Work Package 2 Report

United Kingdom

Work Package 2: Thick descriptions of

- – Salford Integrated Care Programme (SICP) / Salford Together
- – South Somerset Symphony Programme

WP leader:

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The SELFIE project

SELFIE (<u>S</u>ustainable int<u>E</u>grated chronic care mode<u>L</u>s for multi-morbidity: delivery, <u>FI</u>nancing, and performanc<u>E</u>) is a Horizon2020 funded EU project that aims to contribute to the improvement of person-centred care for persons with multi-morbidity by proposing evidence-based, economically sustainable, integrated care programmes that stimulate cooperation across health and social care and are supported by appropriate financing and payment schemes. More specifically, SELFIE aims to:

- Develop a taxonomy of promising integrated care programmes for persons with multi-morbidity;
- Provide evidence-based advice on matching financing/payment schemes with adequate incentives to implement integrated care;
- Provide empirical evidence of the impact of promising integrated care on a wide range of outcomes using Multi-Criteria Decision Analysis;
- Develop implementation and change strategies tailored to different care settings and contexts in Europe, especially Central and Eastern Europe.

SELFIE strands of research and work package (WP) overview
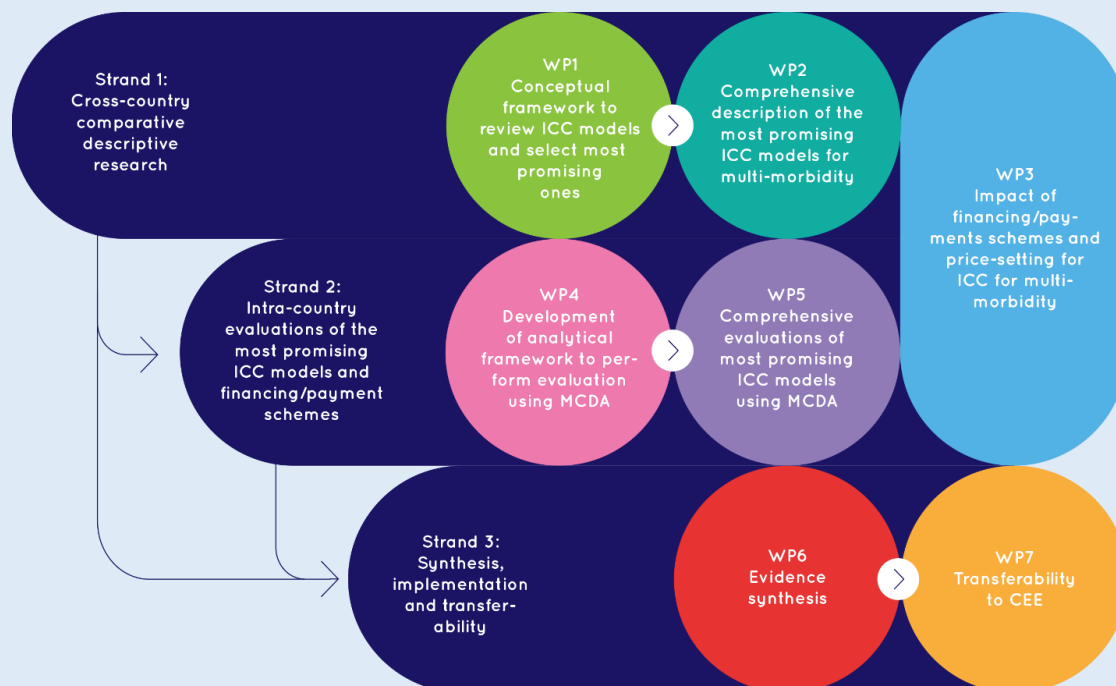
The SELFIE consortium includes eight countries: the Netherlands (coordinator), Austria, Croatia, Germany, Hungary, Norway, Spain, and the UK.

Executive summary

Salford Integrated Care Programme (SICP) / Salford Together

Salford's programme is aimed at the elderly (over 65s) and consists of three broad interventions: 1. Multidisciplinary groups (MDGs) – case management of the highest-risk patients by neighbourhood groups; 2. Community assets – investment in community assets to promote social interaction and active lifestyle; 3. Centre of contact (/health coaching) – a centralised telephone hub to help with navigating services and self-management.

Service delivery
Stakeholders described a dilemma, namely that those with multi-morbidity (particularly the elderly and frail) may be those who struggle the most to self-manage, despite being those who potentially have most to gain from it. Professionals in the Salford programme appear to agree that organisational and structural integration (rather than service delivery changes) are the most important aspect of delivering efficiency savings, and, thus, sustainability. However, the protection of market regulation at the macro-level was felt to sometimes act as a barrier to integration (particularly organisational integration).

Leadership & governance
The usual time pressures faced by professionals outside their programme commitments have made MDG attendance and shared decision-making difficult. There have also been continued issues in coordinating with those not directly involved in the integrated care programme. Supportive leadership, historical relationships and the direction of wider national policy are seen as key enablers of integrated care in the area.

Workforce
The programme has found that MDG team management alone is not sufficient for integration to occur. Co-location is, however, seen as particularly beneficial for relationship building between professionals.

Technologies & medical products
The introduction of shared records was seen as particularly important, but has been difficult to implement due to the macro context.

Information & research
The value of healthcare data used for risk prediction has been questioned by professionals (by definition, patients selected by these tools are already well known to healthcare services). There is some evidence of evaluation fatigue, but the CLASSIC study allows us to ease this workload on the programme.

Financing
Other work pressures beyond those additionally incentivised have remained in place for the professionals. The programme has found non-financial incentives (e.g. access to other benefits

conditional on participation) beneficial for ensuring provider participation. The programme envisions moving towards a single provider of services model, but this is potentially in conflict with the national choice and competition agenda.

South Somerset Symphony Programme

South Somerset's programme is aimed at multi-morbidity (i.e. patients with multiple chronic conditions) more generally, and consists of two broad interventions (with a commonality of 'health coaching'): 1. Complex care hubs – an 'extensivist' GP model with GPs located in a hospital hub and individually managing the most complex patients; 2. Enhanced primary care – co-location of health coaches in GP practices to assist with disease self-management and prevention.

Service delivery
Self-management through health coaching is a major focus of the programme (in both delivery models), but realisation has occurred that changing a complex patient's ability to self-manage is difficult, and there is also the danger of creating a dependency on the additional services offered. Shared decision-making and life goal setting are seen as important first steps to self-management, but this approach is not for everyone (some patients still prefer a traditional paternal doctor-patient relationship). There is plenty of room for informal caregiver involvement in the programme, but some safeguarding issues have arisen with this.

Leadership & governance
Supportive leadership and historical relationships are again seen as key enablers. There have, however, been issues with connecting with those outside the immediate professional boundary of the integrated care programme.

Workforce
Co-location has been seen as particularly beneficial for relationship and trust building. New less-professionalised roles have been seen as positive for addressing patients' needs and in allowing professionals to work to the top of their license. However, some patients might see their interaction with new roles as a 'downgrading' of their own importance.

Technologies & medical products
A single shared electronic record has been exceptionally difficult to implement given the macro environment, but is nonetheless seen as an essential enabler of integrated care by the professionals. Patient interaction with technology has been available, but uptake has so far been poor (there have been some teething problems + the elderly and IT-illiterate are perhaps those least likely to use it). Use of tele-health is developing through the programme and is seen as positive for keeping patients at home, but requires active participation, so the ability of neediest complex patients is again questionable.

Information & research

The data-driven risk tool used has been seen as a potentially useful starting point for identifying patients, but not entirely adequate for the selection of the 'right' patients. Instead, GP knowledge is seen as the ultimate deciding factor. There has been a gradual move away from a focus on the highest-risk patients to attempt to prevent escalation in the first instance rather than 'fire-fighting'.

Financing

Pump-prime funding has been available and seen as necessary, but the amount given was not as requested, so the programme has not been implemented entirely as planned. National competitive tendering and governance policies have again found a tension with the envisioned formation of an Integrated Accountable Care Organisation (IACO). Independent GP practices have been particularly difficult to contract and to integrate into the hospital's vision (as GP contract is not directly held by the programme).

1. Methodological approach

This report is part of WP2 of the project SELFIE. The WP leader is the *Institute for Advanced Studies* (IHS) in Vienna, the WP co-leader is the *August Pi i Sunyer Biomedical Research Institute* (IDIBAPS) in Barcelona. The stated objective of WP2 is to comprehensively describe the 17 integrated chronic care (ICC) programmes selected in the course of WP1, covering the following features:

- **Barriers to and facilitators of implementation**: how were the most promising ICC models implemented and what were the barriers and facilitators during the implementation phase?

- **Patient centeredness**: how is the delivery of care designed around the patient?

- **Use of modern ICT**: which ICT (information and communications technology) applications are used in the most promising ICC models to support the care process and what are the requirements for implementing them successfully in the treatment of patients with multi-morbidity?

- **Use of self-management interventions**: which self-management interventions are used in the ICC models and how are they adapted to patients from different cultural and socio-demographic groups as well as to distinguish the conditions for their successful implementation?

- **Involvement of new professional roles**: are there new professional roles (e.g. physician assistants, nurse practitioners) involved in the ICC models and what are the barriers and facilitators in their successful introduction?

- **Existing evidence**: what is the existing evidence of the impact of the most promising ICC models?

The methodological approach chosen to achieve this objective is that of a "thick description". For each of the eight countries participating in SELFIE, this report contains at least two[1] thick descriptions of the programmes selected in the respective country, resulting in a total of 17 thick descriptions.

The method of thick description is a well-established qualitative empirical approach. The basic idea was first introduced by the philosopher Gilbert Ryle (Ryle, 1949). In the 1970s, it was established as a qualitative method to investigate implicit social practices in their specific contexts by the anthropologist Clifford Geertz (Geertz, 1973). Geertz himself does not provide an explicit definition of this scientific approach. Studying thick descriptions by Geertz himself as

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[1] Three in the case of the Netherlands.

well as other scholars, however, makes it possible to deduce the main aspects of the method. In the following quote, Geertz outlines the aims of the method:

> *"Setting down the meaning particular social actions have for the actors whose actions they are, and stating, as explicitly as we can manage, what the knowledge thus attained demonstrates about the society in which it is found and, beyond that, about social life as such. Our double task is to uncover the conceptual structures that inform our subjects' acts, the 'said' of social discourse, and to construct a system of analysis in whose terms what is generic to those structures, what belongs to them because they are what they are, will stand out against the other determinants of human behavior. […] provide a vocabulary in which what symbolic action has to say about […] the role of culture in human life can be expressed." (Geertz, 1973: 22)*

In recent decades, Geertz' methodological and conceptual work has influenced empirical research in several disciplines (McCloskey, 1988). In sociology, it is widely used in a variety of research fields, including research of care practices (Maloney-Krichmar and Preece, 2005).

As shown in Figure 1, a thick description covers several levels of depth of analysis. The starting point is a formal description, which provides information on the surface of the studied phenomenon.
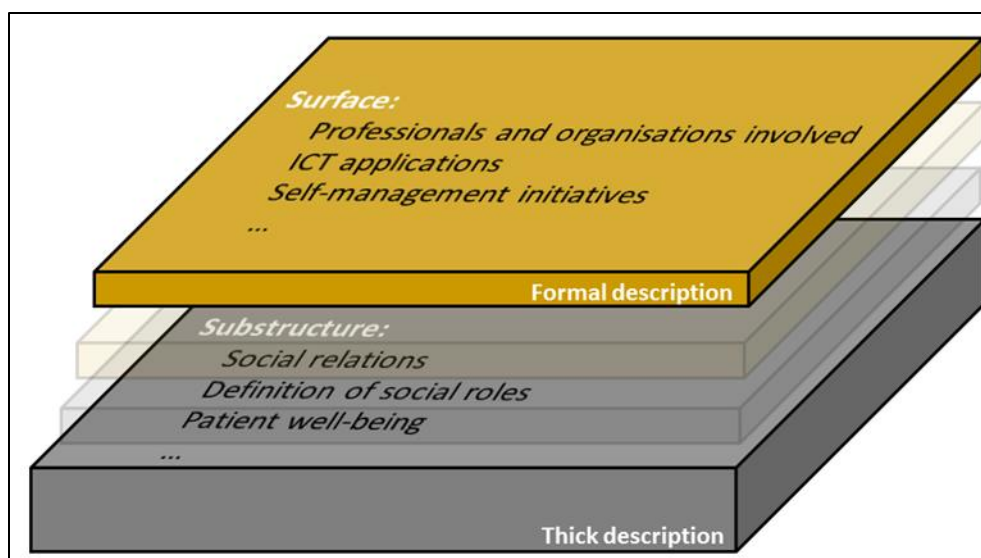
Figure 1: Levels of the programme description. Source: HIS (2015).

In the specific context of the SELFIE project, this formal description pertains to the general organisational structure of the programme and formal relations of the involved stakeholders. The formal description is valuable in itself, because it gives an overview of the domains and levels of integration, the individuals and organisations involved, the tools used and the processes employed. In particular, the formal description includes the following information:

- Name of the programme
- Contact details of the programme management
- Starting date of the programme
- Geographical scope of the programme
- Target group of the programme (type of individuals/scope/included combinations of morbidities)
- Number of persons treated in the programme (total and development over time)
- Aim of the programme
- Definition/understanding of "integrated care" (as far as described in documents)
- Definition/understanding of "multi-morbidity" (as far as described in documents)
- Definition/understanding of "person centredness" (as far as described in documents)
- Definition/understanding of "self-management" (as far as described in documents)
- Organisational form and ownership of the programme (including legal form)
- Involved partner organisations (payer(s), medical and social service providers), including subdivisions (e.g. departments of a hospital)
- Involved disciplines and professions

The formal description is mainly based on available literature, a variety of documents (e.g. official documents of the programme, grey literature) and expert information. A document analysis was performed on these materials, which comprise the first source of information and the basis for obtaining "hard facts" on the respective programme.

However, written documents are in general not suitable to give a deeper understanding of what actually constitutes the programme below its surface when put into practice. These substructures are, however, essential for the functioning of the programme. In addition to the formal description, the method of thick description therefore aims to gain insights on what lies beneath the surface of the studied phenomenon (see Figure 1).

For the purpose of gathering the necessary information, interviews were conducted with different stakeholders involved in the programme. These served as the second source of information. While the interviews were also used to complement the "hard facts" gathered in the course of the document analysis, their main aim was to obtain "soft facts" about the substructure of the programmes. Therefore, questions of "how" and "why" were at the centre of the interviews and the subsequent analysis of their contents. This comprehensive approach allows for a deeper understanding of what daily practice in the programme looks like and in which way multi-morbidity is addressed in the specific context of the programme.

A set of stakeholder types to be interviewed was defined in advance. This set consisted of the following stakeholder types:

A. **Manager(s) of the programme**

B. **Initiator(s) of the programme**: individuals or representatives of institutions that participated in initiating, conceptualising and planning the programme (e.g. representatives of sickness funds, physicians, etc…)

C. **Representative(s) of sponsor/payer organisations:** individuals or representatives of institutions that fund the programme on a project basis or on a regular basis (e.g. representatives of sickness funds, representatives of municipalities, representatives of associations, etc…)

D. **Medical and social staff**
   D1: physician(s)
   D2: non-physician medical staff (e.g. nurses), social staff, new professional groups (if applicable)

E. **Informal caregivers** (e.g. relatives, neighbours, volunteers)

F. **Clients or their representatives** (e.g. clients or persons in their close environment, representatives of self-help groups)

G. **Other stakeholder(s)**: individuals or representatives of institutions, who turn out to be of specific relevance for the respective programme and do not fit in the categories A.-F.

For each stakeholder type, the WP leader set a minimum number of persons to be interviewed. However, considering that the 17 selected programmes involve very different kinds of stakeholders, a specific sample of interviewees was developed for each individual programme. The partners discussed these samples with the WP leader, in order to ensure a balanced sample structure in each programme.

For each of these stakeholder types, thematic focus areas were defined. Based on these focus areas, a set of interview protocols was prepared by the WP leader. The protocols accounted for the different backgrounds and relevant themes of the individual stakeholder types. This served the purpose of gaining insights into the programme from various perspectives. The included questions concerned, for example, the stakeholders' perceptions of delivery of care for persons with multiple chronic conditions, their roles and relationships in the programme, their specific problems and their personal views.

In general, all interview protocols were structured according to the following outline:

- A Brief introduction about SELFIE and the interviewer as well as clear information about the goal of the interview
- Signing and exchanging the anonymity agreement and the declaration of consent for recording
- First question: Regarding the person's qualification and position in the programme

- Next question: Regarding the main work of the interviewee and his/her specific role in the programme
- 1-2 main questions: Regarding the work in the programme (covering selected focus area of respective stakeholder type)
- (Direct and indirect follow-up questions)
- Last question: valuation of an important aspect of the programme

The interview protocols were adapted by the partners according to the specific context of each programme and interviewee, using prior knowledge obtained from the document analysis and from previous interviews. The interviews were carried out face-to-face and the interview duration was between 30 and 90 minutes. The interviews were recorded and transcribed. The resulting transcripts were analysed using the method of content analysis developed by Mayring (Mayring, 2001). This method involves the following steps of abductive interpretation[2]:

- Selecting units of analysis
- Paraphrasing these units of analysis
- Transforming the paraphrases to short forms
- Constructing categories, where possible

The thick descriptions are structured according to the elements of the conceptual framework developed in the course of WP1. The model is depicted in Figure 2.

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[2] Timmermans and Tavory (2012) define abduction as a "creative inferential process aimed at producing new hypotheses and theories based on surprising research evidence."
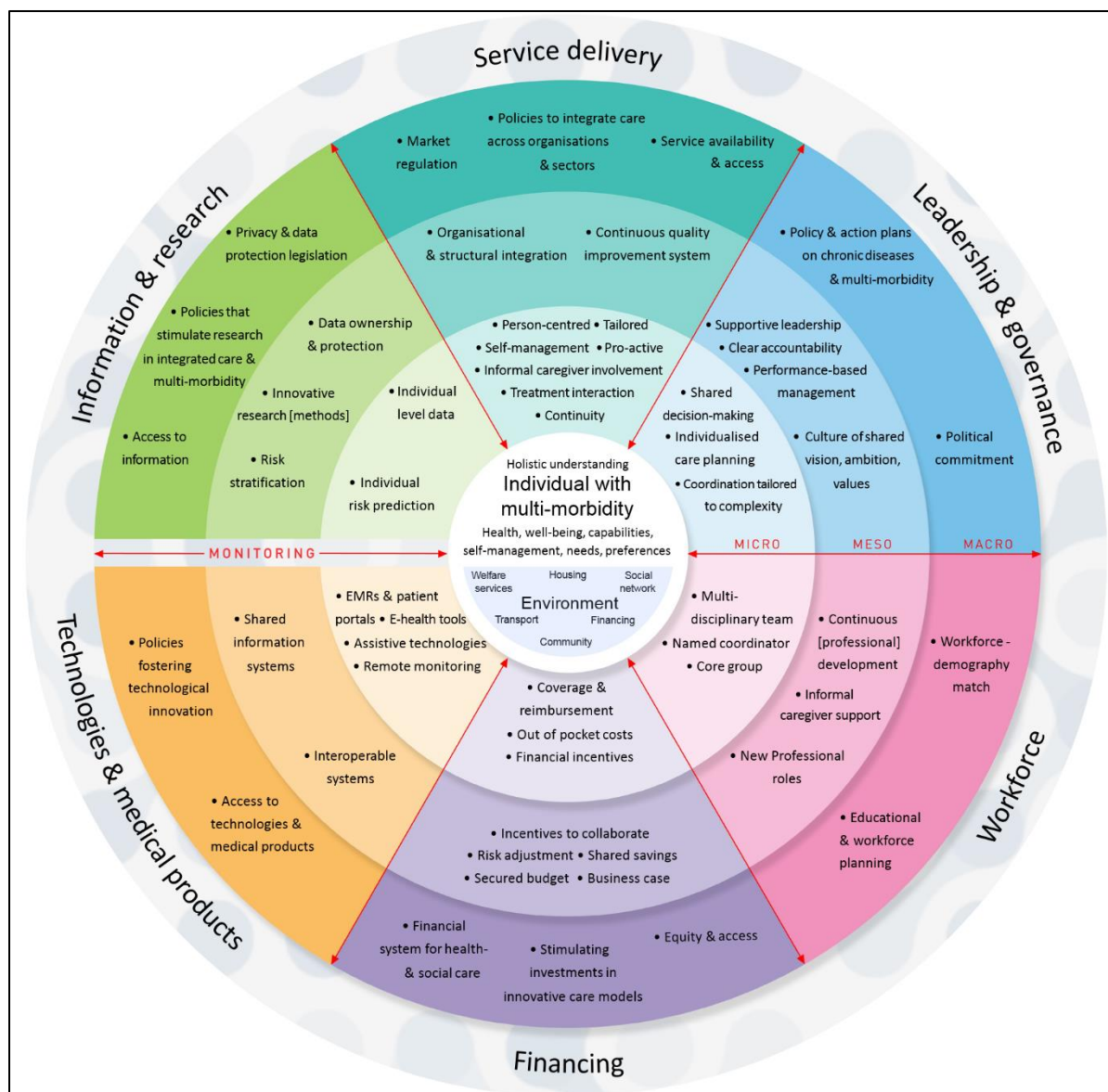
Figure 2: Conceptual framework for the delivery of care for persons with multiple chronic conditions. Source: Leijten et al. (submitted manuscript, 2016).

Simultaneously, each thick description covers the eight tasks of WP2 set out in the SELFIE proposal, as well as one supplementary task (denoted by TS), which was agreed on by the project consortium at the kick-off meeting and actually belonging to WP3:

- **Task 1:** To develop the approach for the qualitative analysis of ICC programmes
- **Task 2:** To investigate how the most promising ICC programmes were implemented as well as to identify barriers and facilitators during the implementation phase
- **Task 3:** To analyse how the delivery of care is designed around the patient in the most promising ICC programmes

- **Task 4:** To analyse the relationship with long term care, social care and other partners beyond the healthcare system
- **Task 5:** To investigate which ICT applications are used in the most promising ICC programmes to support the care process as well as to explore the requirements for implementing them successfully in the treatment of patients with multi-morbidity
- **Task 6:** To analyse which self-management interventions are used in the most promising ICC programmes and how they were adapted to patients with multi-morbidity from different cultural and socio-demographic groups as well as to distinguish the conditions for their successful implementation
- **Task 7:** To explore new professional roles (e.g. physician assistants, nurse practitioners) involved in the ICC programmes as well as to identify barriers and facilitators in their successful introduction
- **Task 8:** To review existing evidence on the impact of the most promising ICC programmes
- **Task TS:** To explore the experiences of the stakeholders regarding financing and payment schemes

The WP leader provided the partners with continuous guidance in order to ensure that all partners are able to follow the methodological approach described above. This guidance mainly consisted in three parts. First, in the preparatory phase of WP2, methodological guidance materials were developed by the WP leader for all partners. These materials were presented to the partners in the course of the 2nd steering committee meeting in Vienna on January 25th and 26th 2016. Second, a special training course was held at IHS Vienna for researchers directly involved in the thick description on April 14th 2016. Third, all 17 thick descriptions were reviewed in order to ensure that they are harmonised to a certain degree. In this third part, the WP leader received support from the WP co-leader. The review process was divided as follows:

- **WP leader:** Germany, Netherlands, Norway and Spain
- **WP co-leader:** Austria, Croatia, Hungary and United Kingdom

However, it is part of the method that thick descriptions are not standardized but instead should be guided by what the prominent features of the individual studied phenomenon are. Therefore, the diversity in the thick descriptions reflects different topicalities, approaches, challenges and solutions.

As mentioned above, the method of thick description allows for a deep understanding of the implicit structures of the investigated programmes. This is of utmost importance also as a basis for further work packages of the SELFIE project. In the context of WP3, this deep knowledge can help to understand incentives of payment methods better and thus help to develop a comprehensive guide to financial and payment schemes that facilitate the provision of ICC to

multi-morbid patients, as well as a guide to pricing of ICC programmes. In the context of WP4, this knowledge it can help to identify the relevant indicators to measure outcomes of ICC programmes. In the context of WP5, it can help to gain ideas regarding how to set up a suitable empirical evaluation of these programmes. Furthermore, it may help to better understand and explain the outcomes of the empirical evaluation.

