sections of this plan, is predicated on the work underway on integrated commissioning and service delivery, embracing new investment models, new ways of working, neighbourhood approaches, partnership agreements and alliances and clear efficiency and outcome ambitions.

9. The aim of implementing the local integration plan is to bring about whole-system change and service redesign in the context a place based approach which maximises contributions of stakeholders including citizens and patients.

10. Oldham is committed to achieving a cooperative future, where citizens, partners, the Clinical Commissioning Group and the Council work together to ensure a productive borough with confident and resilient communities. The aim is that everyone ‘does their bit’ with everyone benefiting.

11. Oldham is developing a Cooperative Public Services Model which takes the opportunity provided by the difficult and challenging times facing the borough to reshape fundamentally the relationship between public services and residents.

12. In this way it will:
   - help create social value for citizens and communities;
   - enhance citizen autonomy, capability and resilience;
   - unlock citizen resources
   - support existing social networks and build collective community capacity

13. A new model of public services requires a new way of working with new delivery models and approaches to investment being part of this.

14. Work in Oldham to date has shown that to be successful in delivering better outcomes, promoting independence and reducing cost, there needs to be continued work on developing partnership relationships and ways of working together effectively at a strategic level as well as at an operational level. This includes working with central government and Greater Manchester organisations as well as partners in the borough.

**Partners involved and governance**

15. The wider PSR approach to integration includes a wide range of partners much broader than health and social care, including police, probation, schools, voluntary, community and faith organisations, citizens and patients. The governance for the PSR work is through the Chief Executives Management Board at a high level, as it is a senior level Partnership Board.

16. The Oldham Urgent Care Partnership Board was established in April 2012. The partners are NHS Oldham/CCG, Pennine Acute Hospital NHS Trust, Pennine Care Foundation Trust, Go to Doc, North West Ambulance Service and Oldham Council. This has developed into the urgent care alliance underpinned by a Memorandum of Understanding, key result areas and an investment model.

17. The specific work around urgent care and long term conditions is ‘owned’ by the Urgent Care Alliance as providers (including primary care providers) and the Integrated Commissioning Partnership as joint commissioners. The delivery vehicles are respective strategy and operational groups covering specific areas such as Integrated Health and Social Care Teams, continuing care etc.

18. An Alliance Leadership Team and an Alliance Management Team is being established to take forward the urgent care integration agenda within Oldham. It is proposed that the Leadership
Team consists of the Chief Executive, the Director of Finance, the Director of Operations and a Clinical lead from each organisation. There will be a requirement for the leadership team to meet regularly in the early stages, to support the Alliance to gain momentum, however this is likely to reduce over time.

19. It is recognised that urgent Care is one element of the integration work overall.

20. In respect of governance it is important that community/political leadership are closely aligned with NHS clinical leadership and GP structures and that key leads work together to get a good understanding of what is required at both a local and strategic level.

### The people

21. Oldham has an overall population of approximately 220,000. The place based prototype is being worked up on two ward areas totalling around 24-30,000 people.

22. In delivering the urgent care agenda, the populations at question will vary depending on the theme or age group being addressed.

23. In relation to targeted work around the work of health and social care teams, the risk stratification tool is being used to identify the top 5% of cases within practices.

### The new service model

**Context for Place Based Approach**

24. The new service model will be set in the context of PSR and the work underway with partners, particularly around the urgent care alliance and place based approaches to tackling behaviour change and new ways of working.