Each report is structured in the following way: After the methods chapter, chapter 2 provides general information on the national health and social care system with a special focus on integrated chronic care for persons with multi-morbidity. This chapter covers the macro level of the conceptual framework and has the purpose of giving insight into the specific context the two selected programmes are embedded in. The programmes are subsequently described in detail in chapters 3 and 4, respectively. The descriptions present important findings obtained from the document analyses as well as the interview analyses. After a short overview of basic information about the programme, the findings are structured according to the six segments of the conceptual framework: service delivery, leadership and governance, workforce, technologies and medical products, information and research/monitoring and financing. Furthermore, the implementation process is described in an additional section. The descriptions conclude with a discussion of the respective programme. The discussion summarises the distinctive features of the programme and puts the empirical findings in context of the conceptual framework.

The report includes several quotations from the interviews. These are intended to present the stakeholders' perspectives in their own words. They were selected in the process of "abduction" and are used as a source of, e.g., typical forms of care practices, cooperation forms and motivations for participating in the programme. All quotations are anonymised and translated into English. In the appendix, however, they can be found in the respective original language.

1.1.   References

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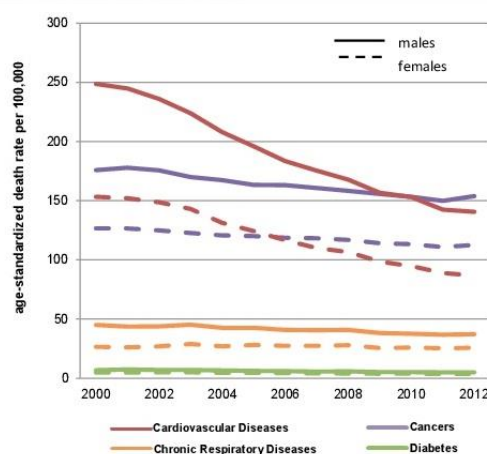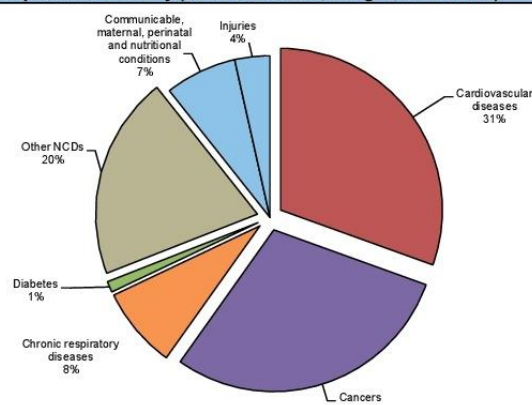
2. Macro level

United Kingdom

Total population: 62 783 000
Income Group: High

Percentage of population living in urban areas: 79.6%
Population proportion between ages 30 and 70 years: 51.0%

Age-standardized death rates

Proportional mortality (% of total deaths, all ages, both sexes)

- Communicable, maternal, perinatal and nutritional conditions 7%
- Injuries 4%
- Cardiovascular diseases 31%
- Other NCDs 20%
- Diabetes 1%
- Chronic respiratory diseases 8%
- Cancers 29%

Total deaths: 557,000
NCDs are estimated to account for 89% of total deaths.

Adult risk factors

	males	females	total
Current tobacco smoking (2011)	22%	22%	22%
Total alcohol per capita consumption, in litres of pure alcohol (2010)	16.5	6.9	11.6
Raised blood pressure (2008)	30.7%	25.0%	27.7%
Obesity (2008)	26.0%	27.7%	26.9%

National systems response to NCDs

Has an operational NCD unit/branch or department within the Ministry of Health, or equivalent	Yes
Has an operational multisectoral national policy, strategy or action plan that integrates several NCDs and shared risk factors	Yes
Has an operational policy, strategy or action plan to reduce the harmful use of alcohol	Yes
Has an operational policy, strategy or action plan to reduce physical inactivity and/or promote physical activity	Yes
Has an operational policy, strategy or action plan to reduce the burden of tobacco use	Yes
Has an operational policy, strategy or action plan to reduce unhealthy diet and/or promote healthy diets	Yes
Has evidence-based national guidelines/protocols/standards for the management of major NCDs through a primary care approach	Yes
Has an NCD surveillance and monitoring system in place to enable reporting against the nine global NCD targets	No
Has a national, population-based cancer registry	Yes

Source: World Health Organization - Noncommunicable Diseases (NCD) Country Profiles, 2014

The health systems of the different nations that make up the United Kingdom (UK - Scotland, England, Wales and Northern Ireland) are all devolved and unique at the macro-level. Because the two sites chosen in the UK (South Somerset, and Salford) are both from England, this section focuses only on this devolved health system context.

	England
Key facts and figures	
Population	54.8 million
Population ≥ 64 yrs (%)	18*
Model of care	Beveridge
Life expectancy (yrs)	79 M & 83 F
Birth rate	12.1/1000 inhabitants
Gross mortality rate	9.2/1000 inhabitants
Infant mortality	3.8/1000 live births
Healthcare expenditure % GDP	8.5% (83% public expenditure)*
Healthcare expenditure per capita €/year	3475 €*
Coverage (% population) (paid by taxes)	100%
Public Payer	One Public Payer (NHS England)
Suppl. private insurance (% population)	11
Number of physicians per 10,000 population	28*
Number of hospital beds per 10,000 population	27*

* = UK estimate

Service delivery

Description of the main policies and regulations shaping the health and social care system

In England, the Department of Health organises healthcare (the National Health Service (NHS)) at a national level, while the social care system is organized at a regional level, under the control of City Councils. The NHS, as a tax-funded system, is closely tied to politics, and regularly undergoes re-organisations with successive governments. The most recent re-organisation was the Health and Social Care Act 2012, which resulted in the formation of 211 new clinician-led commissioning bodies, Clinical Commissioning Groups (CCGs). CCGs were contractually mandated to 'promote integration' at a local level, although how this integration would be delivered was not prescriptive. In practice, in previous work (Stokes, J. 2014. CCG implementation of integrated care in the NHS. *BMC Health Services Research,* 14**,** P119.), we have estimated that the majority of this integration has taken the form of multidisciplinary team (MDT) case management at the service delivery level.

More recently, the Five Year Forward View (FYFV) for the NHS, published in October 2014, has highlighted the pressing funding gap in the NHS (estimated at ~£30 billion / year by 2020), and proposes changes to models of care (including a heavy reliance on integration of health and social care services) as a potential solution to address this.

Description of clear and well-designed national/regional policies/plans and programmes supporting integrated care for chronic patients with multi-morbid condition/complex care needs

The FYFV outlines five overarching model of care propositions. These are currently being piloted across the country as Vanguard sites (localities receiving additional national funding chosen as 'best practice' sites to exemplify new models of care. Previous to Vanguards (2015 and ongoing), there have been similar initiatives. These schemes include the 'Integrated Care Pilots' (ICPs, 2009–2012), the 'Integrated Care and Support Pioneers' (wave 1 began in 2013, and wave 2 in 2015, both ongoing), and most recently announced, 'Devolution' of health and social care (first to Greater Manchester, starting in April 2016). Both SELFIE sites, South Somerset and Salford are part of the Integrated Primary and Acute Care Systems Vanguard.

1. **Multispecialty Community Providers**
   Concentrated on moving specialist care out of hospitals
2. **Integrated Primary and Acute Care Systems**
   Concentrated on joining up GP, hospital, community and mental health services
3. **Acute care collaboration**
   Concentrated on linking together local hospitals to improve their clinical and financial viability
4. **Urgent and emergency care**
   Concentrated on improving the coordination of urgent and emergency care services and reducing the pressure on A&E departments
5. **Enhanced health in care homes**
   Concentrated on offering older people better, joined-up health, care and rehabilitation services

Description of specific policies for integration of social and healthcare programmes for management of patients with multi-morbidity with current or potential social needs?

Specific macro level policies for integration include those highlighted above, to incentivise local configuration, where a 'bottom-up' approach to integration has been adopted in England. Additional national funding initiatives have also been adopted to incentivise this, including the Better Care Fund, and practice payments including Directed Enhanced Services (see Financing section, below).

Leadership & Governance

Briefly describe how governance of the health and social care system is structured at national/regional level and who the main actors are

Health policy in England is decided directly by the UK Government, through the Department of Health (DoH). A variety of regulators (e.g. Monitor, Care Quality Commission) and arms-length

bodies (e.g. Public Health England, NICE) work under the DoH, with NHS England distributing funds to CCGs and specialist and primary care services (see Figure 3). As mentioned above, social care is a more regionally governed service.
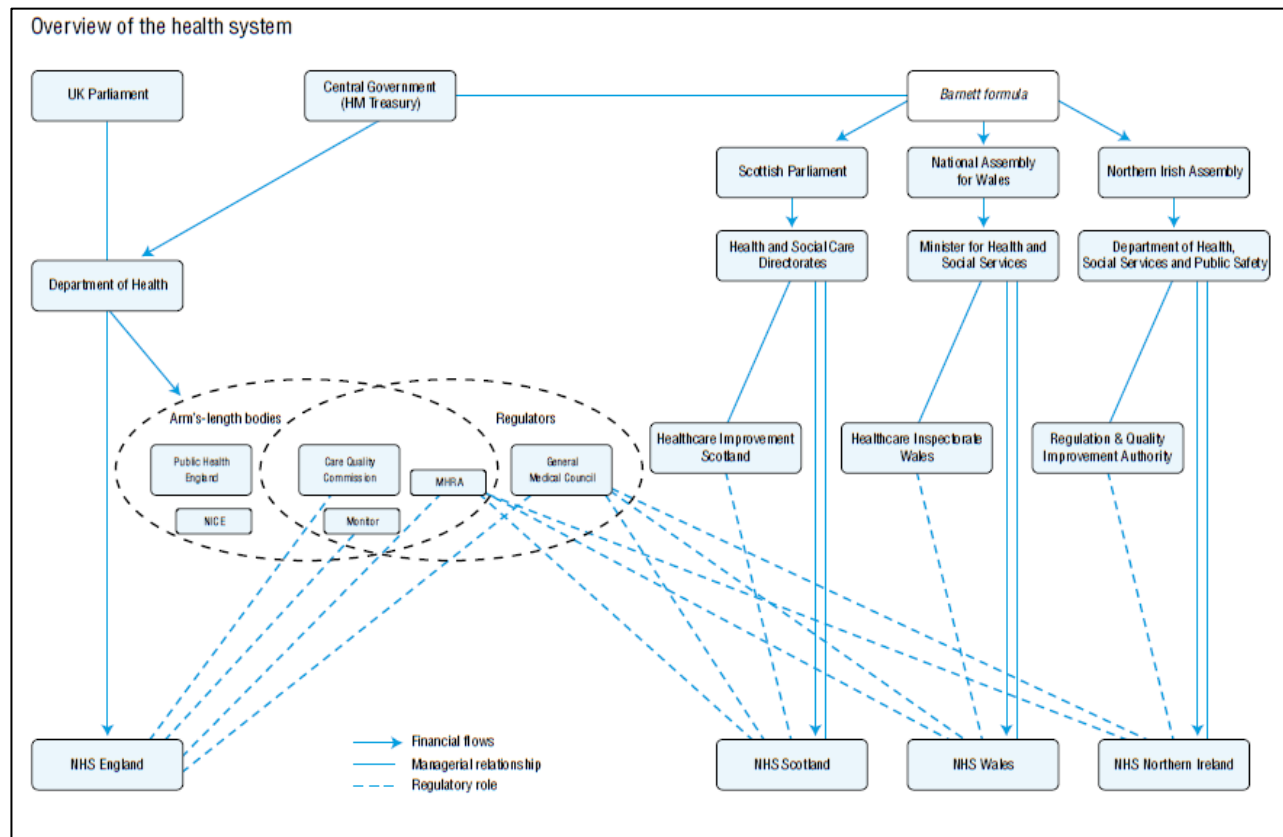

Figure 3: Overview of the health system. Source: Cylus J, Richardson E, Findley L, Longley M, O'Neill C, Steel D. United Kingdom: Health system review. Health Systems in Transition, 2015; 17(5): 1–125.

Briefly describe how governance of the integrated care initiatives/programmes at national/regional level is structured and who the main actors are

Integrated care initiatives are governed at a local level, with CCGs/Hospital Trusts/City Councils mainly responsible. When additional national funding is received, however, e.g. through the Vanguard programme (or Integrated Care Pilots, or Pioneers before that), the local actors who secure the bids are accountable to the national funder for the extra financing received.

Workforce

How is the workforce prepared for and involved in the transitions and scale-up of integrated care?

Again, decisions about workforce (e.g. new roles) are being made locally according to local needs and in line with the local integration programme. In general, nationally, there are issues foreseen with being able to meet future needs with the current workforce and training levels.

Due to the current financial NHS funding gap (detailed above - affecting both primary and secondary care, and separately, under-funding of social care) the workforce is under immense pressure, and there has been a marked increase in those taking early retirement/leaving to other countries to continue their careers. Therefore, scale-up of integrated care is likely to be more difficult than ever.

Describe the occurrence of new professional roles and occupations involved in integrated care.

Generally, the most widely implemented delivery model of integrated care has been through case management at the service delivery level. This was initially led by nurses taking on the case manager role, through the Community Matrons programme. More recently, the trend of case management has been through MDT delivery, with various professional backgrounds acting as the primary care coordinator (but tending to be nurses or social workers). Additional roles introduced in a number of localities have included health coaches, tending to be less professionalised roles, and assisting in patient education, as well as linking patients to services delivered in the community, e.g. by voluntary organisations.

Financing

Brief description of the funding system for the health and social care sector in general and integrated care specifically

Traditionally, the healthcare and social care funding systems have been completely separate in the UK, with universal coverage and access to healthcare in the NHS through tax-funding, and, in England, social care (increasingly) privately-funded (with some state provided benefit, according to need). Within healthcare, the single national payer acts through NHS England to distribute funding to CCGs which primarily commission secondary and tertiary care services for their populations. Primary care, however, has traditionally been delivered by independently owned (usually by GP partners) practices and contracted nationally. Increasingly, however, CCGs are also now taking a role in co-commissioning primary care services for practices in their local areas.

As detailed above, there have been various additional funding schemes in an attempt to stimulate innovation in integrated care nationally. The ICPs, Pioneers and Vanguards have involved local areas bidding for a pot of national money with plans of what they want to deliver, whereas Devolution is based primarily around pooling existing health and social care budgets in a local area.

In addition, the Better Care Fund is a single pooled £5.3bn budget that aims to fund ways that the NHS and local government throughout England can work more closely together. This is again a fund of money that local areas (CCGs) can apply for a share of.

Are financial policies aligned with large scale implementation of integrated care?

The piloting policy of funding arrangements fits with the local delivery policy of integrated care which has been presented in national documents. Furthermore, the additional 'best practice' funding schemes highlighted above are tied to national policy direction (e.g. the Vanguards tied to exhibiting the new models of care in the FYFV). Furthermore, some national pay-for-performance incentives are clearly tied to delivering integration (although less explicitly so). For example, there are incentives through Directed Enhanced Service (DES) payments to primary care practices in return for case management of a specific percentage of their highest risk patients.

How is sustainability of funding for integrated care ensured?

The sustainability of the programme funding mentioned above is unsure in the long-term. Furthermore, policy analysis bodies such as the Health Foundation predict that total healthcare spending is likely to be decreased as a % of GDP spend in future years, with additional cash obtained for FYFV transformation front-loaded. The hope is that the added stimulation now will be able to produce self-sustaining and ultimately cost-cutting delivery programmes in the future. However, this predominantly rests on the assumption that the integrated care programmes will be able to deliver decreased emergency admissions (for which there is little consistent evidence in the integrated care literature to date), and that providing care in the community instead will be a cheaper alternative (again, an assumption with little evidence base to date).

Technologies & medical products

Describe national/regional policies to promote the use of ICT to support integrated care?

There are multiple providers of both primary, secondary care and social care electronic recording systems. For example, within a local CCG area, different primary care practices can each be on different patient record systems which are incompatible. Previous national attempts to introduce a single joined up record for the population (e.g. 'Connecting for Health' in 2002) have failed. Current government plans include patient access to their own electronic health records, joined up between services by 2020. It remains to be seen whether this is a realistic deliverable.

Describe national/regional policies stimulating e-health applications and assistive devices?

The largest telehealth/telecare project has been the Whole Systems Demonstrators pilots, in three areas in the UK from 2006. An evaluation by the Nuffield Trust published in 2012 found some positive effects of the use of these systems, e.g. decreased use of secondary care and mortality. However, they found no significant reductions relating to overall health and social

care service use, and that use of the technology was not cost-effective as an addition to standard support and treatment. More details of the Whole Systems Demonstrators can be found here: http://www.nuffieldtrust.org.uk/our-work/projects/impact-telehealth-and-telecare-evaluation-whole-system-demonstrator-project?gclid=CJar2_3O3M4CFaEW0wodLj0Hfg.

Information & research

Describe legislative framework on data privacy with respect to integrated care? Does it follow the current EU directive? Is it constraining implementation of integrated care?

The Data Protection Act 1998, a result of the Caldicott Review sets standards which must be satisfied when in contact with personal data. The Act is summarised under eight key principles. Personal data must be:

1. Processed fairly and lawfully
2. Processed for specified purposes
3. Adequate, relevant and not excessive
4. Accurate and kept up-to-date
5. Not kept for longer than necessary
6. Processed in accordance with the rights of data subjects
7. Protected by appropriate security (practical and organisational)
8. Not transferred outside the EEA without adequate protection

The various NHS bodies were previously working cooperatively to feed in to the EU directive, in an attempt to ensure development of the new models of care was enabled. Recent developments in the relationship of the UK with the EU make the relevance of the EU directive, planned to come in to force in May 2018, unsure.

Describe specific national/regional research programmes for integrated care and/or multi-morbidity

In England, each of the nationally incentivised integrated care programmes (e.g. the Vanguards) are being evaluated by commissioned researchers. Local integrated care programmes may be working with local universities or commissioning private evaluations also, but these evaluations are not overseen nationally.

Describe if and how they are embedded in larger (European-wide) innovation & research platforms for integrated care?

Five English regions have been successfully recognised as European Reference Sites in Active and Healthy Ageing (EIP-AHA), including Greater Manchester, North West Coast, North East

England, Liverpool, and Yorkshire and the Humber. England also has involvement in other EU platforms, including the European Institute for Technology – Health (EIT-Health).

3. Progamme 1: *"Salford Integrated Care Programme (SICP) / Salford Together"*

3.1. Basic information

Name of the programme

Salford Integrated Care Programme (SICP) / Salford Together

Contact details of the programme management

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Starting date of the programme

The Initial implementation of the programme was gradual across the eight neighbourhoods in Salford. Initial tests of change were conducted in two of the neighbourhoods from 2013 [1].

Salford Together is the most recent Salford-specific addition to the programme, and is part of the national 'Vanguard programme' (granted this status in March 2015) exemplifying best practice in integrated care in the UK, particularly formalising organisational entities and contractual issues (see sections below). DevoManc (devolution of health and social care leadership to Greater Manchester – implemented in April 2016) also involves Salford as a local participant, but as this initiative occurs at a higher level of analysis than Salford, we only briefly outline the consequences in terms of organisation below.

Geographical scope of the programme

Salford (Greater Manchester) in the north-west of England. Population of nearly 250,000, of which around 35,000 are age 65 or older [1], expected to rise by nearly 30% by 2030 to just over 43,000 people [8]. The increase forecast for the number of elderly people means many more will be living with multiple long-term health conditions [9]. The population has comparatively high levels of deprivation (Salford is one of the 20 local authorities with the highest proportion of areas in the most deprived decile in England) and illness (22.8% living with a long-term illness, compared to national rates of 17.9%) [1]. Health inequalities are also rife, the gap in life expectancy between those living in the poorest and more affluent areas in the city is 12 years for men and 8 years for women [10]. This inequality also relates to healthy life expectancy [6]. The Salford area contains around 50 primary care practices, clustered in 8 neighbourhoods [1]. The area is made up of 60 % green space, with 18 square miles of

countryside and parks, and 30 miles of rivers and canals (Britain's largest inland waterway), very close to Manchester city centre [5].

Target group of the programme (type of individuals/scope/included combinations of morbidities)

The Salford Integrated Care Programme is designed to improve care for the broad population of people with long-term conditions [1]. However, the initial focus for testing the methods of change and scaling up the programme has led to a focus on older people, targeting the population aged 65+ with long-term conditions [1]. A significant proportion of health and social care expenditure in Salford relates to older people (in excess of £100 million per annum), which will increase substantially as the population becomes older. At the same time, Salford faces unprecedented financial challenges and the prospect of a sustained period of public spending reductions [8].

Number of persons treated in the programme (total and development over time)

Table 1 below illustrates the gradual roll-out of the multidisciplinary neighbourhood group (MDG) component of the SICP (the main aspect which relates to multi-morbid patients). Rollout is clustered by neighbourhood and practices within each neighbourhood [3]. Note that only a stratified proportion of each practice population is treated by the programme, and only elderly patients to date. For illustration purposes, the ongoing CLASSIC cohort (a research study led by the University of Manchester, taking place in Salford - see Task 8 for details), has recruited over 4000 older people with long-term conditions [1].

MDG (based on Neighbourhoods)	Wave	Start date	Participating GP Practices	Practice Population
Eccles	1	March 2014	4/5	34,564
Swinton	1	March 2014	4/5	33,492
Ordsall & Langworthy	2	Jan 2015	5/5	18,959
Claremont & Weaste	2	Jan 2015	tbc/6	21,357
Irlam & Cadishead	2	Jan 2015	4/5	19,157
[1]East Salford (Broughton)	3	Mar 2015	6/10	34,687
*Little Hulton	3	Mar 2015	tbc/10	53,887
*Walkden, Worsley & Boothstown				
				216,103
Care Homes Practice (CHP)	N/A	April 2013	1/1	1,089

*Combined MDGs; 1Includes 1 practice (CHP) who operate their own MDG.

Table 1: Roll-out of MDG component and practice engagement [3]

Aim of programme

By having GPs, community staff, mental health services and social workers working together in a much more joined up way, the programme aims to:

- Help patients to improve their wellbeing (physical and mental health) so they are less reliant on health and social care services
- Care and support patients better at home, when they need it, instead of having to go to hospital or into a care home. The aim is to have 2,000 fewer emergency hospital admissions of older people and have 84 fewer permanent admissions to residential care homes per year by 2020
- Have health and social care professionals involved in a person's care work together on a single shared care plan so patients don't have to repeat themselves to each new health or social care worker and can go to a single named care co-ordinator
- Help patients to use technology and equipment to stay living at home for longer.
- Help patients to look after their own health better – for example, aiming to increase the number of people over 65 having the flu vaccine from 77% to 85%
- Help patients to feel able to tell professionals where they would like to die and, when the time comes, help them to be in their preferred place [9].

Definition/understanding of "integrated care" (as far as described in documents)

Similar to the NHS-adopted definition of integrated care, Salford adopts a 'patient perspective' understanding of integrated care. Following their own consultation, a Salford resident summarised this definition, " *'I can plan my care with people who work together to understand me and my carers, allow me control and bring together the outcomes important to me.'* In other

words – tell your story once: with one service, one assessment, one key worker and one pooled health and social care budget" [9].

Definition/understanding of "multi-morbidity" (as far as described in documents)

There is no detailed definition of multi-morbidity found in the current documents, only the understanding of 'multiple long-term health conditions' as adding complexity to the management of older patients, and its association with elderly patients and so increasing prevalence with an ageing population [9].

Definition/understanding of "patient-centeredness" (as far as described in documents)

During development of the programme, the managers have been sharing ideas with older people every step of the way and using the fictional character of 'Sally Ford' to explain how the Integrated Care Programme will work in a patient-centred way. "Sally was 'born' through us talking to Salford's older residents about their individual and family's needs to create a fictional character representative of the older people who live in Salford" [9].

"In Salford, our population is represented by four 'types' of Sally:
'**Able Sally**': approximately 25,000 people aged 65+ who are living independently and looking after themselves
'**Needs Some Help Sally**': 6,000 older people who can generally look after themselves but may need a little help from carers to manage their health
'**Needs More Help Sally**': 3,000 over 65s receiving home and intermediate care several times a week
'**Needs a Lot of Help Sally**': approximately 1,000 older people who rely on 24/7 care." [9]

Definition/understanding of "self-management" (as far as described in documents)

The programme does not explicitly detail a definition of self-management, although like in South Somerset, it is highlighted as a key component of the programme. However, the programme does give some examples of ways that self-management may be improved (see section 3.2.2).

Organisational form and ownership of the programme (including legal form)

The health and social care system in Salford is largely coterminous, with one local government partner (Salford City Council), a single health commissioner (Salford CCG), mental health provider (Greater Manchester West) and a principal provider of acute and community health services (Salford Royal). Salford's ICP is underpinned by a formal partnership between these four statutory strategic partners:

1. Salford Clinical Commissioning Group (CCG) – lead NHS commissioner, with 48 GP Practice 'members'
2. Salford City Council (SCC) – public health commissioner, provider and commissioner of adult social care and community support, commissioner of supported housing
3. Salford Royal NHS Foundation Trust (SRFT) – provider of acute and community health services and some primary care (out-of-hours, Care Homes Practice)
4. Greater Manchester West Mental Health NHS Foundation Trust (GMW) – provider of community, secondary and specialist mental health services [8]

The SICP has been managed through an Integrated Care Board, comprising the above statutory agencies, and jointly chaired by Salford CCG's Local Authority Liaison Clinical Lead and the City Council's Strategic Director of Community, Health and Social Care, with chairing responsibility rotated between meetings [8]. The programme is overseen by Salford's Health & Wellbeing Board, which has identified older peoples' access to care and services as a key priority [1]. Figure 4 outlines the schematic of the programme structure.
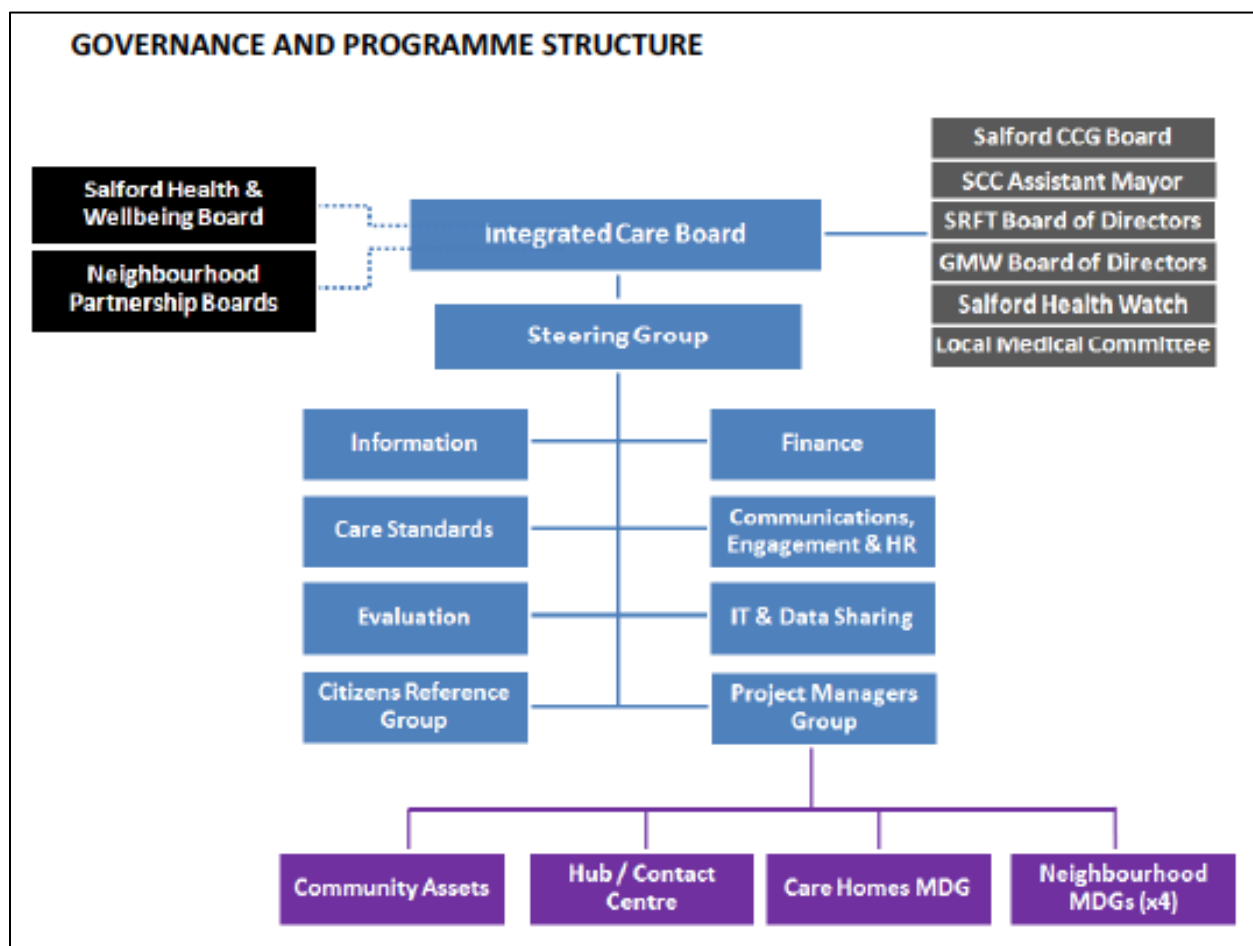
Figure 4: Governance and programme structure of the SICP [8]

The Integrated Care Board was given delegated responsibility to:

- "Set improvement targets and timescales
- Determine the neighbourhood(s) that would be the focus for the first phase of the integrated care programme
- Establish arrangements to enable the development of new models of care.
- Secure appropriate resources to complete the design phase of work
- Review existing initiatives to align complimentary workstreams and consolidate projects
- Establish clinical leadership and project management arrangements
- Develop a financial model, including risk and benefit sharing, proposing changes to existing payment mechanisms and contractual arrangements where necessary
- Establish arrangements for engaging with patients, service users and local communities
- Develop a robust evaluation framework to ensure progress can be measured against the Programme's aims and improvement targets
- Promote learning that could be shared with other programmes and / or applied to different client groups" [8].

The most recent initiative, the 'Salford Together' partnership (which has been granted Vanguard status) plans to build on the SICP, with increased formal co-operation between the organisations (see Financing section for additional details). "The Vanguard is made up of the following organisations: NHS Salford Clinical Commissioning Group; Salford City Council; Salford Royal NHS Foundation Trust and Greater Manchester West Mental Health NHS Foundation Trust, which together form the Salford Together Partnership. In addition, there is active support and engagement from Salix Health, the local GP provider consortium. Salford intends to create an integrated care organisation. It believes that by pooling its expertise into one organisation, residents will receive more coordinated care as it will be provided by health and social care professionals working within the same organisation. The integrated care organisation will be established giving Salford Royal lead responsibility for meeting the health and social care needs of the population through both direct provision and contracts with other local providers" [11].

It encompasses:

- Four high performing partners – within broader network of partners
- £98M Pooled Budget - Integrated Care for Older People (ICP)
- Governed by Alliance Contract (agreed in October 2014 [10])
- Underpinned by 2014-18 Service and Financial plan (including Better Care Fund)
- Formal Programme Management approach (ICP)
- ICP as one of three major transformation initiatives [12]

The local integrated care programme in the Salford area (one of the ten local areas in Greater Manchester) is also part of a wider Greater Manchester programme of work (Healthier Together/DevoManc) [5]. A key principle of the governance arrangements at the Greater Manchester level is that local commissioning will remain a local responsibility. Integrated care in localities will also remain a key feature of this larger area planning (see Figure 5). However, "it is also likely that there will be opportunities to collaborate on specific issues across Greater Manchester. This could include areas such as information sharing and risk stratification, where the Greater Manchester Commissioning Support Unit will play a key role. There will also be complex issues, such as developing new contractual models, where it may be sensible to jointly commission external advice" [8].
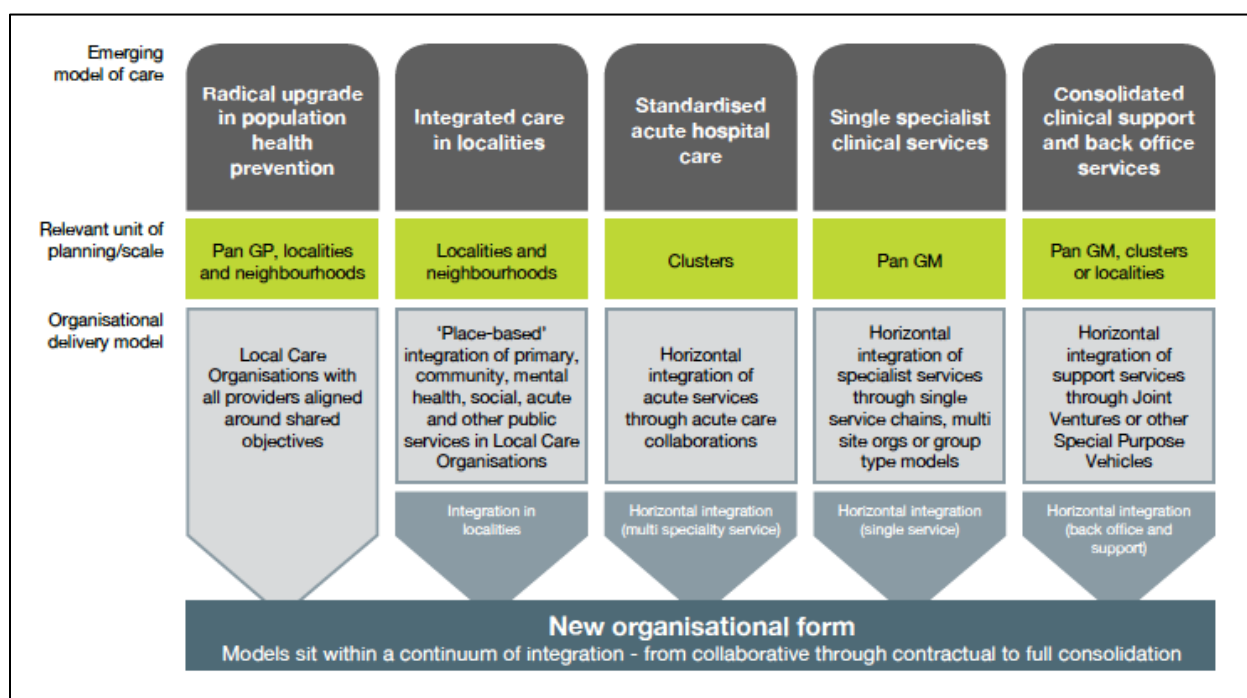

Figure 5: Emerging models of care with relevant planning and organisational models in Greater Manchester [13]

Involved partner organisations (payer(s), medical and social service providers), including subdivisions (e.g. departments of a hospital)

As is clear from the above, the Salford programme encompasses the entire health and care economy, with all coterminous major players heavily involved. Furthermore, there is added involvement of voluntary and third sector partners (see section 3.3).

Involved disciplines and professions

Primary, secondary and social care services are involved in delivering the models. Specifics are detailed for each model in section 3.2.

3.2. Service delivery

3.2.1. Design of delivery of care

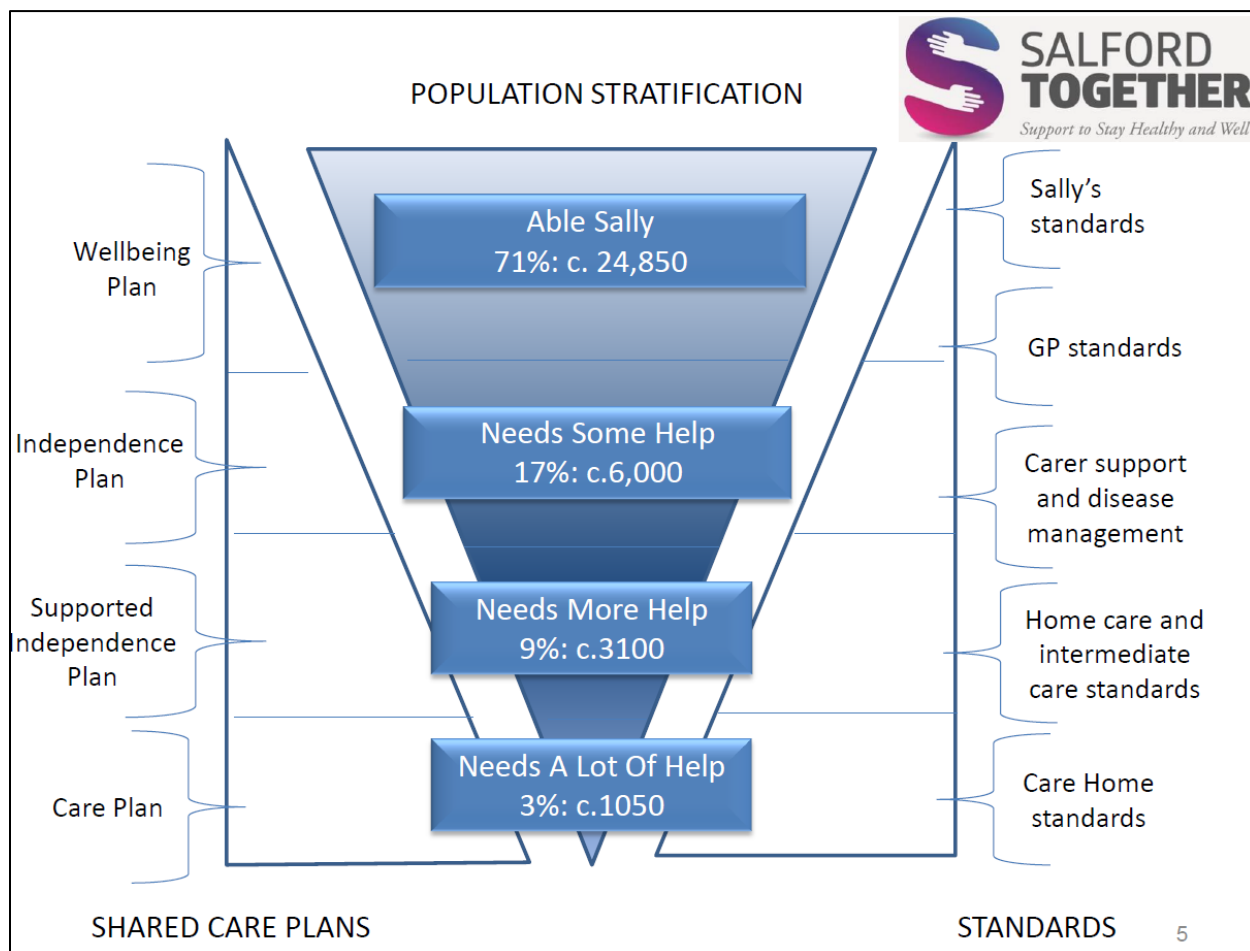The Salford programme takes a population stratification approach to care delivery (see Figure 6).

Figure 6: Salford 4-strata population stratification approach [12]

Utilising this stratification approach, the NHS, local authority, and voluntary and community sector in Salford are working together on three aspects of Salford's Integrated Care Programme [9]:

1. **MDGs (Multi Disciplinary Groups)** – staff including district nursing, social workers, community mental health staff, GPs and administrators to provide targeted support to older people who are most at risk and have a population focus on screening, primary prevention and signposting to community resources [10].
2. **Community assets** – investing in voluntary groups and local facilities to increase the opportunities for older people in Salford to socialise and remain active [9]. These are

      groups and organisations that enable older people to remain independent, with greater confidence to manage their own care [10].

3. **Centre of contact** – with just one telephone number that elderly residents and their families and carers in Salford can ring for advice on any of health and social care issue or concern [9]. This acts as a central health and social care hub, supporting Multi Disciplinary Groups (MDGs), helping people to navigate services and support mechanisms, and coordinating telecare monitoring [10].

Approach 1, the MDGs managing the highest risk patients, is most relevant to patients with multi-morbidity, therefore is the focus of the description below, although we also briefly outline the other two approaches.

MDGs (Multi-Disciplinary Groups)

The case management function in the SICP is being undertaken by MDGs, 'multidisciplinary health and social care groups'. "The model underlying these groups is as follows. The multidisciplinary health and social care groups involve a mix of professionals (with a maximum of around 10) who dedicate time and resources to regularly attend meetings of the group. All groups involve recruitment of a project manager, and professional disciplines represented in the group include GPs, practice managers, practice nurses, social workers, district nurses and staff from the local authority. Groups meet monthly at a minimum to identify people at risk, deliver appropriate interventions, and assess the impact of those interventions" [1].

In planning, the MDGs hold a register of all 65 year olds in a 'neighbourhood' of federated practices (as mentioned above, these have been rolled out gradually to neighbourhoods creating a natural experiment). Appropriate risk stratification tools are applied to assess risk of hospitalisation and care home admission. Shared care protocols are agreed, including care plans. Support is proportionate to need, with patients at high risk further supported by multidisciplinary care conferences to better plan, co-ordinate and deliver their care. Initially, the core impact of the MDGs was therefore planned to be patients at the highest tier of the current 4-strata classification system used in the SICP (Figure 6), which are the patients who are at highest risk of hospitalisation, and who might stand to benefit most from significant multidisciplinary input. Figure 7 outlines the process of MDG working.
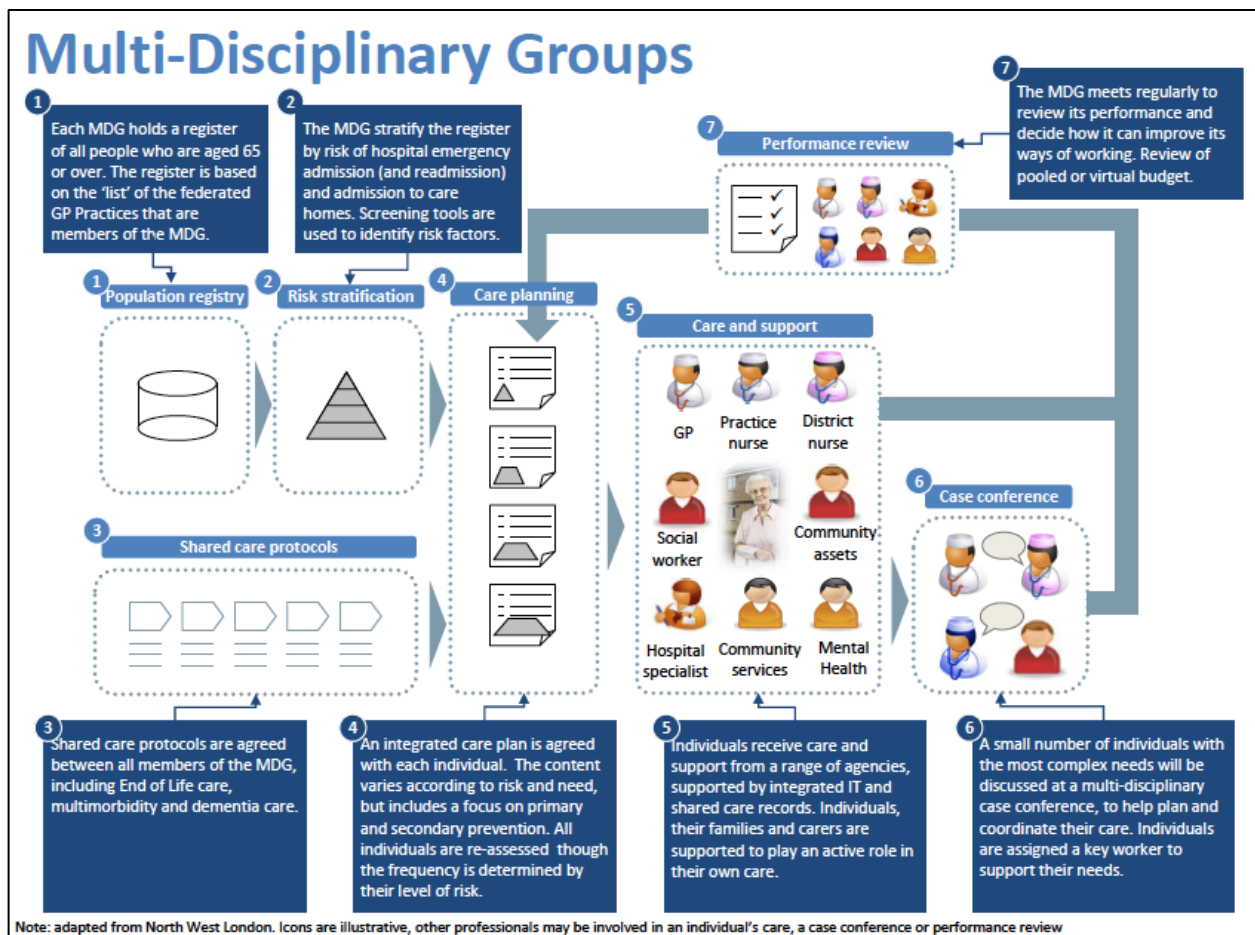
Figure 7: Outline of the MDGs [6]

Figure 8 outlines the core dimensions of the MDG model, according to the framework used by Goodwin et al to describe models of co-ordinated care in the UK [1].

Table 1 Core dimensions of case management and integration in long-term conditions[1]

General description	Objectives	Development stage	Target population	Population coverage
MultiDisciplinary Groups provide targeted support to older people who are most at risk and have a population focus on screening, primary prevention and signposting to community support	The aim is to achieve greater independence and improved wellbeing for over 65s in Salford by integrating care within communities. The focus is on reviewing and problem solving complex cases, providing anticipatory care plans for service users, and assisting with navigation through the health and social care system.	Currently being piloted in two sites, with support from QI team and regular use of PDSA cycles to develop model	Older people with long-term conditions and social care needs	All people in the Salford area
Caseload	**Funders**	**Breadth and degree of integration**	**Shared medical records**	**Risk Stratification**
Each MDG holds a register of all people who are aged 65 or over. The register is based on the 'list' of the federated GP Practices that are members of the MDG.	Funding comes from the SICP. The four statutory partners (NHS Salford Clinical Commissioning Group, Salford City Council, Salford Royal NHS Foundation Trust and Greater Manchester West Mental Health NHS Foundation Trust) have all formally signed up to the SICP and delegated authority to an Integrated Care Board. Partners have signed up to a high level risk and benefits sharing agreement. As part of the SICP, the partners are exploring pooled budgets for health and social care, a joint venture / alliance contract, and a capitation funding model.	Horizontal integration with some vertical integration based on improvements in co-ordination between primary and acute providers, and between health and social care professionals.	The Salford Integrated Record provides unique linked primary care and secondary care data. Current linkage with social care less well developed but has been a critical part of the early PDSA cycles in the pilot phase	The MDG stratify the register by risk of hospital emergency admission (and readmission) and admission to care homes. The SICP uses a four strata model of risk stratification, with the role of the MDGs focussed on those identified at levels 3 and 4 and at risk of escalation Professional judgement used to inform stratification of patients, alongside formal risk stratification tools
Providers	**Single point of referral**	**Patient eligibility criteria**	**Single assessment**	**Care planning**
GP/Practice Nurse (with link to community geriatrician as and when required; social care worker (link into housing and health trainers when required); district nurse (link to hospital and discharge support); mental health; OT; and administrator.	Patients identified by risk stratification tool, complemented by professional judgement, as well as direct referral from members of the MDG	As identified by risk stratification tool or professional judgement, based on risk of hospital emergency admission (and readmission) and admission to care homes.	Yes	An integrated care plan is agreed with each individual. The content varies according to risk and need, but includes a focus on primary and secondary prevention. All individuals are re-assessed though the frequency is determined by their level of risk.