25. It has become clear that a key problem with previous pilots and prototypes is they have been operating in isolation, and are often seeking to change an individual’s or a family’s behaviour, without changing the things that are driving them to behave in that way. This has led to the following thinking:

- Outcomes for local people and communities are hugely impacted by their behaviours, and unless we can change these behaviours, outcomes are unlikely to significantly improve, regardless of any other public service inputs. Understanding the drivers behind these behaviours is therefore crucial.
- In-depth customer research has demonstrated that some of the most important influencers of people’s behaviour are their social contacts and community networks – whose views are driven by local social norms and local economic circumstances.
- In order to impact on people’s behaviours in a meaningful and sustainable way, we therefore need to ensure that their social contacts and community networks are influencing in positive ways and reinforcing positive changes in behaviour.
- In order to improve outcomes not just for individuals but for communities, a focus on understanding, working within, and changing where necessary the social norms in an area is therefore vital.
- This community-wide improvement in outcomes will then drive a reduction in demand on key reactive public services (such as A&E, unplanned and emergency admissions to hospital, Policing and Social Care), which can be translated into freeing up resources currently tied up in responding reactively to crisis situations.
26. It is proposed that the learning from thematic work (including Early Years and Health and Social Care – will now be layered into a whole system/whole place approach that will seek to address community and place issues as well as targeting particular individuals and families.

27. It is recognised that most people, most of the time, solve their own problems. The public services role is to encourage and support this, extending individuals/communities role to helping support others.

28. As such, it will be adapted to respond to the particular communities partners are working within – both in terms of influencing service design and in terms of building capacity within the communities to do more for themselves. An additional layer of work will be included across the whole community looking at developing community capacity and (where necessary) starting to shift social norms so that the community polices itself effectively.

29. For example, a key piece of learning from local community insight work in St Mary’s and Coldhurst is that the communities in that area prefer to resolve issues for themselves, rather than bringing in public services. However, they do not currently have the skills to do this effectively, so issues escalate to the point where they are serious. Rather than coming in and setting up a service to ‘deal with’ this, as part of a whole system/whole place approach, partners would look instead at how they can build the community capacity so that citizens can deal with the issues they want to deal with more effectively.

30. Fundamentally the aim will be to reform public services to:
   - Work co-operatively with other services and residents to improve residents' outcomes, so they are more productive and self-reliant, and therefore less dependent on public services
   - Understand and agree where demand is reducing and where it is therefore possible to safely take capacity out of the system

**Urgent Care Alliance**

31. The development of the Urgent Care Alliance will support the integrated care objectives for the whole system through a new way of addressing the challenges, risks and issues facing the health and social care economy.

32. A Memorandum of Understanding, key result areas, performance frameworks and investment models have been developed to help deliver the partnerships’ aims of improving the macro (LTC Urgent Care Population) health status of a given population segment and the experience of LTC & Urgent Care for the individual (provided & self-managed) in a way that demonstrates optimal resource management.

33. The integration of services across Primary Care, Community Care and Social Care is a major priority for the partners. A significant amount of integration work has already commenced within the urgent care partnership, however the focus needs to be widen to include the whole of the patient’s pathway experience from daily self-care, through core Primary Care into Community Services and subsequently into the Acute and Mental Health sector. Whilst significant progress has been made with clinical and pathway redesign, and establishing closer relationships, this is not yet supported with a robust governance, performance management and contractual infrastructure.

34. The ultimate key success factor will be for local people (the Oldham family) to indicate that they have seen a positive difference to the way in which contributors to their care are more organised, systematic and appreciative of their individual care requirements.
The Model explained

35. The new service model for both the place based and whole system aspects of urgent care/long term conditions can be described diagrammatically as shown on pages 8 and 9.

36. The first shows the concept of the PSR Model for whole system, whole place reform. It shows the complexity of the relationships. It requires a totally connected public service system, based on a premise of 'placed based' leadership, connectivity, resource deployment, contributions and community engagement.

37. The second diagram shows the model that illustrates 'Making a difference to the Oldham Family'. The case study used in the example relates to 'Ethel' and show how the Oldham model delivers better outcomes and a more joined up response. The success of the work being done will be 'Ethel' feeling in control of her life.

38. The outer blue wheel describes the local public services partner connections and contributors. The lighter blue wheel describes the processes that partners need to get better at connecting – all of which contribute to integrated care.

39. The central premise is that every asset at the whole systems disposal should be connected to improve value for the local people in the community in question.