Care co-ordinator/case manager	Multidisciplinary team	Financial and non-financial incentives	Self-management support	Carer assessment and support
A small number of individuals with the most complex needs will be discussed at a multidisciplinary case conference, to help plan and coordinate their care. Individuals are assigned a key worker to support their needs. The key worker will be identified based on who is likely to have most input into care for that individual patient	Yes	Partners have signed up to a high level risk and benefits sharing agreement. As part of the SICP, the partners are exploring pooled budgets for health and social care, a joint venture / alliance contract, and a capitation funding model.	Provide links to Centre of Contact (including care navigation and health coaching) and Community assets strands of the SICP (including self-help groups in the community)	Although carer needs may be part of the person-centred assessment and care planning, formal involvement of carers is not prioritised at present
Voluntary sector **Peer support**	**Co-production**			
Although not a formal part of the MDG remit, voluntary sector and peer support have been identified as important issues in the early piloting and may be involved through MDG links to the Community Assets theme of the SICP	Patient involvement has not been a high priority in the design of the MDGs, although there has been input from patients in some of the higher level learning sessions in the development of the SICP			

Figure 8: Core dimensions of the MDG case management model [1]

The dynamic and skill-mix within individual MDGs was variable in practice. Individual MDGs appeared to operate primarily in a siloed and individual manner. However, there was an aspiration that shared learning would occur across MDGs:

> "it's heavily personality dominated. So [this is] the story of the MDGs. We're absolutely convinced it will be easier rolling it out, because they're only going to be given really one format, or one structure, way of working. We've been doing lots of PDSAs" (IP02_1)

Target groups varied3 and decisions regarding changes to the target groups (with patients often referred to in terms of levels not by individual need) of patients eligible for MDGs were made over time and seemingly in a localised and individual manner with professionals pre-determining which patients would benefit/respond best to the intervention and the underpinning criteria for these decisions varied:

> "Well they're saying they're encouraging us, now, to bring those patients. Because what they're saying to us is, there might be something that you know about that we need to put in place before we discharge that patient home, that's going to stop a readmission. So I can see the point in that, I think that's very valid. But a lot of the time, you go to these meetings, and everyone goes, oh, well he's in hospital, let's talk about him when he's home. Which, perhaps, isn't what we need to do." (IP05_1)

> "Yeah. And then when we get to maturity, people, when they slide into there…or should only slide when they've got a shared care plan, because we should already have picked them up with our antennae. So that has been the next challenge for the MDGs, trying to get their heads round why are you making us leave those to concentrate on these. And plus at the same time the enhanced service, the national enhanced service for GPs, you know, that they get paid incentives if they do certain things." (IP02_1)

> "So I've met recently with [name] at Salford Royal to discuss aligning more the MDGs with people who are on your unplanned register. With the MDGs we need to start looking at people before they fall and we need to look at triggers that make people fall." (IP11_1)

Getting the right skill-mix was seen as critical to the success of MDGs (see section 3.4, also) but the new modes of close inter-disciplinary, face to face or co-located ways of working, were seen as an improvement with perceived positive repercussions for patients in terms of health outcomes, coordination and continuity4 as well as timeliness and responsiveness:

> "So yes, as time's gone out, I suppose, personally speaking, I'm getting my orientation from these MDGs as well, being somebody new to the area, but it's faces to a name. You're dealing with GPs on a piece of paper or you're ringing a surgery and it's a faceless

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[3] Preventative; high risk or vulnerable as well as those facing discharge were all discussed. Multi-morbid patients were mentioned, but more emphasis on generally 'vulnerable' patients

[4] achieved primarily via GPs and some professionals working across MDGs

name, but seeing now the district nursing and you think this has got to be better for the clients, if we're coordinating and communicating with each other." (IP10_1)

"No, basically, we allocate a named GP to, well, we've had to, to all our over 75s. So what we did was printed a list of all our over 75s, and we went, right, who knows this person, who knows this person. So we've all got our own list, and we know exactly, the moment you open the records, you know who's over 75 it is. But sometimes it changes, because sometimes that GP is away, and then you get involved in an episode of illness, and you carry on seeing them. So I tend to know...I think when we did our list, I think we had five GPs, and I think something like 30, 40 per cent of them were mine. Just because that's my sort of following, which is why I do the MDG." (IP05_1)

"So I got a phone call from a lady I don't know, I got a messaging saying, please can you ring this lady. I had no idea who she was and I gave her a ring and she said, you've really helped my mum but I'm really worried about my friend and she's a patient of yours. And she told me this awful story and we knew nothing, nothing, and she wasn't that old, to be fair, she was 70 or 69, and I was so concerned about her, she didn't use the phone, she didn't like talking on the phone, I got permission to go and see her in her own home with her friend, so I got permission from the doctors and I got the patients permission. And I went to see her on a Monday morning, at that time we were having our risk meetings and ours was the next day, and I took her to the risk meeting and everything was in place within 24 hours." (IP11_1)

"So whilst it doesn't seem an obvious, i.e. they might not be able to join with the line dancing directly, do get benefit from being there. Now, with that example, particularly the lady who wanted to attend, her carers, the timing of the carers didn't fit with the timing of the group, so if that now was brought into an MDG, we'd be able to sit around the table and have that discussion quite quickly and come up with a resolution rather than the toing and froing that had to happen, because sometimes the groups we run are time limited, there might be an eight or 10 week and by the time things have changed, the group might have finished and the person might not have benefited from participation. So the MDG offers a more immediate response to those issues and sometimes they do partake, because they might sit there and do the arm movements or whatever, so, you know, it's about not making the assumption about what that person can and can't do as well." (IP12_1)

Information sharing within groups and signposting patients to other relevant services was also seen as an added and unintentional benefit to the new ways of working:

"I: Do you ever refer people into other services?
R: Yeah.

I: What sort of things do you refer?

R: So health trainers, so I have done…I can't remember the name, what do you call it, not Park and Ride, the bus service that goes and picks them up and takes them places…Ring and Ride, yeah. So it's a bit of a pain because it seems to be that you do it electronically so I end up doing that. So I've referred patients for Ring and Ride who don't go out because of their mobility, so it's not that they can't walk they just can't walk very far and they miss going to the shops. So I've organised a few patients for Ring and Ride, I've organised Silver Line for a few patients, health trainers, day care centres." (IP11_1)

"So the MDG has helped me with certain patients, 'cause I never knew these education classes existed. And I hope that this family will find them beneficial. But what's been really great is I've given them the links, everything I've been given, I've photocopied and sent to them and said, you know, if you want to, get involved in this, and then they've gone ahead and done that.

I: So it's more of a signposting, it's enabling you to signpost people to…

R: Yeah." (IP05_1)

It was also clear however that MDGs were not operating in the manner or as effectively as they were intended. Incorrect skill-mix,[5] staff turnover/lack of continuity and poor attendance at meetings were viewed as barriers to MDG working and opportunities for shared learning across groups were not evident:

"Swinton have struggled particularly. And they'd had more change in GP membership than Eccles have, so it's a bit like a retraining and a retraining, and a refocus." (IP02_1)

"I: That's one MDG, one practice in one MDG.

R: Yeah, so, I mean, that's crazy, because that's exactly the sort of stuff that should be happening more reliably across the patch, you see, so why isn't that being replicated or…?" (IP06_1)

Patient/carer involvement was complex and issues such as trust and getting patient/carer consent were critical to meaningful involvement. However, it was also clear that in many cases patients were being included and discussed within MDGs and care planning without their knowledge or consent and feedback from the outcomes of MDG meetings to the patients themselves (although not all cases, as some MDGs took place in the patient's home, for instance – however, even in these circumstances, carers were not always satisfied that the patient's or their own views were fully considered). In addition, where outcomes from MDG

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[5] Geriatricians and mental health involvement seen as particularly important to fully effective MDG working but were often lacking, particularly initially during the lifetime of the programme

meetings were agreed they were not always fulfilled and patients/carers did not necessarily feel equipped or their input welcomed:

"So asking them personal stuff really so it's like building a relationship with them, so are they okay financially because of the amount of stress that puts on people which then means you've come to the GP for maybe not the reasons, because nobody understands what's going on. How their mobility was, how they were managing around the home, did they see anybody, did they go out shopping, did they have friends and family members, so that I knew if they were isolated or not. And I put loads of things in place for these people, so one 80 odd year old man told me that he was struggling to get his wife in and out of the bath, and when I looked at his records I thought, well, I'm not surprised. And I got an assessment and it was great. So that was how we then had our own risk meetings, we set our own risk meetings up and I worked with Dr X and I invited Rapid Response" (IP11_1)

"we're missing an opportunity to say…I think what we should be saying is, we do the thing and we go back to them and we say, what do you reckon about this? And they say, well, that's a load of crap, isn't it? Because when that happens, I can't go there, I'm meant to do this and what do you mean this, that's not me and blah, blah, blah. And then that should be fed back, you know, one or two of those should be fed back to the MDG, for example, and go actually, you know, this is how it ought to be presented, you know, there's so much stuff we can be doing and that's involving the bloody patients, you know, the whole idea is to be coordinating care around the patient, but the patient isn't party to any of it, it's bonkers." (IP06_1)

"I: sometimes I've heard other people say, you know, we're going to have a meeting about you, which…
R: It's a bit scary.
I: There are a few people who've said, no, you're not going to. I don't want you to do, and it is funny that some of the others…
R: It's not a meeting about them though, is it? The meeting is about lots of clients and it's about bringing the information, why? Well, we want to support you in your home in order to… You're having these falls, you want to stay here, we're looking at how best that can be coordinated. We'll discuss it, we might meet with you again separately outside that meeting, because it's not just the patients, it's the relatives as well, isn't it? Especially if you're dealing with people where, you know as you as an individual professionally you've explored every avenue and you may have spoken to all these individuals separately and you think I'm having this conversation again about Mrs X, let's bring it here. Again I think it's professional etiquette.
I: For them to at least know?

R: Yes." (IP10_1)

"I: And you mentioned before about…when you were asking about a shared care record, they were saying, your mum's got a shared care plan, or a care plan. Have you ever seen the care plan?

R: Oh yes. I've got a copy of it.

I: Is that a big pink one?

R: No. Do you want to see one?

I: I'd be really interested.

R: You might also have picked up that the week before last they changed the care plan without discussing it with me. I really was annoyed with them about that. You've no right to do that, I said to them. That has to be discussed with my mum or her advocate, which is me." (IP08_1)

"that meeting for me, that was the beginning of taking me down the path where I thought I really am wasting my time spending time in this process. So a very brief conclusion was that everything from the last meeting was done, and I said, well, please, that is not the case, and I went through item by item and there were several which hadn't been done or had only been half done. And I do remember feeling I'm a nuisance here, I don't want to be a complainer and a nuisance, but I'm clearly coming across as a nuisance. So we went over all these points and then we agreed new courses of action to see that these things would get done" (IP07_1)

Mental health was seen as particularly challenging and difficult area for interventions to work in, due to issues around consent, but also in terms of what the patient could be offered:

"I: input from mental health and…?

R: I mean, yeah, I mean, it's clearly very important, I mean, I feel sorry for mental health, because the chap that's there with us, he's great, but they're just so limited to what they can offer and a lot of the people they talk about, you know, that's really relevant to their problems where it's a dementia problem, whereas, some of the younger ones, you know, but certainly with some of the older ones when it's a dementia problem, it's just very difficult and it's difficult from our point of view in that also we don't really know what's going on, you've got to, sort of, feel from far off as to what the issues are, but we don't know until we see somebody who is, you know, maybe struggling, but equally is probably right to try and support them as long as they possibly can be supported, it's just…and there maybe lots of things in place there to try and mitigate for those risks, and so on, we just don't know.

I: Do you think it's more difficult because the mental health is dealt with by another organisation that's quite separate to SRFT?

> R: No, I don't know, I think it would be just as difficult if they weren't, it's, sort of…I don't think that's an issue to be honest, I think there's buy in from mental health, I think the problem is literally what they're able to deliver, you know what they're able to deliver is fairly limited and the need is massive." (IP06_1)

Interventions were seen by some as a duplication of pre-existing services/structures with little planning and integration:

> "But from an NHS point of view I just…I look at all the time that's wasted. All the duplication of effort that's wasted between people, all the phone calls and messages that are unnecessary if there was a process; and my view is that it needs managing, and it isn't managed" (IP08_1).

> "I: I think there are quite a lot of community assets out there.
> R: There's loads and we don't know about them and I think the MDG, if they really thought about it carefully, if we looked at some of these people more carefully and thought about their problems more carefully and looked to see how best, actually we might, as an MDG learn more about the, sort of, community assets that are there in the first instance, so we might get a better understanding through or we might be able to more appropriately refer people on or in or…some of these people might become a community asset themselves, you know…Because there is that community assets work stream and it's how do we use that in the MDGs?" (IP06_1)

Community assets

Investment and linkage to community assets, such as, "carer support, self -management, community groups" has been another aspect of the Salford integration agenda [1]. This aspect primarily relates to the lowest risk patients in the strata, and may therefore not be our priority in the SELFIE project. Figure 9 gives an indication of what these 'community assets' involve.

Figure 9: Outline of the community assets component [6]

Some feel that the three work streams should be better linked together, however:

> "Because there is that community assets work stream and it's how do we use that in the MDGs? Now we do use health improvement and there's people who do attend all of these, but there's, you know, we almost…it's not…we don't want just them to be using their service, we want them to be our, you know, ears on the ground that can tell us, you know, we want people to be in our face and go, oh, this person sounds like she's perfect for this or I'm going to really try and I'm going to take that or…" (IP06_1)

Centre of contact

"Although some services in the Centre of Contact will be reactive (i.e. patients calling in for assistance in navigating the health and social care system), the 'health coaching' intervention will deliver a proactive intervention to older people identified as potentially benefitting from self-care support. Staff in the SICP or in participating practices will identify patients in the middle two strata of the current SICP 4-level risk stratification model. This decision is based on assumptions that patients at the highest stratum are too ill to benefit from the intervention and

too low in prevalence to provide significant potential to impact on utilisation, while those at the lowest stratum have insufficient capacity to benefit given their relatively high level of function" [1].

The intervention uses a mixed model, blending three interventions. A previous 'diabetes CareCall intervention' has been adapted to meet the needs of multiple conditions and utilises an information and motivational model, focussed on understanding of disorders, readiness to change, and adherence to medical advice. They also utilise a social network model from the previous BRIGHT trial, using an existing website and scripts to assess patient needs and signpost them to community resources designed to address the range of health and social problems related to living with a long-term health problem (linking with the 'community assets' strand of the SICP). Finally, they also include assessment and management of mental health needs including brief evidence based CBT interventions such as behavioural activation and motivational interviewing for lifestyle changes [1]. Figure 10 outlines the core dimensions of the model, as initially planned.

Populations	Identification	Technology	Responsiveness	Model
Preventive	Self-referral	Standard telephone support	Reactive	Counselling
Existing single long-term condition	Routine delivery	Telemonitoring	Proactive	CBT
Mixed single long-term conditions	Risk stratification models	Videophone	Scripted	Self-efficacy
Multimorbidity	Clinician referral	Automated telephone support	Unscripted	Defined protocol
High health care users	Post discharge referral	SMS		
High risk of admission		Combinations		
Target	Practitioner	Intensity	Care context	
Education and information	Peer	>1 call per week	Stand alone	
Decision making	Trained non specialist	1 call every 1-2 weeks	Part of wider programme	
Motivation and self-efficacy	Nurse	1 call every 2-4 weeks	Linkage of health coaching to primary care	
Self-care	Medical	1 call every 4-6 weeks		
Health care utilisation	Automated	Variable		
Mental health				
Substance abuse				

Figure 10: Core dimensions of the 'centre of contact' model [1]

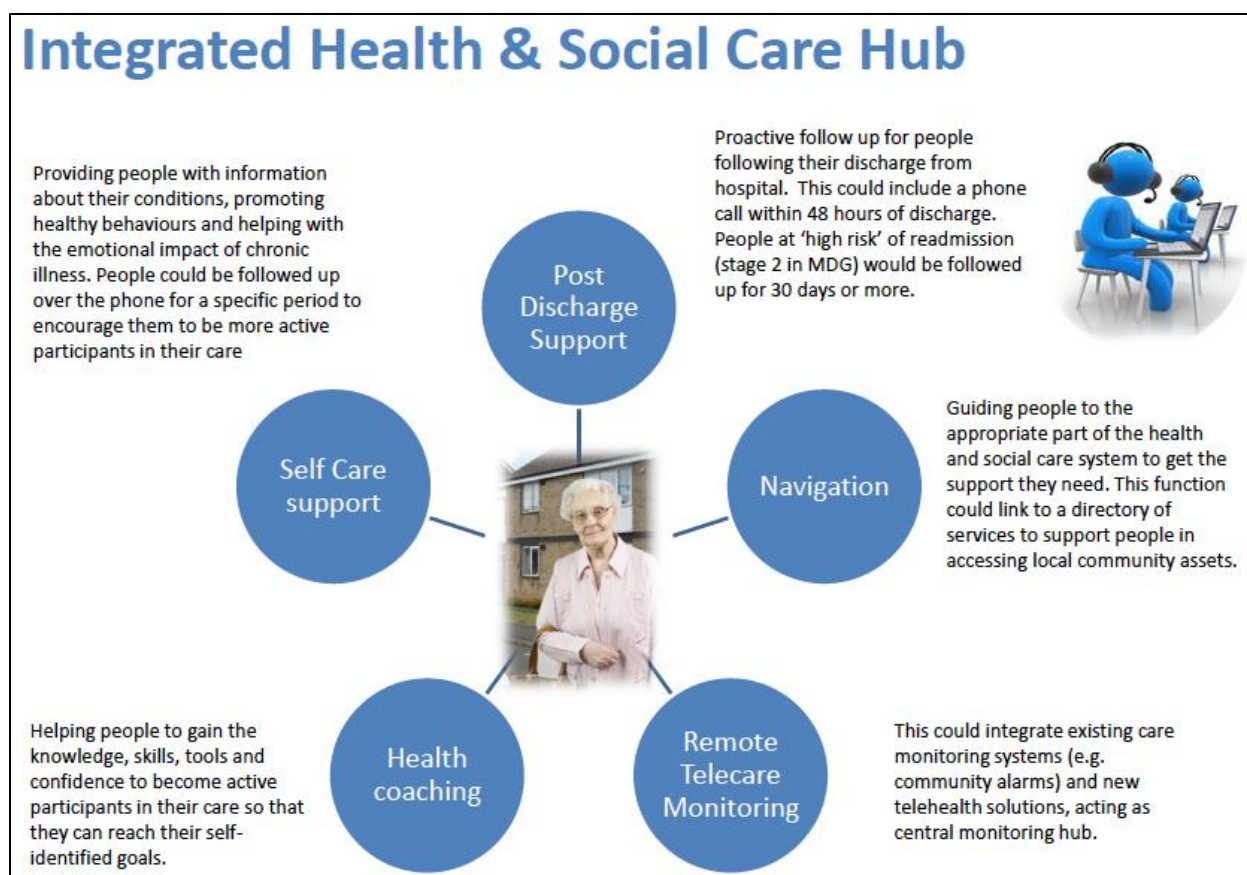Figure 11 outlines the key aims of the model.

Figure 11: Outline of the centre of contact (integrated health and social care hub) [6]

In practice, the health coaching approach includes (6, monthly sessions, around an hour each) telephone calls with a Health Coach (nurse), discussing lifestyle (e.g. diet, exercise) and mood primarily, but also a general chat to deal with issues of loneliness and setting life goals, coping strategies plus pointing to community assets. Patients generally appear to have enjoyed and feel they have benefited from this approach.

> "I felt as though I'd benefitted greatly, because she'd be on, probably, sometimes the best part of an hour, so you got through a lot of information. I'd make little notes, if something cropped up, you know, that's what I need to do now.
>
> I: Notes on what she was saying, or notes for you to ask her?
>
> R: Notes for me to ask her, you see." (IP13_1)

3.2.2. Self-management interventions

As highlighted in the section above, the self-management support is primarily through provision of information, improved access to community resources and support (e.g. self-help groups), as well as through access to an integrated contact centre to support patient navigation and as a

'one-stop-shop' for this information to be obtained [1]. As highlighted above, this self-management emphasis is more pronounced for lower risk patients (i.e. those receiving health coaching/linking to community assets). The emphasis was less pronounced for those receiving MDG management. However, the programme appears to be moving towards focusing on the people who are slipping rather than the highest risk, i.e. where the MDG can potentially have the most impact with a plan that will keep them from slipping, through preventative measures written in the care plan.

> "So the way it started out they wanted everybody with a who code of three, I suppose part of the cynical side of me was, well, we know they're all okay because they've got all the services involved but I understood that we needed to get the care plans done. Whether there was another way that that could have been done I don't know and maybe the way it's been done was the right way because, fortunately, we got through ours fairly quickly. And it's your twos and your ones even, because in the blink of an eye things change, don't they?" (IP11_1)

> "So the MDGs started to work to try and find these people, because we were the…because that is ideally what you want an MDG to do, if you see somebody slipping, that you put a little bit extra in to keep everybody afloat for X or Y amount of time longer. So when we've moved into this… So that's what they were doing, and A, we had to get them to work differently, and B, we had to get them to think differently, and C, we sent them off to try and find these individuals, and they were working quite hard in their new format to support these individuals. When we started now to implement the programme we've said that what we need them to do now is to start reviewing the patients in this category here, because they're already having support from services, and it's no point us taking a nip, dip, dash approach to these people – ad hoc approach – because we need to know that at least the people who have got regular contact from services actually have a plan in place, and then once we've got 100 per cent coverage of those then we can start working back to these more high-risk individuals. Do you see what I'm trying to say?" (IP02_1)

3.3. Leadership & governance

As outlined above (particularly in the MDG component), integration and involvement of social care is a key component of the programme. A range of independent and third sector partners are also involved in the programme (potentially most importantly in the 'Community Assets' component - see Figure 12).

- Age UK
- Care Homes (multiple)
- Chamber of Commerce
- Citizens Advice Bureau
- City West Housing Trust
- Community Pharmacy
- Domiciliary Care Providers
- General Practice
- Helping Hands

- Inspiring Communities Together
- Mature persons group
- Salford Community Leisure
- Salford CVS
- Salford Multi-Faith Forum
- Unlimited Potential
- Your Housing Group
- Other third sector organisations

Figure 12: Independent and third sector partners [8]

As highlighted in the Service Delivery section above, the role of the patient as a leader of their own care is perhaps slightly lacking in comparison to what was initially planned, with a tendency for them not to be necessarily involved or sometimes even aware of the care planning process.

Leadership at the meso-level, however, appears to be more established, with the partner organisations feeling like equal partners, with shared aims across the organisations and a shared commitment. However, there is recognition that Salford Royal has taken the driving role, as the original drivers of the programme, and a respected high-performing organisation:

> "I think all organisations have gone this system can't carry on as it's currently going because it will collapse under the demand and the need so we have to work together. So, I think that's been equal." (IP04_1)

> "This isn't a leadership role where it's about power and control, it's just one organisation having to organise and contribute …So I think when an organisation has done something, it's been with the consent of others" (IP01_1)

The Alliance agreement which has been in place was the formal mechanism tying all organisations in to a single strategic direction, with shared overarching improvement measures used as the basis of discussion for monthly Board meetings. However, the Alliance Board was never a formal decision-making body, and moving towards the ICO to this end was always planned:

> "The alliance agreement, it is the mechanism by which we tie all of the four statutory agencies into, the strategic direction, into sharing the risks and the benefits that will fall differentially across the organisations and so it ties us into responding to that, if you

like, and it provides us also with a framework for delegated decision making..for each of the organisations so we've got a clear framework in place now" (IP04_02)

"Alliance Board - chaired by [name], it takes place always, in the City Mayor's office, but people are quite frank with each other in there, it's not a decision making...unless people agree that to do something, it's got no formality, it doesn't link with anything else, so it's just the senior leaders coming together to say, is everybody okay, all the things that we're doing, is there a bit of intelligence that needs to be shared before we go into discussing it at Board? So I think that works well." (IP01_1)

The shared overarching improvement measures include targets to:

- "Reduce emergency admissions and re-admissions
- Reduce permanent admissions to residential and nursing care
- Improve Quality of Life for users and carers
- Increase the proportion of people that feel supported to manage own condition
- Increase satisfaction with care & support provided
- Increase flu vaccine uptake
- Increase the proportion of people that die at home (or in their usual or preferred place of dying)" [15]

The leaders of the different organisations have had to adapt to each other's ways of working. For example, there are different traditional statutory duties, funding arrangements/flexibility, and political/board accountability felt by different organisations, particularly different between city council representatives and health leaders. This means that everyone has had to adapt to new ways of working:

"But they also have to think about what is politically advantageous and not advantageous for them. They've just got a political angle to their job, which luckily...I say we don't have, but obviously because we work in partnership there's an element of that, but we don't have it in the same way.