40. The models are underpinned by a number of assumptions and requirements:

- Integration does not start with cost reduction, it is about doing the right things in the right places, at the right cost at the right time
- Demand management is essential across all parts of the system
- Capacity is needed across the system to deliver the required changes at pace
- Approaches should demonstrate an understanding and agreement where demand is reducing and where it is therefore possible to safely take capacity out of the system
- A Co-operative model of reform is required with everyone 'doing their bit' to create a more prosperous Borough
- There is a need to capitalise on local relationships with and within communities
- Behaviour change and addressing social norms is essential for delivering effective PSR
- High quality, contribution based primary care is the cornerstone to integration particularly around urgent care
- Shared decision making needs to form the basis of all consultations
- Community based services will be re-specified (health and social care)
- Contracting vehicles need to be geared up to support whole system integration and risk management across providers
- Robustness of assumptions and calculations must be continuously refined
Risks

41. A key issue and risk for the whole system at a time of significant resource pressures and organisational change will be maintaining and developing the required capacity and skills to deliver this complex and challenging agenda. This challenging environment however does provide the necessary drivers to maximise opportunities to reconfigure and transform services through creative commissioning and innovative partnering arrangements.

42. The role of the NHS Commissioning Support Service alongside the emerging structures for the Integrated Commissioning hub will need to be explored to ensure they can support this agenda effectively for Oldham.

43. The demographic context shows increasing demand through an ageing population with higher level of long term conditions including dementia. Policy changes, in particular welfare reform will have an impact on the need for services and support.

44. Public sector services are seeing significant reductions in their budgets and so there needs to be a ‘buy in’ to a collaborative approach which involves different ways of working, pooling resources and trust and co-operation. This involves cultural shifts which pose risks if not managed effectively across the system.

45. In addition risks also relate to different and potentially conflicting priorities, different levels of commissioning (potential tensions between district/borough/AGMA/GM based approaches) and overall pace of change with organisational structures and functional changes.
The PSR Model for whole system, whole place reform

1 The financial information are illustrative and more work is being done to quantify this
Making a Difference to the Oldham Family: Case Study Ethel

Meet Ethel

Ethel is 70 years old. She lives alone in Lees and, although she has family, they don’t live nearby. Ethel is a long-term smoker who has diabetes and heart failure and is prone to falls. She can’t remember things as well as she used to. She lives in a cold, damp house and depends on benefits to make ends meet. As she becomes frailer, she finds she sees her friends less. She regularly forgets to take her medication. She regularly attends Accident and Emergency and is often confused. She is most afraid of losing her independence.

Outcomes

Ethel will benefit from improved access to services when she needs them. The holistic management of her long-term condition will improve her mental wellbeing.

Partners will work together to improve Ethel’s home environment, which will help her to stay well and live independently.

Ethel will be supported to take her medication and will need to attend hospital less frequently.

When she becomes unwell, health and social care will be co-ordinated to ensure she receives continuity of care.

Ethel will feel in control of her condition, have fewer episodes of confusion and will regain her confidence to go out more.
The Investment proposition/Money Flow

Place based approach

46. Investment models and options are currently being worked up to support PSR ambitions and the place based solutions.

47. It is recognised that investment will be needed, principally up-front and one-off, to finance cost of change, programme management and staff changes. This will need to be within the resources currently within the respective financial plans relating to the innovation funds and the joint work between the Council and the CCG.

48. Robustness of assumptions and calculations will need to be continuously refined and tested to ensure they are future proof and fit for purpose.

49. The funding within the system needs to be able to flow to the services that enable the best outcomes. Examples of potential financial mechanisms to address this can include aligning resources virtually, a Pooled Budget or through a Community Budgets approach.

Urgent Care/Long term conditions

50. With urgent care in particular the funding will require shifts in resources to allow a move to more care being provided away from the hospital and at the preventative end of the spectrum whilst ensuring that individual organisations within the partnership are not negatively impacted.