I: Has working with them in terms of the Integrated Care Programme, have you all had to take that onboard, that political side of things, because that's quite a different dynamic, isn't it, to work with like you say.

R: Yeah. It's been a learning period for us all really in that that Steering Group, I've learnt an awful lot about how the local authority...what the governance is and how it works and I suppose the power that the elected members have, and the difficulties in managing that. And I think we have taken it onboard because we had to, because we couldn't afford not to because we wouldn't have been as successful" (IP03_1)

A Health and Wellbeing Board (a nationally implemented board in each locality – with involvement from all of the local organisations) oversees the work of the programme and approved spending allocated under the Alliance contract and "assurance reports [go] back in to each of the key stakeholding organisation key partners." (IP02_1)

Commissioners and providers mixed on the different boards during the Alliance contracting stage. For example, the Operational Board was mostly providers, but a few commissioners also went along to keep an eye on things in case anything was 'lost in translation' from the plans to implementation:

> "So the Alliance Board and the Steering Group would say yes, this is what we want to happen, this is the funding we'll provide, over to Ops Board saying right, you now implement. Now, we were just a bit worried that things can get lost in translation and they might understand what they're being asked to do, but for whatever reason go a slightly different route than what was originally intended. So … and I, who's from the city council, we try and attend the Ops Board. We don't always get there. Just to keep…it's more of an observer role really, and then if we were worried something was going a bit…we could either raise it in the meeting or outside." (IP03_1)

However, as of July 1st 2016, the governance arrangements have changed. There is no longer an Alliance Agreement, and therefore no Alliance Board. There is now an advisory board for integrated care (similar attendance as the Alliance Board) and an integrated adult health and care commissioning joint committee. In this new structure, it appears that the commissioners and providers are separating themselves once again - very different to what they were aiming to do under the Alliance Agreement. The new governance structure is referred to as an 'integrated care system' as the older peoples work (ICP) and the adult population (Vanguard) programmes of work all come under this new governance arrangement.

On the ground, the professionals involved in each of the MDGs have fed into local development and leadership of the model:

> "neighbourhood MDG's, so … each of the partners played into that with GP's, district nurses, social workers, mental health nurses, health improvement teams. So it was across the board" (IP04_1)

Some macro-level leadership issues also arose, mostly regarding the independent contractual nature of primary care, GPs. There was a recognition that to incorporate GPs into the governance system is difficult to envision because of this independence of GP practices. Again, the ICO was seen as way to potentially overcome this, with some GPs potentially becoming directly employed and salaried by the ICO, and others with a "more formal relationship, they're maintaining their practice, their partnership, and we have a contract with them to deliver

services" (IP01_1). In the interim, the GPs involvement in CCGs appeared to be a workaround, where the integration programme was, "done fully in partnership with the CCG in the room and talking with GP leaders about development" (IP01_1).

There was also a recognition that the direction of national policy has so far allowed the model to advance, but that this could be a potential barrier if this was to change in the future:

> "Likewise if nationally whatever is…a policy change, that could cause us a conflict because we might be trying to do something that is actually not in line with national policy. And the worst case scenario there is well, we just have to come in line with national policy because we can't not do it necessarily. Obviously at the moment we're quite lucky because the direction we're going in is completely in line with national policy." (IP03_1)

3.4. Workforce

New ways of professional working rather than new professional roles, especially through the MDGs, are particularly important to the Salford programme. Through the MDGs, there is now also closer working between traditional health and social care roles, with more lifestyle-oriented/ behaviour-change roles such as health improvement officers and patient engagement workers, whose roles involve spending more time addressing the psycho-social needs, linking with community assets, for example local voluntary groups.

Motivations for involvement within the programme varied both by role (new opportunities via roles such as health improvement officers and/or pre-existing role expansion or variations) and individual. Motivations were generally initially high with widespread support for the programme's aims and the potential for opportunities for improved patient care/outcomes due to multi-disciplinary working and meeting previously unmet patient needs:

> "the MDG is a great opportunity, it's a highly resourced opportunity, you've got lots of people earning a fair amount of money who are all paid to be in that place at once and therefore, you've got a huge opportunity to really look to develop ways of responding to people with multiple needs rapidly in the event that they, sort of, it's predictable that they're going to have deterioration and the only problem is it's unpredictable exactly when it's going to happen." (IP06_1)

> "there must be times for people, I would have thought, in community services when sometimes working could be very disheartening because you're working on your own, and sometimes support from the other services might feel a bit distant; whereas hopefully with the way with the shared care plan where anybody can access the care

plan to see what's been agreed by the multidisciplinary group and who should be doing what and who is in contact with that person, then I would have thought it has to make a difference to everyone on the team as well as the individual who is receiving the care." (IP02_1)

"I'm hoping we'll pick more up, I'm hoping that the patients we've never spoken to for ages that will make...we'll make sure that they're alright and that they know that me and my team, if you will, that I'm hoping to get together, are the people to contact for whatever reason, be it financially, be it they're lonely, if they don't know how they're going to manage at home, so for whatever reason. I always end up, just call me, just give me a call. And I've got a couple of voicemails today from family members where I've rang and said, is there anything you need help with? And last week they'd said no and obviously they'd thought about it. So I always leave it and if I'm not here ask for my colleagues.

I: And is that a role that perhaps the GPs had in the past, do you think, or do you think they've just struggled with no help at all?

R: I don't know, I can't think of anybody doing that sort of thing in the past, no." (IP11_1)

Inter-disciplinary working, opportunities for new and shared learning as well as perceived improvements in patient outcomes were particularly viewed as positive:

"For example, for the dementia people, I didn't know, until the social workers told me, that you can get alarms put on the door which will alert the care agency that somebody is leaving the house at midnight, you know, it can be timed. These tracker devices, I mean, they were talking about you can put a tracker device in somebody's pocket, and if they go AWOL, you can find them. But you only find those things out when you sit round a table and talk to people about the problems you're having" (IP05_1)

"The nursing leads and social care leads, so we meet every other week to look out what worked for people, because obviously if you look at the areas, they have different issues. What X will have will be a different issue because X is different from Z and Y and Q, so obviously the GPs are different elsewhere, the way they link to social care, so we're kind of trying to understand and support each other that way." (IP09_1)

"You cannot change things overnight. It will need to progress. It's a big progress for that person because it's a big change for them, so at the beginning… I could see from the other side from that understanding around how it will work and I'm beginning to understand they work. That is very beneficial for service users rather than having the professional antagonising issues, when we come together to have that standard of our work." (IP09_1)

Inter-professional working however also led to new inter-professional tensions and lines of responsibility being outlined. This was particularly evident from non-clinical staff:

"In MDGs people ask me do we do that regularly, whether we offer carer's assessments, they do ask repeatedly. Now those are social work territories, now you are having the sense that now people are beginning to understand that we need to ask for carer's assessments, so one thing with the GP we do is when they then go onto a visit they will check with family and they can be talking to people about you can get carer's assessment even though Mum or Dad, they're not having carers, well, that does not remove the fact that you can get carer's… So they're thinking social work as well, then we would be thinking around medical conditions as well, so we can then check with the GPs this can then be shared or my colleague has said they need a GP to visit and things like that." (IP09_1)

"Some areas are just getting used to the mental health aspect and that we actually have got something to say about these people, that they're not just yours, they're shared." (IP10_1)

Finally, issues surrounding inadequate/slow recruitment to the MDG, achieving the right skill-mix and the impact of the additional programme-related work on the individuals overall workload, and in particular on General Practitioners (GPs), had led to issues in maintaining motivations for the various staff involved in the MDG:

"And the next challenge is for the primary care, the GPs, to think, how do we work differently. Because at the moment they're just seeing all these as extra pieces of work, as opposed to this being the same cohort and how do we restructure, how do we work with our registered patients differently. So if I was a GP, if it was my practice I would be identifying some of my GPs to manage all these patients rather than everybody having 50 of those each, whoever is on their books, and then some will have…you know, and then everybody's got some of those; because otherwise we're not going to get the continuity of care, and it will be difficult for them, and they will be having to have lots of conversations. But because it really means the practice is starting to think very differently they're not…yeah, different practices are at different points, plus the extended hours and other things that they're grappling with, and actually that they…that it feels short, you know, they're advertising for GPs and they're not getting them, so they've got vacancies which then, you know, everybody feels too busy or are too busy to get their head up to take one step back to say, you know, that there's some of that double running." (IP02_1)

'Yeah, but it's only the patients that we're talking about that week, that's the problem. So, like, I've just got my flipping list through, and I want to kill

myself. Because I've been through all the projected lists that we were given ages ago, and I've now got five new patients that pop up a week before the meeting. Now, none of these patients were originally listed, to be talked about on this date. Because we got a timetable right at the beginning, and everybody was kind of put in.

I: So who's given you this, then?

R: So this is [name] the coordinator guy. And I do admit, I wasn't there last week, so none of my patients were discussed. Normally, I would send somebody in my place, but there was nobody to come last week, and it was all very last minute. But now, I've just picked this up, and I've got give people on here. Now, three of them, I know reasonably well, although I'm not their GP. Two of them, I really don't know anything about at all. So I've got a hell of a lot of work to do for the next week, to get to know all these patients, get it all written up on the integrated record. So yeah, I'm overjoyed today!" (IP05_1)

"I: What do you think about the other people sat around the MDG table as well?

R: I think there's plenty of enthusiasm, I really do think there's plenty of enthusiasm there, I mean, when we first met and all the rest of it, people aren't being overly negative, I think they're just getting a little bit more, sort of, you know, losing enthusiasm, but I don't think they're being negative particularly, I mean, there's a few people…there's one or two that are under pressure, single handed and all the rest of it, but generally people are there to…I don't think it would take very much." (IP06_1)

3.5.   Technologies & medical products

A number of 'enablers' of the integration approach are recognised by the programme. Many of these relate to the ICT infrastructure and usage:

- "Cost-benefit analysis of the new delivery model, including an assessment of the likely impact of changes within what is a complex, dynamic system
- Development of more sophisticated approaches to risk stratification, including factors that are likely precipitate admission to a care home
- Creation of Shared Care Record for older people, building on the Salford Integrated Record and the Council's Single Customer Account
- Robust data sharing arrangements, recognising data protection restrictions
- Effective implementation of new contractual and payment arrangements that support 'pain and gain' sharing" [8]

Two key ICT components emerged from the documents analysed.

1. Risk-stratification tool

The programme uses a well-known risk stratification tool to identify those patients that require the most care and support, the Combined Predictive Model [6]. Figure 13 shows the results of the risk stratification tool, with numbers of older people identified in each strata. 23% (8031 persons) of the elderly population of Salford were identified as moderate to very high risk [6].
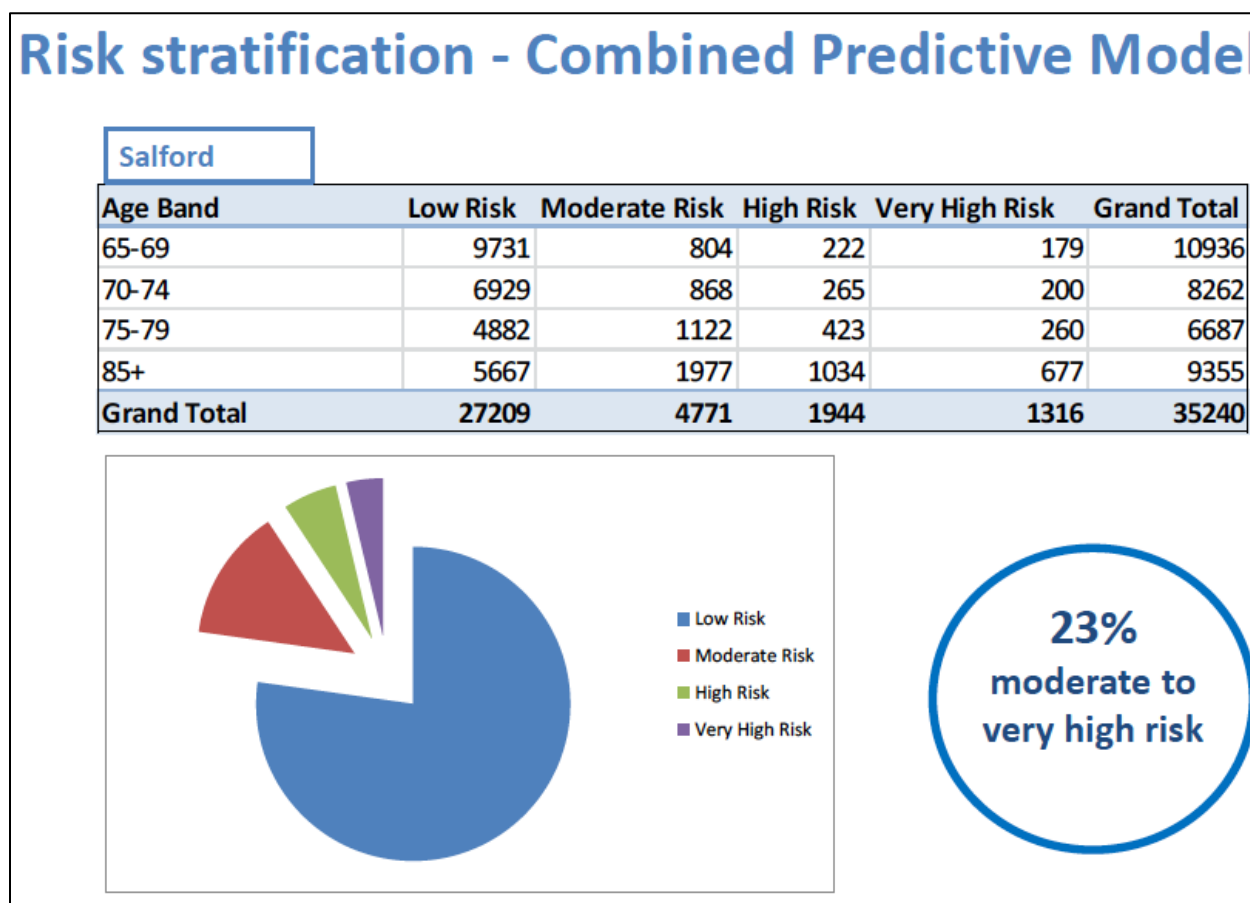

Risk stratification - Combined Predictive Model

Salford

Age Band	Low Risk	Moderate Risk	High Risk	Very High Risk	Grand Total
65-69	9731	804	222	179	10936
70-74	6929	868	265	200	8262
75-79	4882	1122	423	260	6687
85+	5667	1977	1034	677	9355
Grand Total	27209	4771	1944	1316	35240

23% moderate to very high risk

Figure 13: Combined Predictive Model risk stratification outcome in Salford [6]

In previous studies in the Greater Manchester area (particularly Central Manchester CCG – see Stokes et al 2016 in BMJ Open), it has been shown that results of the risk tool were not always acceptable to GPs when identifying patients to case manage, and instead clinical judgement was used in many cases to select patients. A similar finding appears to emerge in Salford.

In practice, because the risk prediction tools used predominantly assign the score based on previous hospital admissions data, they were tending to suggest patients for referral who had already had contact with services, and so were well known to the professionals, generally with good support around them. This is seen by the professionals as potentially the wrong group to target, where things have already fallen apart, and it's more difficult to mobilise the support needed:

"so we'd looked at some of the higher risk patients that were identified by the CPM – combined predictive model – and PARS exactly the same, because I've done that before for the unscheduled care, and we looked at that; and what you find is the high risk people that are identified by this risk stratification models that are promoted nationally, is that the only data that's easy to count is the hospital data, is the HES of your hospital episodic statistics and stuff; so the people that were at the top are the people who have most support from services, that because they have a lot of support from services they're usually quite well managed, and so therefore they are more reasonably stable." (IP02_1)

"it's the support for folk who are starting to get into a position where they're becoming a bit at risk, you know, they're starting to wander and they're starting to struggle in their own home environment, and all that, and it's that point where things are tipping a little bit, where I think we're really, really poor at either upping the support or upping support and making plans should that fall apart that don't involve coming into hospital, whatever, you know...It's not going to get any better, it's definitely going to get worse and I think probably rather than putting in more need, what we should be doing as part of the MDG thing … we're going to make sure everybody is aware that this is it, if it falls apart, this is what's going to happen package, you know, and it might be a graded package. If it half falls apart or if it three quarters falls apart, if it completely falls apart. But every time it falls apart and it's a great big surprise to everybody, then it's really hard to motiv…not to motivate, but to, sort of, mobilise what's required, you know, it's phenomenally complex." (IP06_1)

2. **Integrated care record**

The Salford integrated record is a well-known innovative feature in the NHS, introduced in 2009 (to some extent). This is an integrated, single patient record accessible by primary, secondary and community care organisations in the Salford area [1, 14]. However, the documents analysed report that "implementation of an Integrated Shared Care Record is taking longer than planned, though an interim solution supporting the MDGs is in operation" [10].

In practice, duplication in information entry remains. For example, MDG decisions are coded on practice records/mental health records, as well as shared care records to make sure they are noticed by all colleagues. Only those colleagues directly involved in the MDG (plus colleagues in A&E) have had access to the shared record at first, limiting its usefulness. The record has not been easily accessible in secondary care either, with a learning curve and lack of apparent usability. Therefore, some see the record as having some use in secondary care for giving background information on a patient who presents, but that the technology doesn't seem to do anything to prevent the admission in the first place:

"It flags up, okay, it flags up as a little ICP thing on the headline banner alongside allergies and DNR status and all that kind of stuff, so it flags up right at the top, problem is nobody knows what it is, okay…So they've got ICP up there, they then have to do a search and they have to open up the last three months and it'll come up and it's a bit complex" (IP06_1)

"So it's useful insofar as you know what their background functional status is and you know who their main contacts are, but it doesn't give you very much else. As I say, it's useful to run some background information and it certainly didn't help the patient themselves when it came to their crisis situation, okay" (IP06_1)

Nevertheless, the concept of the shared care record is seen as an essential component of integrated care:

"And it's having a shared care record we need to have access, because having worked in the community for a number of years, it's difficult, you're going to see somebody from a mental health point of view, you've got limited information from the GP, you go in, and there are several other people involved with that person's care. It's then time-consuming to try and contact them, et cetera. We are a little bit on the back foot because we're not electronically au fait, but we're getting there." (IP10_1)

Additional technology measures used include a Dashboard which has been designed for the MDG meetings, to flag up patients for discussion and to pull up records. Some felt this was not being utilised effectively to begin with, and would like to see it used in MDG meetings to give more concrete talking points. Some professionals would like to use it to pull up a couple of patients at the start of an MDG meeting, and discuss the cases in a bit more detail to make the MDGs more patient-focused:

"And then you just use that as a starter for ten. So we need to make it more live and hopefully that will mean that we start using the dashboards a bit more, because they're all there." (IP06_1)

GPs have found additional electronic forms involved in selection of patients for MDG discussion clunky and that it takes a lot of time to use (can take 30-40 minutes to populate boxes per person), sometimes just to say, 'we don't need to discuss that patient'. If filling out for another GP's patient this is particularly true, although they can potentially ask for input from the GP who knows the patient better, and then populate remaining fields (cuts time a bit, 15-20 minutes):

"So I'm expected to go to the records, populate it all, fill it all out, and then just say … don't bother discussing it, put them back, you know, they're not a priority. I'd say it's a good 30, 40 minutes per patient, to peruse all their records, and to go online, and

populate all those boxes. And of course, some of the information we don't have" (IP05_1)

More generally, there appears to have been some challenges in getting technology embedded in day-to-day practice:

"how we get the use of technology more driven and more used and embedded on a day-to-day basis." (IP02_1)

"In terms of IT there have been issues really and they are dealing with it, we're going to be provided with laptops and iPads, everyone, now…they need to act urgently and we send an email to the manager that they needed to act if they want us to approach that way within that aspect." (IP09_1)

In terms of the patient/carer's interaction with technology, some current workarounds, innovations, and potential issues have been identified.

Some carers are making their own workarounds to a lack of care coordination, e.g. a communications book that they ask each person who visits their mother's house to fill in. However, there has been some reluctance from the professionals to use these communications (they don't appear to believe that the other professionals look at it) (IP08_1).

Innovative uses of technologies have been used, for instance with patients with cognitive problems (e.g. dementia), where sensors are used, partly to re-assure the family of the movement of the patient around their house (e.g. indicating lack of sleeping). These can be used on doors in the house (IP09_1), or trackers in patient's pocket (IP05_1), for example. The information can be used to helpfully feed in to their care plans, and potentially keep the patient living independently at home for longer (IP09_1). Technology, such as telehealth, is also being used for things like dermatology consultation:

"tele-dermatology and we're piloting it…the GP will take a photograph and email it and get a decision, they're not doing suspected cancers obviously, but rashes. Yeah, we've done it." (IP11_1)

However, there are potential Indications that technology interventions involving direct patient input will not be suitable for all multi-morbid patients, particularly for the elderly. Potentially though, family members/ other carers might be able to help out to help enable this option. Patients could also perceive over-use of technology as discrimination against older patients/ a cost-cutting exercise:

"it's complete discrimination against the older generation, I mean, it's big business, and they want to do things as cheaply as they can, don't they, and there's nothing we can do about it is there?" (IP13_1)

3.6.   Information & research/monitoring

An ongoing research study led by the University of Manchester (and involving Professor Matt Sutton, as well as colleagues in the Centre for Primary Care), CLASSIC (Comprehensive Longitudinal Assessment of Salford Integrated Care), is currently evaluating the SICP programme.

CLASSIC is based on a cohort multiple randomised controlled trial (cmRCT) design, and has recruited over 4000 older people with long term conditions in Salford, sampling patients with varying number of conditions and associated social care needs. Participants are followed up every 6 months with measures of service experience, health and care utilisation, linked to Salford Integrated Record data on clinical parameters and care utilisation. There is also in-depth qualitative work in the cohort to support research themes. Cohort members have also provided consent to be contacted about sub-studies nested within the CLASSIC cohort, facilitating proactive recruitment of older people. There are 4 four types of evaluation in CLASSIC:

- "**Population level**: The cohort will allow assessment of the effect of the SICP on overall population experience, health and costs over time, with repeated measurements allowing rigorous time series analysis (Campbell 2009)
- **Cluster level**: Individuals in the cohort will be clustered by local groups of practices. Aspects of the SICP will be tested in a 'staged' manner, introducing change in some areas before others, allowing evaluation through comparison of clusters receiving early and late implementation.
- **Individual-level**: Within clusters, we will allocate individuals to certain SICP components such as 'health coaching' (i.e. proactive telephone self-management support) via the 'integrated contact centre'
- **External comparators**: There will be comparisons with sites outside Salford, using routinely available data on service experience, utilisation, and mortality, with appropriate non-experimental methods" [1]

"The overall aim of CLASSIC is to test the ability of the SICP to deliver significant and sustained improvements to the care of people with long term conditions and social care needs. In the initial phase, we will explore the following research questions.

Implementation:

1. How do key stakeholders (commissioners, strategic partners) view the SICP, what do they expect from it, and how is it aligned with their objectives and incentives?
2. What is the process of implementation of two key aspects of the SICP – the 'multidisciplinary health and social care groups', and the 'integrated contact centre'

Outcomes:

1. What is the impact of the 'multidisciplinary health and social care groups' on the outcomes and costs of people with long-term conditions?
2. What is the impact of health coaching from the 'Integrated contact centre' on the outcomes and costs of people with long-term conditions?" [1].

The CLASSIC project is yet to report, although approaching the end of its grant funding, so findings will become known in the near future.

In addition, the recently appointed status as a Vanguard programme puts Salford under additional evaluation as part of the wider Vanguard analysis. DevoManc will also lead to increased evaluation in the area.

In terms of what findings are expected from the evaluations, staff appear to recognise that shorter-term successes of the MDGs are likely to be more process-based than outcomes like admissions/cost of care that are the ultimate longer-term goals:

> "at the beginning the success stories at the moment are about, you know, me being able to go out to some GP practice and just sit down and chat with them and them sending referrals to us, that's a direct result and a success, I would say… I spoke to one lady yesterday and I'm hoping that she's going to join our Health Lifestyles group and knowing a little bit about her, from having spoken to the practice manager and he put a really good write up on the MDG shared information, really facilitated the conversation with her… because she felt that people had cared enough about her to share the relevant information." (IP12_1)

This is further expanded on in the following section, under discussion of the Better Care Fund.

3.7. Financing

There has been a gradual evolution of the contracting and payment system at the meso-level. An Alliance contract (with Section 75 agreement – a mechanism that has been available for them to pool money since 1991) was used to promote integration activity, but the plan was always to move to an 'Integrated Care System', full organisational integration with formation of an Integrated Care Organisation (ICO). This is seen as necessary to ultimately achieve the envisioned efficiency savings:

> "the next layer that comes is … there to be a lead provider organisation on behalf of the alliance agreement … only that way, will we manage to completely redesign … create some of the efficiencies in the system. So at the moment we've got artificial…we've got

hand offs between the different organisations and we need to get those out to create greater efficiencies and to truly look at job roles. Because as long as we have each organisation still commissioned we're still going to have people trying to look after jobs – and that's our work, that's not yours – and we'll continue to have some duplication" (IP02_1)

This has now been realised, as of July 1st 2016, when the Integrated Care Organisation planned as part of the Vanguard funding was operationalised (and was accompanied by a changed governance structure, with the Alliance Board being replaced and the previous work of the ICP, targeting older people, expanded to the wider adult population too). Local Authority staff have now been TUPED over and are working in the Salford Royal Foundation Trust. There are also additional developments with Greater Manchester Devolution and Vanguard funding now being transferred to a transformation pot. However, with these developments so recent, the details currently remain fuzzy. The interim Alliance stage, however, can be discussed in more detail.

As detailed in the sections above, particularly being consolidated in recent years, the integrated care 'Alliance agreement' has played a core part as an enabler of the integrated care changes, and to scaling up the programme to the entire adult population. The Alliance agreement was a formal agreement between the CCG, City Council, Salford Royal and Greater Manchester West, and forms the basis for a pooled health & social care budget and financial risk share; Joint outcomes, measures and standards; and, Integrated management of health & social care services [5]. The pooled budget incorporates the Better Care Fund (a national pooled budget initiative - https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/), and is being done in partnership with the Health & Wellbeing Board, which has responsibility for endorsing the Better Care Fund.

The Alliance has had access to a pooled budget for all of the elderly (over-65s) services in the local area (around £100m worth of services identified that support elderly people in Salford (IP02_1)) and delegated authority to make decisions, and so the combined organisations share decision-making about which services are commissioned from the shared budget, and share risk and reward for financial success or failure. They also monitor the final spending (IP04_1).

"that is the totality of the money that is available for the over-65 services, if there's new services that need money, like stroke who put a business case forward for an early supported discharge team, which we need because that's one of the national standards that we have – early supported discharge – then that money has to be found from somewhere within the alliance. So everybody has got skin in the game as to making sure that if that team goes in people get out of it what they need, and if we fund that then that means that that money has got to be taken out of somebody else's service, so

we've got to understand where that money is coming from, whether that's doable or not" (IP02_1)

Any provider loss of income can therefore be a source of potential conflict (although none has actually been seen to date), and likewise the shared risks (but these are at least agreed by the board) with having separate providers (IP03_1). Therefore, as single individual organisations, providers still had worries about the effects of consultation decisions on their own funding streams (IP12_1).

The Alliance agreement also acted as a "vehicle for redesign" (IP02_1), and set out clearly the agreed rules by which the organisations (who entered into the arrangement voluntarily (IP01_1)) were going to move forward and spend the money (IP01_1, IP03_1).

The move towards integrated financial arrangements was borne from the recognition that the current financial context is unaffordable (see Figure 14):

> "I think if it had been purely outcomes then we'd have been here a long, long time ago but I think it's the money now. The NHS is facing 30 billion pounds, local authorities are cut by half practically and so it makes sense that we pull this lot together and do it together because there are perverse incentives going on in the system at the moment and the system will collapse. It won't serve any organisation. So, Salford Royal can suck as many older people in as they choose to do but if they can't get them out supported by adult social care because there's no money and the right kinds of interventions from primary care then the hospital will collapse." (IP04_1)

> "I think probably because national travel was in the same direction, but you can see if you're going to keep stripping savings out, particularly for the city council, unless they partnered they were running out of options for where to find the savings. Salford Royal brings in a lot of activity, so there were more options in health I think for finding money than there were with the city council, but we all knew – or all know – that it needed managing because of the financial position across the country, options were reducing, so we had to work differently." (IP02_1)

Figure 14: Financial context and implications [7]

Therefore, pooled budgets and alignment of incentives is seen as a key way to reduce secondary care/care home utilisation and therefore potentially cashable savings (see Figure 15).
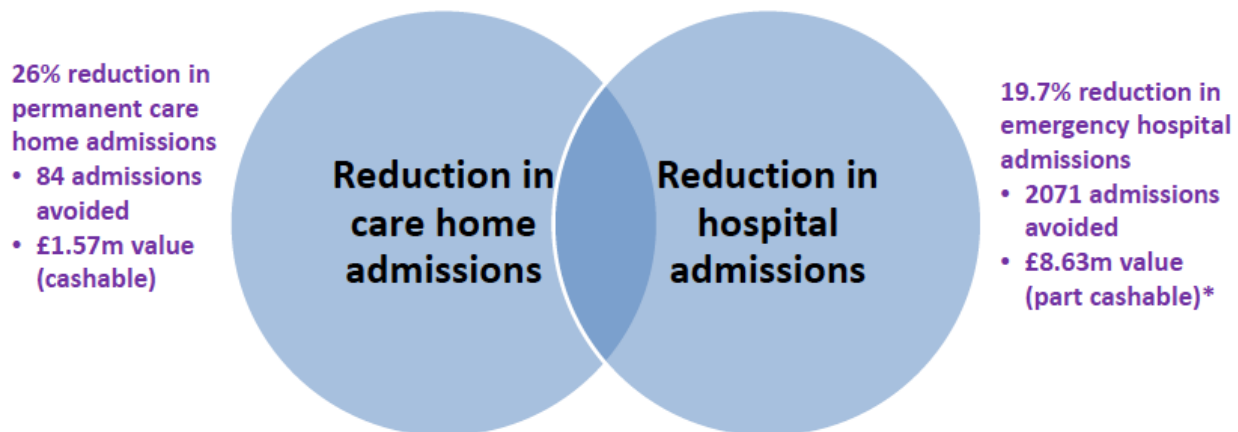
Figure 15: Potential cost reductions [7]

The traditional contracting (multi-contract) arrangements were seen as a detriment to the integration process (see Figure 16).
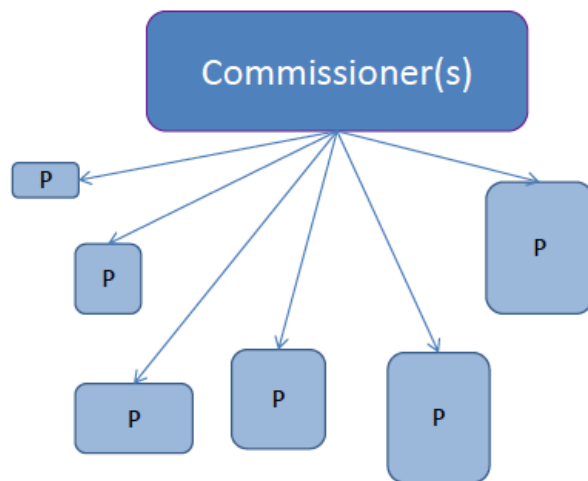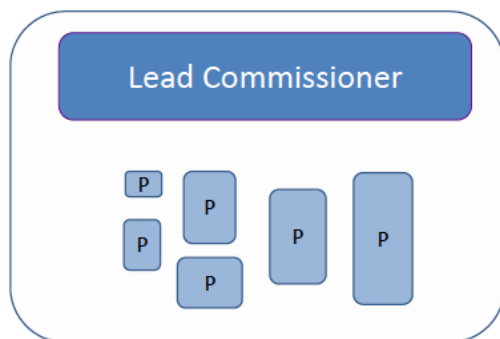
Figure 16: Detriments for integration of traditional contracting arrangements [7]

A number of contracting models were explored to begin with, but the Alliance model was chosen in the interim-period, based on its perceived benefits (see Figure 17) and scope (see Figure 18). The contract was gradually phased in from 2014/15 for older people (health and social care services), and there were always plans to expand the scope to the entire adult population under the Vanguard Salford Together programme.

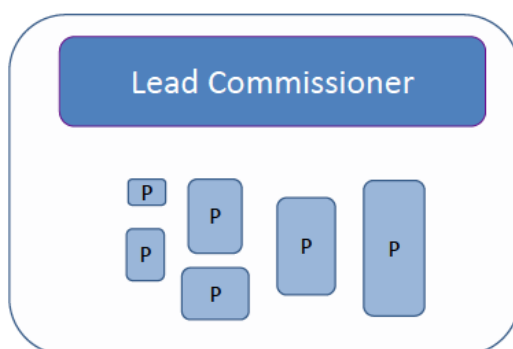**Figure 17: Perceived benefits of Alliance contract [7]**

Figure 18: Perceived scope of Alliance contract [7]

A number of barriers to the new contracting arrangements were also explored, together with a variety of options for resolution. The key barriers were thought to lie in tensions between local and national level policy regarding competition, choice and procurement (see Figure 19). Some external support was commissioned through the King's Fund to develop a Memorandum of Understanding (MoU), as a staging post to implementation of the new contractual arrangements, setting out the scope of the new contract, key principles and commercial terms [8].

Competition, choice and procurement

	Potential Adverse Impact	Options for Resolutions
Competition between providers	• Inbuilt incentives of capitation could keep older people within services provided by partners to maximise care outcomes and avoid revenue 'leakage' • This form of collaboration could be considered 'anti-competitive' in that parts of the upstream care pathway are captured by an Alliance, to the exclusion of other potential suppliers	• Anti-competitive behaviour is permitted if in the interests of service users. In assessing this, Monitor will carry out a cost/benefit analysis • Monitor will consider whether the changes remove or materially reduces the incentives on providers to provide high quality services, value for money and/or improve services – and whether the changes give rise to any material benefits to users of NHS health care services • It will need to be demonstrated that integrated care improves (not diminishes) quality and VFM and that service users benefit from more integrated care – and that the combined benefits outweigh any costs
Patient choice	• Incorporating GPs, community services, hospital services and social care within an Alliance could reduce the choice available to service users at the point when they would have normally been referred to a community or hospital service for further care	• Commissioners are not required to extend patient choice or promote competition where it does not already exist • For older people, it could be argued that patient choice is less prevalent and that continuity / care coordination is more important than choice • Patients could be offered the choice to access care outside the integrated care system for specialist services and AQP services
Procurement	• Restricting the Alliance to the existing statutory partners could be seen to restrict 'competition for the market', as potential new entrants would not be allowed to tender for services	• Procurement of services without a tender process is permitted where only one provider is capable of providing the services or a detailed review is carried out to identify the most capable provider(s) • The issue also relates to the extent to which new services are required or the focus is on redesigning and integrating existing services • Specific services could be subcontracted from third parties, selected through a competitive procurement process

Figure 19: Potential barriers to Alliance contract arrangements [7]

Barriers to using the Alliance contract in practice have included having to continue to work with the bureaucracy/ statutory responsibility of the individual organisations within it. For example, because there is local city council money within the pooled budget, they must follow different regulations or requirements for spending over a certain amount (around £300k). This is required because the council has different accountability political and procedural accountability than the other organisations. This can therefore slow down decisions (IP02_1).

Each organisation was also required to commit money to be fully involved in the Alliance contract. This has been difficult for primary care especially (despite being a key part of

delivering the MDG) because of the independent nature of the GP business (each practice is an individual provider, as discussed in the macro section of this report). Therefore, commitment cannot be forced via contractual means, but has been voluntary/incentivised through practice payments:

> "it has to be voluntary because you can't make [GP] practices do anything. So it's still voluntary but we're incentivising them to do it, by not only saying we'll reimburse your time, but we've agreed a local commissioned service. It's basically an additional contract whereby if they engage up to a reasonable level, it's actually across five different contract arrangements really. If they engage in all of them they basically get another sum of money. …Each of those five things anyway attracts its own income. But because they were all, bar one, optional, that's not what we want. What we need is citywide coverage of what we deem to be the correct services to provide to our population. The problem with the GP contract is it has a core element, and then lots of little either…they call them local enhanced services, or to the CCG they're called local commissioned services. So lots and lots of them exist, all of them of which are optional. Which when you're trying to implement a radical big thing across…you can't have it because you wouldn't get 100 per cent coverage across Salford." (IP03_1)

In general, there appears to be a recognised need in primary care to simplify the commissioning process. There are currently multiple payment schemes targeting the same patients. The hope from the CCG is that simplifying these contracting arrangements through a long-term conditions agreement may alleviate some of the added workload of satisfying the multiple contracted responsibilities/administration. The hope is that this will allow multi-morbid patients to be better managed too:

> "So the CCG… they can see that it's problematic …for the GPs – have established, or are developing now, the proactive continuum of care; which starts with people with long-term conditions, moves to people who are on the enhanced service emergency avoidable admissions, to the patients who are identified by the MDGs, and then there's everybody who is 75 and older have got a named GP, and then there's the end-of-life care. And they're at the moment building a new locally commissioned service … how they're going to manage the patients in primary care with long-term conditions, and it's a much more holistic approach. So if you've got diabetes and heart failure and acute kidney disease you might manage all those together as opposed to going for your diabetes review, your heart failure review, and your… Which is obviously the way to go. And then they're going to commission GPs to provide all of those services through one agreement, so that you can't opt in or out of these; because what they're saying is – which is right – and one of the practices has done a diagram to show it, that these are all the same patients, they're just in a different part of their journey." (IP02_1)

Providers were paid for the additional time dedicated to MDG meetings. However, in primary care, for example, even though practices were paid for the GPs time dedicated to the MDG, other GP workload was still there (i.e. seeing patients as usual), so this was an additional activity. This might have led to the MDG work being more "ad hoc-ey" (IP05_1):

> "for me to do that, I would have to cancel a surgery, and I think that's wrong, because all these other patients still need to be seen" (IP05_1)

GP partners were also incentivised by non-financial means, e.g. only having access to the long-term conditions agreement described above if participating. There was no real perceived increase in primary care funding as an incentive, but instead money from other previous incentive schemes has been moved around, and a different activity is required to gain the same. The way payments were made also appeared to influence GP attendance (and potentially functioning in terms of familiarity with patients that were being discussed) at some MDGs:

> "the way we're paid for anything that we do, is piecemeal, and it's on the different projects that we take on, and it's the care we provide to patients, but it's all very piecemeal. And as with everything in the NHS, they take with one hand and give with the other. So they take away money from QOF [national pay-for-performance scheme], and then they put it into these other things. So if you want to continue to be able to provide a service, and have a steady level of income, you have to take part in the new initiatives. Otherwise, you can't survive financially." (IP05_1)

> "I think the CCG only reimburse one GP per practice to come, but you do get instances in an MDG where somebody will say, well, I've brought this paperwork, but they're not my patient, I don't really know anything about them….And you might just have, like, one line written on the background and it's not really the same as if it's the GP who is coming, but in other practices, you can have GPs who circulate round, so they all take turns at going and they all take turns at bringing their own patients." (IP12_1)

At the macro-level, the Better Care Fund (BCF) and national policy direction was seen as a driver to incentivise change (IP04_1). Salford was felt to be in a better place than others to utilise the BCF due to their history of partnership working. This meant that they had plans in place quickly to apply for the funding at short-notice:

> "we were lucky because we'd done so much work before the Better Care Fund was announced, we really understood what needed to be done in Salford and what we were planning to do, et cetera. The poor places that hadn't had any of that groundwork had to produce these Better Care Fund plans at really short notice, may have not had the relationships to get everybody together. But it's really, really unusual to get the city

council, your big acute hospital, your mental health trust and your CCG and all the GPs and everything really, really properly honestly working together." (IP03_1)

Salford have bundled the BCF funding into the pooled pot. However, not all BCF money is new funding, so some is already earmarked for spending (IP03_1). But, they are expected to account for direct effects of the money on outcomes (i.e. reducing admissions), potentially a:

> "naive ask that within plans we could demonstrate a clear relationship between everything we were planning to do and where we were trying to spend our money. So that Better Care Fund might be going in 15 different directions. We could directly link the impact that that investment of say £100,000 would have in percentage terms on the reduction of emergency admissions, and that we could evidence base that." (IP03_1)

In addition, some national financial incentives for primary care practices were felt to be potentially in conflict with the attempted move towards managing slightly lower risk patients more preventatively that Salford later moved towards (see sections above):

> "the national enhanced service for GPs, you know, that they get paid incentives if they do certain things….For avoidable emergency admissions, yeah. We thought it was great when that came out because that was asking them to do exactly what we wanted them to do…Anyway, basically all the practices went off and did their own thing on how to identify their most at-risk patients. So a lot of them concentrated on patients with long-term conditions or lived alone, and they were trying to actively pick out this Group 2. Some of them we were asking to use – those that we were working with – we were saying use your Group 3, but then they were…they had to do two per cent of their adult population, so they had to put some extras in. And so that's confused them as… So to be fair, it's not really been easy for them because there's lots of pinch points have come into the system." (IP02_1)

Furthermore, there were some apparent difficulties in terms of perceived borders (geographical/organisational), where the integrated care programme ended. The MDGs also utilise services (e.g. health trainers) from organisations with multiple other contracts who aren't round the table and integrated in decision-making process etc. (IP12_1). There were also some problems with aligning the integrated care in Salford for patients living on a geographical service border. For example, for discharging and linking to local services. However, Salford Royal hospital get paid full tariff for treating patients from other areas, whereas potentially not for ones from Salford in every instance (e.g. when agreed limits exceeded). This potentially leads to a perverse incentive remaining for patients moving between services in/out of the integrated care agreement:

"don't really know what community service they have and secondly, it's, you know, just takes forever more. So they invariably have a longer length of stay and as a result of that, you know, it's not as an effective use of hospital time. On the other hand, you always get paid full tariff for them, whereas, a Salford one, you might get paid, you know, at this time of the year, you get paid 30 per cent of tariff, because we've exceeded the numbers that we're allowed to look after ages ago. So for Salford patients just getting a third of tariff for everybody, for outpatient you get full tariff, but they're in for longer and therefore it's not effective for the hospital as such and the hospital is totally bursting at the seams." (IP06_1)

3.8. Implementation process

3.8.1. Historical information

Identifying key challenges to health and care delivery in the coming years (see Figure 20), the partner organisations have come together to plan a potential service delivery change to address these issues.
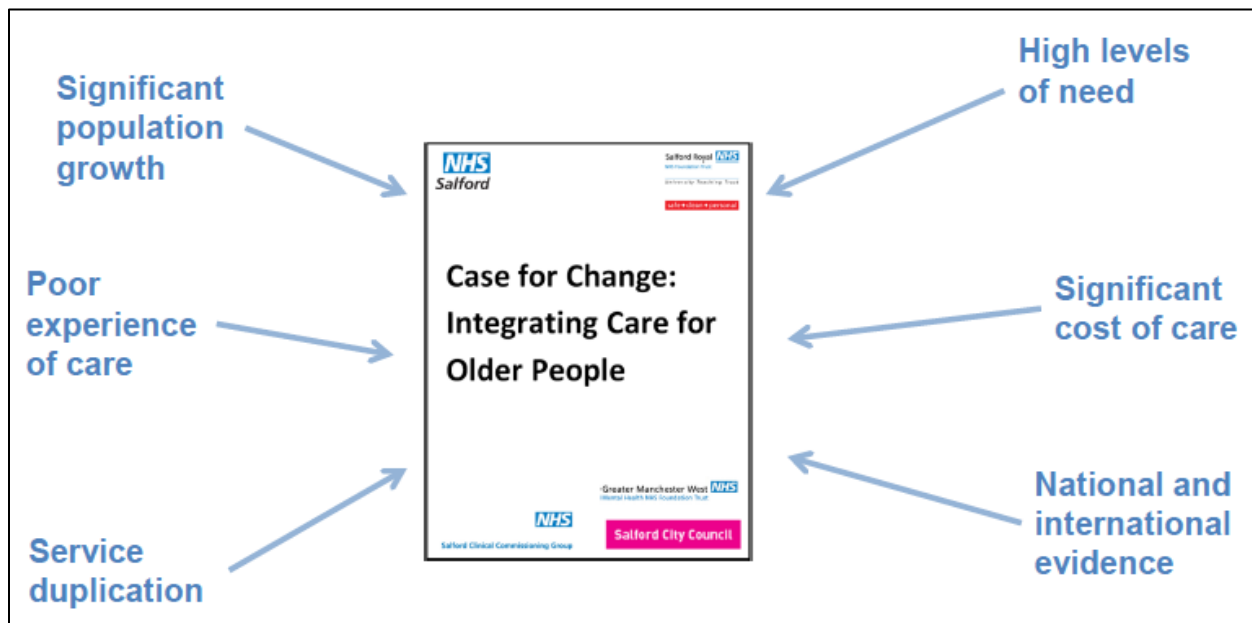
Figure 20: The 'case for change' put forward by the Salford partners organisations [5]

One of the initial debates in Salford was to determine the scope and scale of the integrated care programme [8]. "Since early 2012 senior leaders from partner organisations have been working together to develop an integrated care system within Salford. Although it was recognised that the other client groups could benefit from integrated care solutions, it was

agreed that the principal focus should initially be on older people. The rationale for this was threefold:

a. Older people account for a high use of health and social care services (and therefore cost), straddling the care and cure boundaries

b. Older people often have long term care needs (frequently associated with chronic health conditions) and therefore are likely to benefit from better care planning and coordination across health and social care

c. There is good evidence that integrated care for this client group can deliver better outcomes, improve experience and support cost containment

Older people are frequently socially isolated, with a poor quality of life. They often receive fragmented care, and are not enabled to care for themselves. Salford has some of the highest rates of emergency admissions and admissions to residential/nursing care, with too many people receiving end of life care in hospital rather than at home. Services can fail to address the needs of older people and where care is provided it can be disjointed and not delivered in the most appropriate setting" [8].

However, Initial targeting of over-65s was seen as a test-bed before roll-out to all patients with the Vanguard:

> "we very much know that it's an artificial barrier at 65 plus but that was the cohort we decided to target as opposed to all adults or all age, to frame it, which I think was absolutely right; and there is agreement across the partners that as soon as we've implemented the model or feel confident we've implemented the model for 65 plus then it will get rolled back to all age." (IP02_1)

Salford has a long history of collaboration. For example, Salford's Health Investment for Tomorrow (SHIFT) programme (2007) was one of the first whole health economy approaches to the redesign of care pathways, resulting in transfer of care away from a hospital setting into community and primary care services [8]. This local history of partnership working, each organisation involved being high performing nationally, good starting financial situation, plus co-terminus organisational boundaries appear to have been favourable circumstances for driving integration in Salford (IP01_1, IP02_1, IP03_1, IP04_1). This has made the trusting relationship formation easier. However, the basic processes of the programme are still perceived to be replicable to other areas (IP02_1, IP03_1):

> "We've got a long history in Salford and partnership working and certainly between the CCG and the city council we've had pool budgets in place around a number of client groups…So, we've worked over certainly 10, 12, 15 years now in partnership. And a lot of the same people are involved, senior leaders are involved. So, there's a long history and a lot of trust" (IP04_02).