51. The initial stage, currently being undertaken is to map investment throughout the system and across organisational boundaries. Once this has happened, accurate modelling of the impact of revisions to this will be required in order to understand the changes to both the Council’s and partner organisation’s investment levels and how this is to be funded.

52. £657,000 has been taken from the baseline of the contract with PAHT for 2013/14 for non-elective admissions, based on the interventions already underway within the partnership. This has been based on benchmarking opportunities, and reflects assumptions based on the DOH LTC QIPP programme.

Evaluation/review

53. Performance frameworks and dashboards are in place for much of the urgent care work and will be developed for the place based PSR prototyping. In particular a robust evaluation framework is being set up for the ICC cluster/St Mary’s and Coldhurst place based PST prototype. This includes a control group to measure the comparative results of ‘business as usual’.

54. This evaluation will demonstrate the impact of the place based approach on improving outcomes and reducing demand, providing the necessary evidence base to decommission activity in services where demand has reduced.

55. It will look initially at demonstrating the immediate impact of a place based approach on key indicators between July and September 2013 to provide the basis of negotiations for an investment proposition in the autumn. The evaluation will then continue to track longer term shifts in outcomes.

56. In addition to the PSR evaluation framework, the CCG and council have developed a whole system detailed 100 day action plan for integration with which will be refreshed every 100 days to ensure traction and enable progress to be overseen and addressed.
57. Locally much work is underway on urgent care through the alliance and work of the Integrated Care Partnership. An Integration Implementation Plan has been drafted which supports this executive summary and developing plan.

58. It is important that this plan along with work being undertaken on broader PSR initiatives is reflected in respective plans and reports for consistency.

59. Plans and further work will be aligned as far as possible with District working and linking wards to GP clusters.

60. The diagrams on page 12 and 13 show some of the key timelines and work in progress.
Systems Already Underway

13/14 clinical change programmes

- EQALS – phase 1
- Integrated Health and Social Care Teams – phase 1
- Implementation of falls service (partial year effect)
- Consultant support to Nursing Homes
- Cancer 1:1 Macmillan pilot
- Mental health – memory service mobilisation / IAPT / ASD procurement / CMHT review / Birchwood
- Alcohol liaison service
- ICC cluster selected for phase 1 ‘place based’ pilot
- Planning with OOH and NWAS to reduce OOH admissions
- Mobilisation of integrated diabetes service
- Implementation of ESD (partial year effect)

Outcomes (phase 1 – under construction)

- Reduce paediatric admissions – 10%
- Increase patients who feel in control of their LTC
- Increasing proportion of deaths in preferred place of care
- Reduction in admissions OOH for ACS conditions
- Reduction in NEL admissions from care homes
- Reduction in delayed transfers of care
- Reduction in placements in residential care
- LTC QIPP - £657K

URGENT CARE ALLIANCE
Alliance Contracting (phase 1 – under construction)

- PAHT - £46.7m
- PCFT - £12.25m
- GTD - £2.1m
- OMBC - £6.5m
- CCG (proxy for PC EQALS scheme) -
PSR Place Based approach - roadmap for implementation

Now-end June | Initial: July-September | October-March | April onwards
---|---|---|---
**Stage 1** Design the place-based approach and evaluation model | **Stage 2** Test and evaluate the place-based approach | **Stage 3** Scale up for 14/15 depending on strength of evidence | **Stage 4** Scale up further
Identify current service provision in St M & C | Implement new model | Repeat Stage 1 for new areas | Repeat stages 1-3 in new areas as relevant
Cost current provision | Problem solve, iterate changes to model as learning emerges | Finalise Investment Agreement for 2014/15
Analyse community context, social networks, local economic circumstances | Collect and analyse data | 
Co-design solutions | Agree investable proposition |
Reconfigure services | 
Design evaluation | 
Data sharing and data processing arrangements | 

Ongoing analysis of place-based approach for at least 18 months