> "I think our history of partnership working is the most important issue, and the relationships and the trust and the respect that's been build up over the years. It's that capital that we've invested in each other which I think is allowing our plans now to take shape." (IP01_1)

> "I think it's happening Salford in an incremental way because of the commitment of the organisations in Salford to deliver and their strength of partnership working which goes back some time; but what we're actually doing any area could do if they wanted to do, because once we've got over the initial hurdles we've put in a process and it's just a matter of replicating the process." (IP02_1)

Partner organisations (excluding the mental health trust which joined later) were involved in developing the initial three workstreams, which meant buy-in at organisational exec level (IP02_1, IP03_1). This helped build trust moving forward (IP01_1, IP03_1). This emphasis on 'partnership was felt to be a key to selling the programme within the execs own organisations. Regular weekly meetings appear to have helped build programme momentum and encouraged this working style:

> "I can't remember at the beginning how many times I said this is a partnership approach, it's a partnership approach. Because people used to say things like oh well, it shouldn't be Salford Royal dictating how that happens. Well, it isn't Salford Royal, it's a partnership and we're in the room, we get listened to. And it was just constantly reassuring." (IP03_1)

> "And I think one of the things I learnt from the programme is that momentum of meeting weekly, being really, really disciplined in doing the work and meeting weekly really started to pay off quite quickly, in that it really got the momentum going in that project." (IP03_1)

The mental health organisation partner was invited late to join, so not involved in early stages of planning. But, this partner was clearly felt to be an important part to delivering the models, particularly to those elderly patients with dementia (IP01_1, IP02_1, IP03_1, IP05_1, IP10_1):

> "And I think very quickly it was seen as an oversight. These were discussions that this Trust was having with the CCG about who do we improve our services, and as I say this was rooted beforehand in the way we organised Urgent Care Services, to reduce the impact in the A&E Department, and so we naturally continued the conversations with them and the Mental Health Service were not a mainstream part of those conversations, so when we started talking about Integrated Care Services, Mental Health Trust wasn't there. As soon as somebody said, well actually there is a significant element of care and service that they provide, not only to the elderly but the adult

population, and look at the incidence of mental ill health, it's much more prevalent in those people who have long-term conditions, and so it all made sense that they very quickly became partners in process too." (IP01_1)

Salford have taken a 'tests of change' approach to implementing the integrated care plans (using a PDSA cycle for learning and improvement), rolling out the programme gradually across the eight neighbourhoods. The programme was initially rolled out in two of Salford's neighbourhoods (Eccles, Barton & Winton and Swinton & Pendlebury). The approach was designed to enable gradual development and testing of the evidence base for integrated care, as well as allowing tailored solutions at a neighbourhood level. The initial two neighbourhoods were chosen on the basis that they [8]:

- Contained a critical mass of older people (nearly 40% of Salford's elderly population are registered in GP practices in these neighbourhoods)
- Had a history of early integration of health and social care services
- Had relatively high demand / service use
- Had complexity of need but were not a demographic outlier
- Had limited cross border flows (outside of Salford)

"A 'loose / tight' philosophy has been followed, where the ICP's aims and improvement measures are tightly defined but there is significant flexibility, within neighbourhoods and integrated teams, as to how these are achieved" [8].

Figure 21 gives an overview of the programme phases. As outlined in Table 1 (Service Delivery section), the programme has now been rolled out across all neighbourhoods, as planned.

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

Figure 21: Programme phases [8]

Public engagement has also been critical to the SICP, which aims to improve person-centred care. 'Sally Ford' is a character developed to provide a patient focus, and board members are constantly challenged to keep her and her family in mind in their decision-making [1].

Events have also been held with older people in the area, to help identify priorities for the programme. "Their key outcomes were: reduced emergency and permanent admissions to

nursing and residential homes; enabling people to have more control over daily life; and improved satisfaction with care. An additional indicator (supporting people to die in their place of choosing) was also added. SICP has also been informed by engagement undertaken by Public Governors" [1].

Other stakeholders have also been consulted in the development phase, and together have highlighted their top priorities for the programme, as shown in Figure 22.

Top 10 priorities from Salford's engagement

- Integrate IT systems and care records
- Rationalise points of access (e.g. single contact centre, shared portal)
- Increased support for carers and to enable self-management
- Asset mapping (incl. use of neighbours, third sector, community signposting)
- Maintained Directory of Services for the public and professionals
- Extended / consistent hours (incl. 24/7 response)
- Engagement and communication with service users regarding change
- Care Coordinator / Key Workers to support people with complex needs
- Pooled budget / joint management for health and social care
- MDT / forum for supporting people with complex needs

Figure 22: Top 10 priorities from Salford's stakeholder engagement exercise [6]

At the early stages, carers/patients have potentially been frustrated at the length of time it took to get up and running, however, and that the reality of the programme did not immediately reflect what had been advertised to them during planning:

"So, I just feel that through all that, the public, those that are interested, those that have a need from this system are being sold a system that doesn't actually exist. There are some efforts being made for it to exist. The multidisciplinary group was excellent, but, as I say, the communication beyond that meeting again suggests that very little of the…not the individual items but little of the concepts that we discussed, were actually then carried through in terms of effective…not just communication, effective communication. And it's all fallen apart again" (IP08_1)

3.8.2. Present information

Figure 23 gives the overview of the resulting integrated care programme. The centre of the diagram represents the overarching outcomes the programme aims to achieve, with the patient, 'Sally Ford', at the heart. The blue boxes detail the three approaches that are aimed at achieving these outcomes (detailed further in section 4.2).
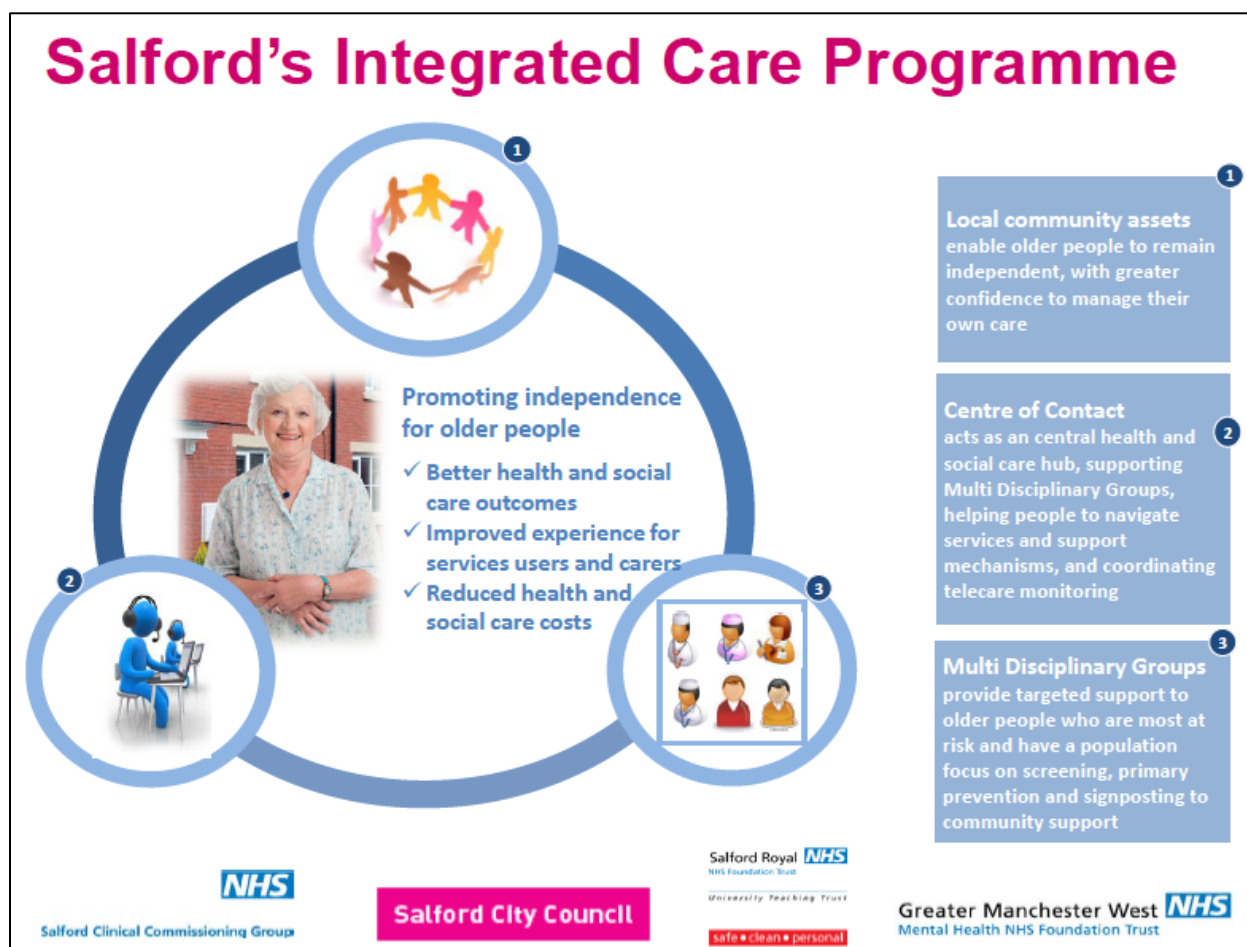
Figure 23: Overview of the resulting Salford programme [5]

Implementation to date has had to be step-by-step, because of the scale of the change needed. It was felt that this couldn't all be implemented at once, attention was required on one thing at a time. In addition, for example, working relationships take a long time to form (IP02_1, IP05_1).

3.8.3. Future implementation/development

Moving forward with the Vanguard 'Salford Together' programme, they plan to build on the common purpose and strong relationships already formed. The plan is to extend the vision to 1)

Population health improvement beyond 'out of hospital care' 2) Single system of governance for health and social care 3) Full population list. To accomplish this, there was a strategic commitment to develop an 'Integrated Care Organisation', again with an initial focus on adults and older people [12]. Figure 24 shows the planned implementation strategy when first conceived.

Implementation

By June 2015 – new care models for older people
- Rolled out our new model of integrated care
- Commenced extension to the entire adult population

By 2016 – Care Homes
- Quality Incentive Scheme – evidence based personalised care

By 2016 – Integrated Care Organisation
- Transfer adult social care services to SRFT, subcontract domiciliary & care homes services
- Establish supply chain management arrangements for mental health services
- Develop models to included general practice

By Dec 2015 – Integrated Care Record
- Incorporate social care and mental health (adding to acute, GP and community)
- Platform for population risk stratification – better care co-ordination & management

During 2015-16 – Pooled Budget & Alliance Contract
- Extend to the full adult population
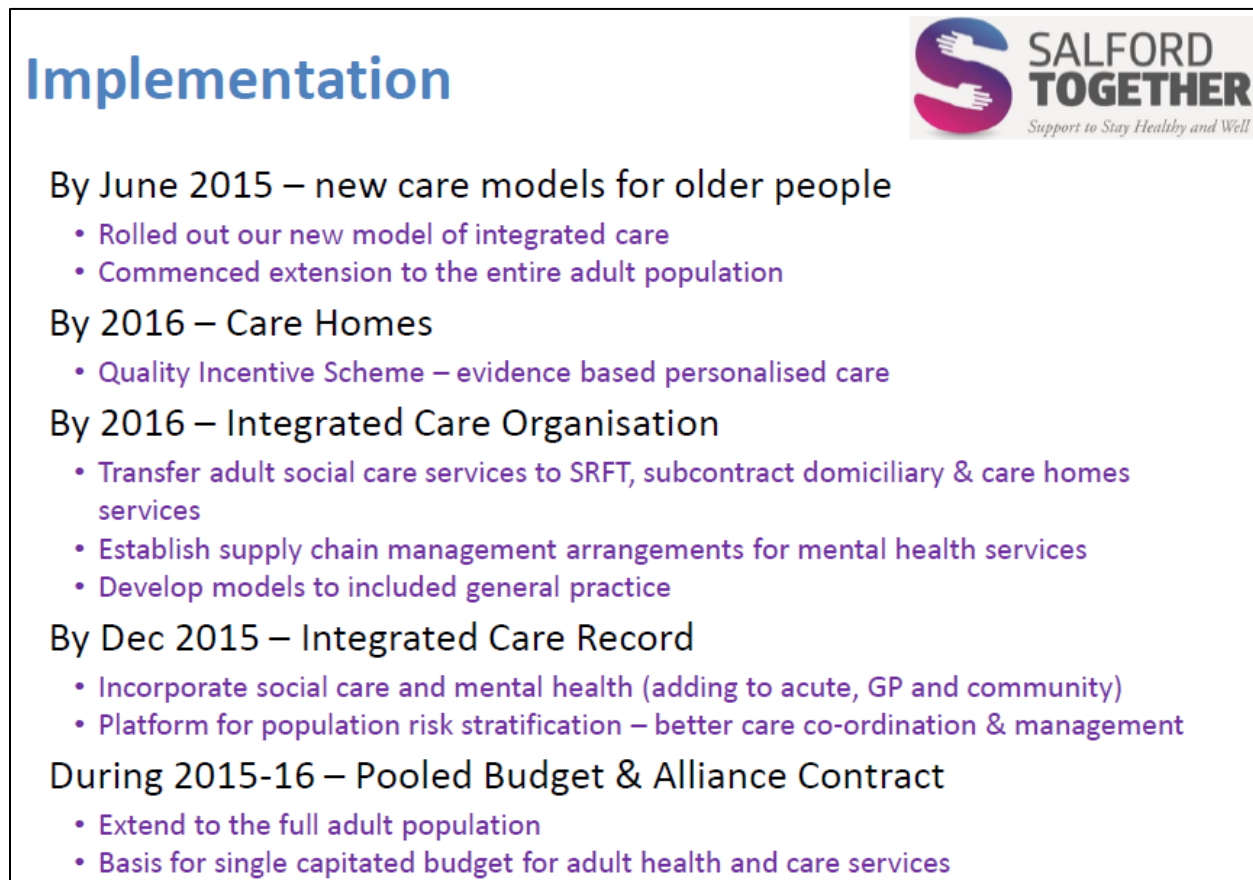- Basis for single capitated budget for adult health and care services

Figure 24: Planned implementation strategy for Salford Together [12]

The Integrated Care Organisation (ICO) is to act as a single provider organisation, commissioned by commissioners. The idea being to cut the number of contracting arrangements, and simplify for efficiency:

> "So the Integrated Care Organisation is a provider, so they will still be commissioned by commissioners. So it will just be the contractual relationship will be different than things are now. So at the moment there are contracts between commissioners and numerous providers. So with the idea of the Integrated Care Organisation that will significantly reduce the number of contracts there'll be, because there'll be a lead provider. That lead provider will then have contractual relationships with subcontracted providers or actually become the provider themselves in the case of potentially adult social care. So the staff will be TUPE'd to them and they'll become the provider. So it reduces the

number of commissioner to provider relationships that will exist. So there'll still be that commissioner provider relationship." (IP03_1)

As mentioned previously, this next step was initiated in July 2016. This organisational integration, rather than the model delivery has always been seen as the key to achieving the underlying financial aims of the programme. Salford Royal was seen as the obvious lead organisation for the Integrated Care Organisation (ICO) envisioned in the Vanguard proposal:

"I think the model that we're putting in will help because it's facilitating the services to work differently in specific areas. But the real efficiencies…so that's a different way of working, but the efficiencies have to come through the integrated care organisation, I believe" (IP02_1)

3.9. Discussion

3.9.1. General discussion

The Salford programme illustrates the complex nature of integrated care programmes more generally. Despite having only three main components to the care delivery model, descriptions of the programme in official documents do not necessarily reflect the realities of the programme when implemented. Furthermore, the programme is adapting and changing over time, so we are not evaluating a single intervention over a time period, but an evolving intervention with changing organisational relationships and target groups realised up til now, and planned for the future.

Unfortunately, we were not able to schedule our own interviews in Salford, as we had delays in governance approvals, and a request by the programme management team to prevent research-burden on the professionals who had recently been involved in the CLASSIC research project. Fortunately, having good links with CLASSIC researchers, we were able to access relevant transcripts with the information we needed. While the interviews thus reflect the period of November 2014 to June 2016 (see Appendix), this helped for reducing recall bias particularly when describing the initial implementation stages of the programme. We will continue to monitor the development of organisational and governance structured planned, and very recently (July 2016) implemented as part of the Vanguard.

3.9.2. Discussion of the programme in the context of the conceptual framework

Service delivery

The framework emphasises the importance of self-management for those with multi-morbidity. However, those with multi-morbidity (particularly elderly and frail) may be those who struggle the most to self-manage, despite being those who potentially have most to gain from it.

Professionals in the Salford programme appear to agree that organisational and structural integration is important (perhaps the most important) aspect of delivering efficiency savings, and so sustainability.

There was a suggestion, however, that the protection of market regulation at the macro level, can sometimes act as a barrier to integration (particularly organisational integration).

Leadership & Governance

The Salford programme suggests that despite having the intention of shared decision-making in a programme, this is not always easy to implement. Time pressures etc. can make it difficult for professionals to attend MDT meetings and to fully involve the patient.

There may also be issues remaining with coordinating with those not directly involved in the integrated care programme, so if the integration is not universal, there will always remain a section of the system that is not integrated (and this might come at geographical boundaries, for example, if the programme is localised).

Supportive leadership and historical relationships were seen as important enablers for integration, together with shared vision and values. While a core set of performance indicators were implemented, each organisation nevertheless has an obligation to meet national targets and measurements.

The direction of wider national policy was seen as a key enabler of integration.

Workforce

This analysis suggests that multidisciplinary team management is not sufficient for integration to occur (at least as perceived by the patient/carer). However, involvement of the patient and carer in the team appeared to be lacking in the early stages of the Salford programme.

Co-location of the workforce was seen as particularly beneficial for inter-professional relationships to build.

Financing

While adequate financing seemed to be provided to the professionals involved in the programme, other work pressures remained, which meant that these added finances were perhaps not fully sufficient for ensuring sustainability.

Non-financial incentives appeared particularly (potentially more) beneficial in ensuring participation, particularly of GPs who appeared to appreciate the simplification of contractual obligations offered by the CCG as an incentive to participate.

The Salford programme is keen to move towards a single provider of services that is commissioned in order to simplify commissioning and align risk and benefits across organisations. Again, this may be seen as monopolisation, however, so there is a potential tension with national policy direction towards choice and competition.

Technologies & Medical Products

While shared medical records are seen as particularly important to enabling integration, they have been particularly difficult to implement given the macro context in England, and multiple private suppliers of systems.

Information & Research

The value of individual level data held by healthcare organisation for risk prediction is questioned by the Salford programme. Professionals felt that because the risk scores were calculated with data recorded by (and so already known to) health services, those found to be at highest risk were generally already well provided for, and that their current admissions might be necessary.

The Salford programme, as a well-recognised high-performing organisation in the UK, has clearly been subjected to some evaluation fatigue. The current macro-level situation (NHS spending gap) might be a further contributor to this in recent times.

3.10. References

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[3] = CLASSIC MDG roll-out table. 2016

[4] = Protocol for the CLASSIC study. 2014. Available at: http://www.nets.nihr.ac.uk/__data/assets/pdf_file/0010/129790/PRO-12-130-33.pdf

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[14] = 'Salford integrated record' booklet. Available at: http://www.salfordccg.nhs.uk/download.cfm?doc=docm93jijm4n524.pdf&ver=680

[15] = CLASSIC implementation 1: interim report. 2015

4. Programme 2: *"South Somerset Symphony Programme"*

4.1.   Basic information

Name of the programme

South Somerset Symphony Programme

Contact details of the programme management

Berge Balian (Programme Chair): Berge.Balian@crewkernehc.nhs.uk

Jeremy Martin (Programme Director): Jeremy.Martin@YDH.NHS.UK

Paul Mears (Chief Executive Yeovil District Hospital/Programme Board): Paul.Mears@YDH.NHS.UK

Starting date of the programme

April 2014 [6].

Geographical scope of the programme

South Somerset (South West of England). Population of ~115,000, ~1500 with 3 or more chronic conditions (multi-morbidity) [4]. Almost 25% of the population is over 65, compared to the national average of 17%. This is forecast to increase by 20% by 2021 (with those over 85 projected to increase by 30%) [6]. The area consists of 19 GP practices, 4 community hospitals, 1 community mental health team, 1 district general hospital (Yeovil District Hospital) [3]. The area predominantly consists of small market towns and villages with a poor public transport network [3].

Target group of the programme (type of individuals/scope/included combinations of morbidities)

The programme targets people specifically based on multi-morbidity. Those with 3 or more conditions have been estimated to drive the majority of cost of care, and so have been targeted by the integrated care programme [4]. The programme is based on a population segmentation model. Complex care hubs for 'Complex patients with many conditions' (~4%); Enhanced primary care for 'less complex patients with fewer conditions' (~18%); Proactive health and wellbeing support for 'mainly healthy patients' (~78%) [1].

Number of persons treated in the programme (total and development over time)

The programme initially to target the group of around 1500 patients with 3 or more chronic conditions [4]. Around 250 patients have currently been through the complex care hub.

Aim of programme

The programme aims at a vision encompassing three main goals:

1. "Informed people, empowered to take responsibility for their health and wellbeing" [1]
2. "An ambitious and adaptive workforce, working creatively to deliver exceptional care" [1]
3. "A seamless, integrated and responsive network of care services, working together to do the right thing for patients" [1]

With the model they have developed, they estimate £2.1m in savings from the acute sector, and ability to provide 20% of social care at home [2].

Definition/understanding of "integrated care" (as far as described in documents)

The programme understands integration in light of the national context: "as a means of offsetting the demographic and funding pressures facing health and social care services" [6]. It is also hoped that improved integration will "improve the experience of the growing number of patients that have complex needs or a wide range of conditions – factors that bring them into regular contact with many different services" [6]. Integration of care in the UK focuses on the integration of health and social care primarily. Joint working and financing is seen as key to integration by the programme, with 'alliance contracting' taking a central role as an integration enabler (see section 4.7) [6].

Definition/understanding of "multi-morbidity" (as far as described in documents)

The programme worked initially with the University of York during the planning stages, attempting to identify primary cost drivers. Here they looked at a number of potential target groups (including looking at specific diseases of interest e.g. diabetes/dementia and their co-

morbidities) for the intervention. Multi-morbidity, defined as 3 or more diseases from a set of 8 deemed most important by local GPs was used as the original selection criteria for the programme [4], giving the ~1500 patient number referred to above. The disease count is based on United Health's RISC tool (see section 3.5), which looks at ICD10 and Read codes in the patient's GP and hospital records, and records chronic conditions from relevant diagnostic information. Diagnostic information is summarized by Episode Treatment Groups (ETGs), and the tool records 49 chronic conditions [4].

Definition/understanding of "patient-centeredness" (as far as described in documents)

The programme describes patient-centeredness as, "Right care by the right person in the right place at the right time" [1]. It involves "helping people and their carers to manage their own health and achieve their goals" [1].

Definition/understanding of "self-management" (as far as described in documents)

The programme does not describe self-management in the current documents, despite drawing attention to it as a major aim of the programme. However, this understanding is expanded on from the interviews, in the Service Delivery section (4.2) below.

Organisational form and ownership of the programme (including legal form)

The programme is headed by a Programme Board (consisting of Commissioners: Somerset CCG, Somerset County Council, Bristol, North Somerset, Somerset and South Gloucestershire Area Team; Providers: Yeovil District Hospital NHS Foundation Trust, Somerset Partnership NHS Foundation Trust, Symphony Primary Care Group, Adult Social Care; and Other Project Board Members: South Western Ambulance NHS Foundation Trust, South West Commissioning Support Unit, South Somerset District Council, and North Dorset CCG) [3], with a number of smaller working groups and cross-cutting themes (See Figure 25).
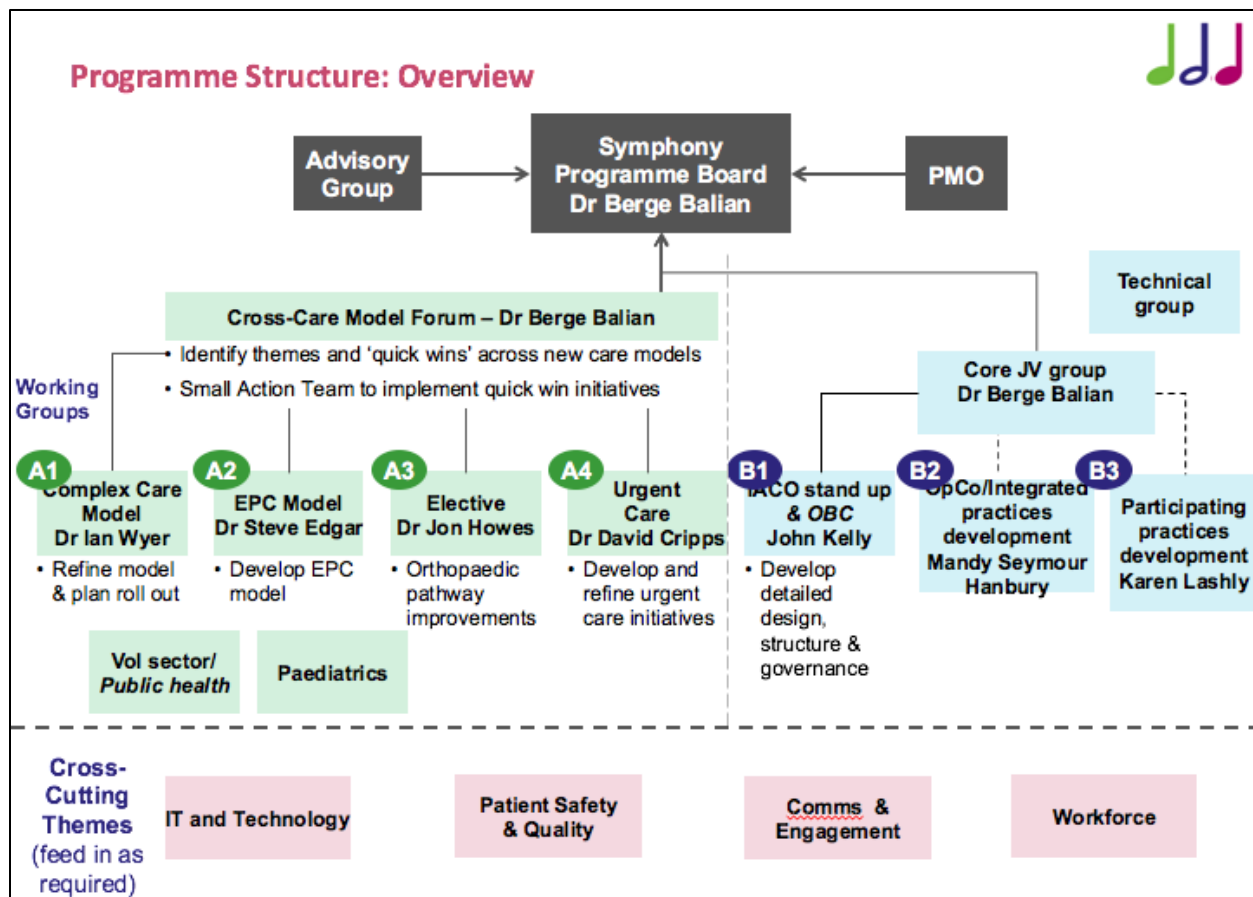
Figure 25: Overview of Programme Structure [1]

A core Joint Venture (JV) group between GPs and Yeovil District Hospital have planned formation of an Integrated Accountable Care Organisation (IACO), and to hold the Outcome Based Commissioning (OBC) contract [1]. The organisational structure of the IACO JV is shown in Figure 26.
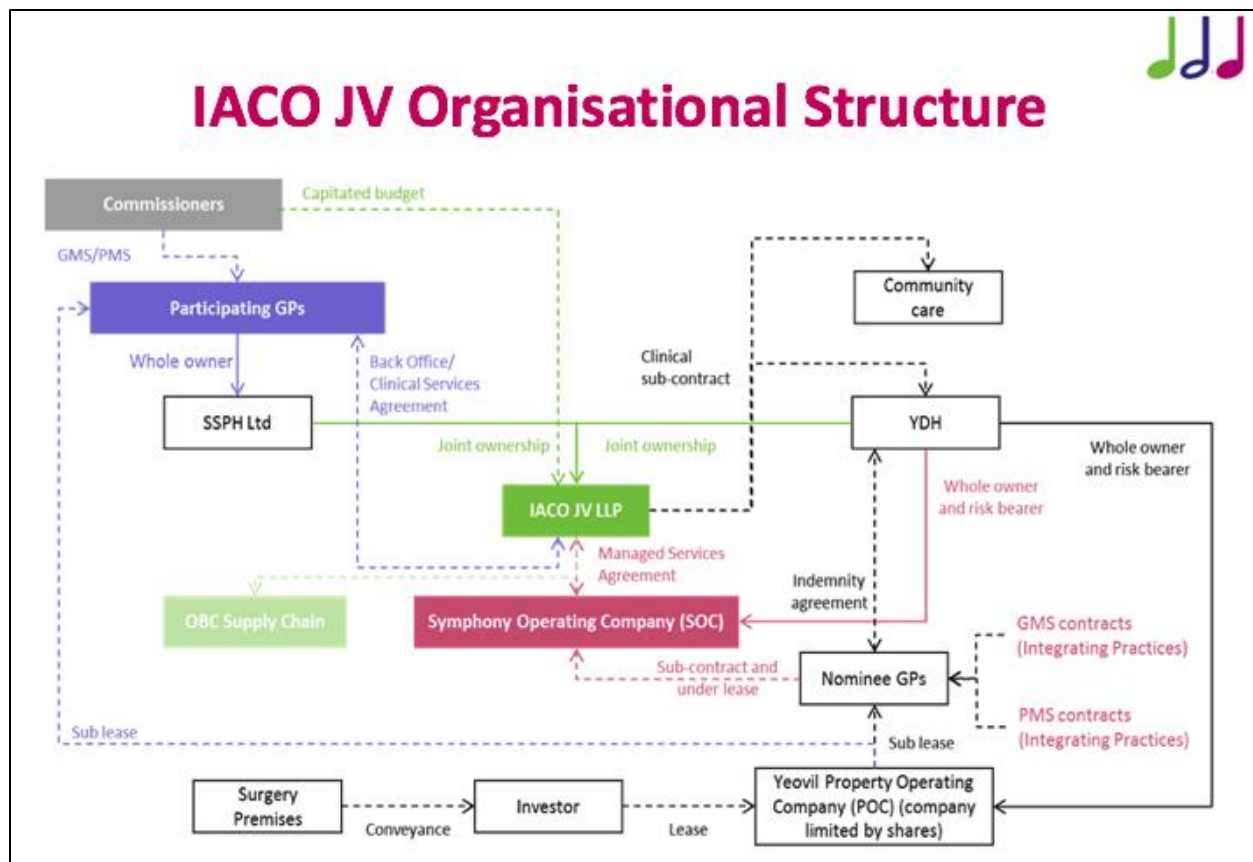
Figure 26: Organisational structure of the Integrated Accounatble Care Organisation [1]

Involved partner organisations (payer(s), medical and social service providers), including subdivisions (e.g. departments of a hospital)

As is clear from the above, the majority of providers and payers in the local health economy are involved in the programme directly. Furthermore, the programme works in conjunction with voluntary organisations and communities [1]. The main programme is a partnership of Yeovil District Hospital NHS Foundation Trust (secondary care provider), Somerset CCG (payer headed by primary care providers), South Somerset Healthcare GP Federation (network consisting of primary care providers) and Somerset County Council (social care payer/provider) [5].

Involved disciplines and professions

Primary, secondary and social care services (as part of the extended team) are involved in delivering the model. The two layers of the stratified model relating to multi-morbidity differ slightly in the composition of the teams. These are:

1. Complex Care (Extensivist care model): Core care team (extensivist GP (expert generalist), care coordinator, complex poly-chronic patients, key worker), Extended care team (mental health, social care, therapies e.g. physio, frail older person's assessment

service (FOPAS) crisis support), care programmes (diabetes, respiratory, CHF, dementia, other programmes) [1].

2. Enhanced primary care model: Core care team (GP, practice nurse, patient with chronic condition, key worker/health coach), extended care team (mental health, social care, therapies e.g. physio), care programmes and specialists (diabetes, respiratory, CHF, dementia, other programmes) [1].

4.2. Service delivery

4.2.1. Design of delivery of care

The patient forms the core of the Symphony programme. The programme aims to "put the patient in control of their care and ensure they get the most from local services" [7]. There are three core functions to enable this to happen, shown in Figure 27.
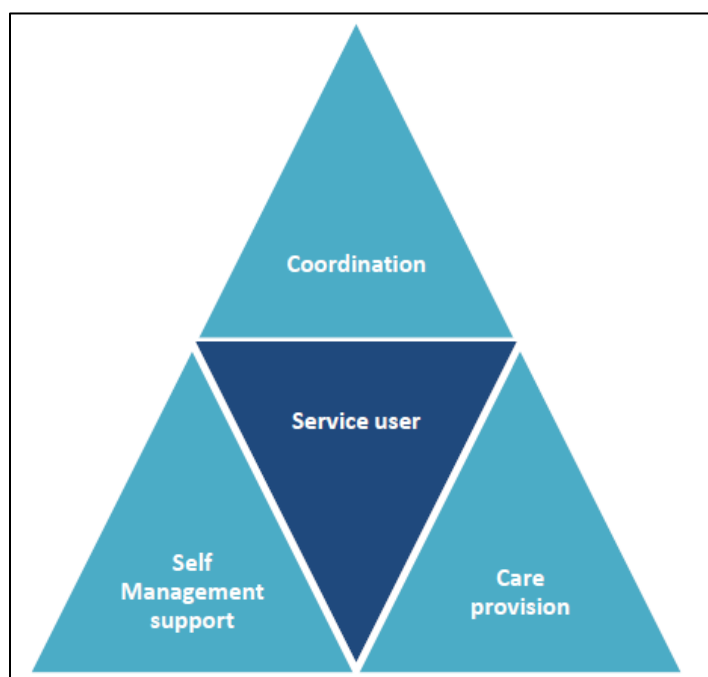
Figure 27: Core functions of the Symphony programme [3]

The Symphony programme takes a population segmentation approach. The idea is that the most complex patients with many chronic conditions (and who require the majority of health spending) are treated in 'Complex care hubs', the less complex patients with fewer conditions receive 'Enhanced primary care' (EPC), while the remaining mostly healthy patients receive proactive health and wellbeing support, to keep them healthy as much as possible [1].

As described above, this population segmentation approach was initially based on the number of chronic conditions (3 or more conditions from a selection as the top level cared for in chronic

care hubs) based on United Health's RISC tool ("a patient-centric predictive modelling tool" [8]), and analysis of linked patient IT records (described in section 4.5).

More recently, the programme board have come to the realisation that those highest risk patients (e.g. top 5%) tend to have admissions that they need (i.e. these are not always preventable). Therefore, the target of the programme has moved to the top of the level below the highest risk patients (e.g. the 5 to 10% group). They have also made more of a distinction between 'stable complex' patients and 'unstable complex' patients. There is now a more stepped (blurred) approach dependent on risk (IP01_2):

1. EPC only
2. EPC + care coordinator
3. Extensivist primary care (complex care hub) + own GP
4. Complex care hub only (the most complex patients only, who require this intensive care management)

The Symphony programme has also been working more closely with other units in the hospital e.g. the Frail Older Person's Assessment Service (FOPAS) to try and prevent admissions through A&E.

Complex care (CC) hub model

> "the complex care service, it's like putting primary care into the hospital, in terms of its links with the outside world, rather than it just being, ah you're in, or you're out." (IP05_2)

The original plans were: the complex care model is the central treatment model for those with multi-morbidity (the 1500 patients discussed above). The model would focus on a cohort of patients, selected with the RISC tool [3]. The complex care model consists of a comprehensive assessment of the individual's physical, mental health and social care needs, which is used to develop a single personalised care plan (in co-development with the patient and their carer [7]). The care plan brings together details of all care and support already being accessed by the patient, and any other suitable support, making it easier for the patient and carer to get an overview of, and control over their health and wellbeing. Patients can choose any carers or family that they would like to have joint access to the plan, through a safe, secure online platform called 'Patients Know Best' [7]. There is support coaching for patients and carers to understand and manage their own conditions and to access support in the community. Routine monitoring of patients' and carers' health conditions and care needs takes place. Escalation plans ensure that patients and carers recognise deterioration triggers, and that there is early intervention through a co-ordinated and planned response. And, rapid response occurs in the event of a crisis, an unplanned deterioration or a change in the patients' or carers'

circumstances [2]. There is input from expert generalists, a single care co-ordinator managing transition from the current multiple care pathways to a single coordinated pathway, key workers to build relationships and act as health coaches and support to improve self-management skills, combined with the hospital team and social care which both input to care [3]. Figure 28 shows the schematic of the professions involved, and key elements of the CC model [1].
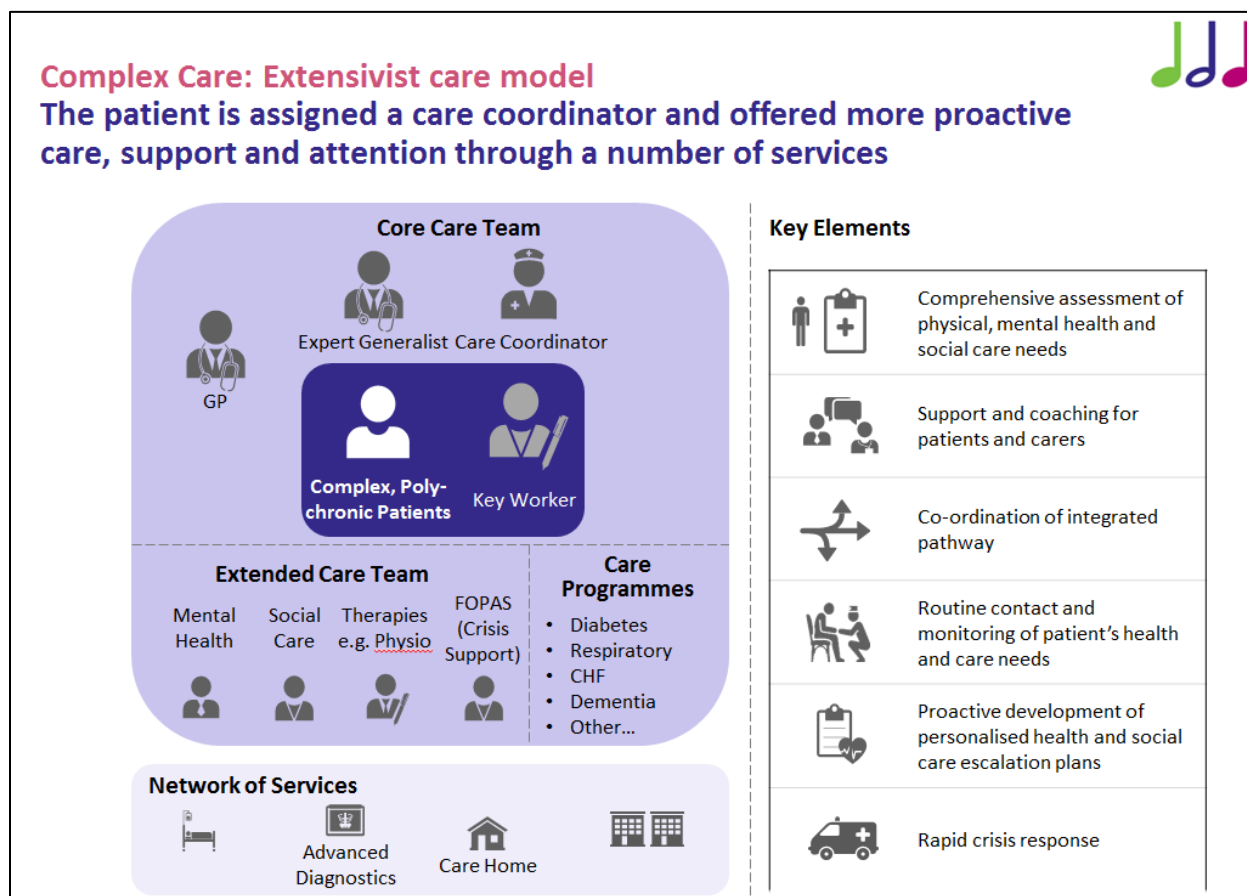

Figure 28: Schematic of the Complex care model [1]

The CC model was originally planned to be carried out in 3 new purpose built hubs that bring together primary, secondary and other care services in one location [5]. The first of these hubs is located at Yeovil District Hospital [7]. The hubs allow care co-ordination and access to senior medical input with the single personalised care plan allowing patients to better look after themselves.

Under the new care model, a patient who suffers, for example, from "diabetes, hypertension and depression will see improvements in the way people work together to meet their needs. Their treatment will be guided by a care plan that they will design with their care coordinator, setting out what they want from their care. When the patient visits the hub, their team of different professionals will work together to deliver the plan. In between visits, the patient will

be supported by remote monitoring of their condition, and will use the 'Patients Know Best' web platform to view their plan and keep in contact with the hub team. Under the new joint working patients will see improvements in the way people come together to meet their needs, with less duplication, fewer delays and more proactive health and care services. GPs, hospital consultants, community staff, and social workers will work as a single team to share information about patient care needs, and deliver a more integrated set of services which meet their individual circumstances and prevent unnecessary admissions to hospital" [5].

In practice, due to funding changes, one hub has currently been implemented, with another currently being set up in the East of the county. The second hub is planning to manage patients at a slightly lower level of complexity to the first, acting as a sort of intermediate stage between the Yeovil hub and EPC (IP06_2, IP09_2).

To date, an estimated 250 patients have been through the Yeovil complex care hub. Originally, referrals were slow, however, the referral process is being expanded so that consultants can refer directly, through 'hot on-boarding' (managed for a short period of time before discharge to community), so that patients are discharged as quickly as possible (care is stepped down through the hub and patients go back to the community) (IP01_2, IP06_2, IP07_2, IP08_2).

The care coordinators who function as part of the extensivist model team are mostly from a nursing background and involved in the care planning process (so require some medical knowledge). The key workers are mostly from a social work background and act as health coaches (IP01_2).

There is an emphasis on team 'huddles' at the beginning of the day (as in EPC, below):

> "So both in the hub and in EPC, they will have a huddle, which is like a team meeting. There are two sorts of huddles, they have regular huddles…now in complex care, that's daily, in EPC it varies from practice to practice, some it's daily, some it's two or three times a week, and that's where they discuss all their patients who are ten on the Symphony scale so the ones they're most worried about. They tend to be the ones who have just come into hospital, just come out from hospital, massive change in circumstances so if one of them has just gone into the hospice or something like that that's changed for the patient, so they tend to be discussed on a daily basis. Then there's what we call mini huddles, but then they have a huddle where they discuss all the patients on their caseload. Now for complex care that's all the ones who've been referred into complex care. In EPC it will be all the ones that the health coaches have got some involvement with, so who are within the Symphony cohort, obviously not all the thousands and thousands of patients within that primary care practice, just the ones that have been designated as needing a different approach. So the huddle is a key thing and tends to happen early-ish in the day." (IP03_2)

The hub functions virtually, with a telephone line, plus visits to patients in their home, and on wards etc. There are teams split into geographical areas, but they are co-located (IP04_2, IP06_2, IP07_2, IP09_2). As well as the patient having contacts with the core team, the patient still interacts with multiple other services, although the core team attempts to co-ordinate this:

> "So we can arrange multidisciplinary meetings, you know, we're always on the phone to Social Care or, you know, Environmental Health colleagues and, yeah, we just…it's just, like, we're an extension of everybody's team and it's, kind of, a nicer way to explain it to patients, you know, because we have access to RiO, which is partnership's notes, so community services, district nurses and so we're able to log in and see what's going on and then we can phone, because all of their contacts are there as well, so we can just say, oh, I see you've been out to see Mrs so and so, you know, what are your thoughts? And we'll get their input on the care plan as well, you know, if they're seeing mental health team and then they would be part of that process as well, because it's really important to get that whole patient journey and get everybody that's involved in it." (IP09_2)

The informal caregiver has the opportunity to be very involved in some cases, although safe-guarding issues have occasionally arisen:

> "It would depend upon the patient and obviously, you know, some patients want their family involved and others don't. We work very closely with some families. Often what we have found on a number of occasions is, you know, somewhere that a GP has raised a concern and referred the patient because they are worried they are not coping. Often as you become involved with the family and then maybe more distant members of the family know you were involved, things will come out. A lot of safeguarding issues have arisen - families being able to have a contact to say I'm concerned, you know, my granddaughter is taking money or that the family are not coping. Not only can the family help us for the patient to achieve the goals or we can help the family by them having someone that they know they can regularly go to and communicate with. We can attend - so the patient is admitted in a hospital and a family meeting is called in a hospital, we can attend and we go to those. If Social Services call, we can attend, we work closely with the social workers for some patients." (IP06_2)

Many of those interviewed spoke about the need to be careful that a dependency is not created and that the service is not simply replicating others. There appears to be a bit of a tension between complexity, that necessarily requires a lot of care, and self-management. Creating more of a link between the complex hub and EPC might help alleviate this, stepping care back down through EPC:

"Because we started off quite small there's a cohort of them that are quite dependent now on the service and that perhaps wasn't the initial intention. But if you give people with multiple long term conditions quite a lot of intensive input it can become a bit of an expectation perhaps that that's there. So trying to balance that with developing that self-activation, self-management proactive care by the patients and their families is tricky at times." (IP03_2)

"We've sort of created a new silo, by creating the complex care service" (IP05_2)

"what we have to make sure we don't do is become another service that people become reliant on. So we don't want to create dependency, we want to create people that learn to manage their conditions...and what we've had to be careful of is that this new model, and this service, doesn't try and plug gaps. And then, you know, plug gaps in other services that aren't there, or they don't have the provision there, and then we become another service which is overwhelmed and can't cope." (IP08_2)

"I think the key thing for us is that we don't start to do other people's jobs, you know, we know exactly what we need to be doing and that we don't, you know, do things that district nurses would do or hospital teams, it's just been very clear, you know, about what our role is." (IP09_2)

In addition, the new care model is not for everyone. Perhaps a shift in the patient's mind-set is required too:

"patients decide, you know, they might decide, actually, I don't like this coaching approach, I'd rather go back to conventional GP, so they would opt back out of the service." (IP08_2)

"I mean some patients love it, some patients, you know, are used to their GP and, you know, does my GP not want me anymore… The doctor is not always the first point of contact as it happens in Primary Care, because that is just unsustainable, we all have to – everybody has to change...Patients have had to get used to the fact that they may not see a doctor as much as they did when they were going, when they were able to access them through Primary Care, which is often a reason why they are referred to us because, you know, the demand on the Primary Care is so great. Now we've learnt to say that upfront so we are saying a doctor and GP, but I've got a team of really, you know, highly trained nurses and they are all at sister level, that will be your initial contact and they will involve me when it's needed because the model has to change. Some patients have not, you know, when you always thought you'd have a doctor and it was your right to see the doctor all the time, when you are not seeing your doctor all the time and you are seeing other clinicians it feels like a change, but then they are

having much more contact anyway, because we are proactively contacting them. That has been a shift that patients have had to get used to." (IP06_2)

Enhanced primary care (EPC) model

The enhanced primary care model is described as a 'new model of primary care'. It involves a broader team (e.g. Physios, Community Practice Nurses, Pharmacists), a new triage system where the GPs focus on people with long-term conditions, with health coaches to provide extra support for patients with less complex conditions [5], and they can raise potential polypharmacy issues with the GP (IP05_2). 18/19 practices are signed up to deliver both the EPC and CC models [1]. **Figure 29** shows the schematic of the professions involved, and key elements of the EPC model. However, the model delivery varies from practice to practice (with the consistency of the added Health Coach role).
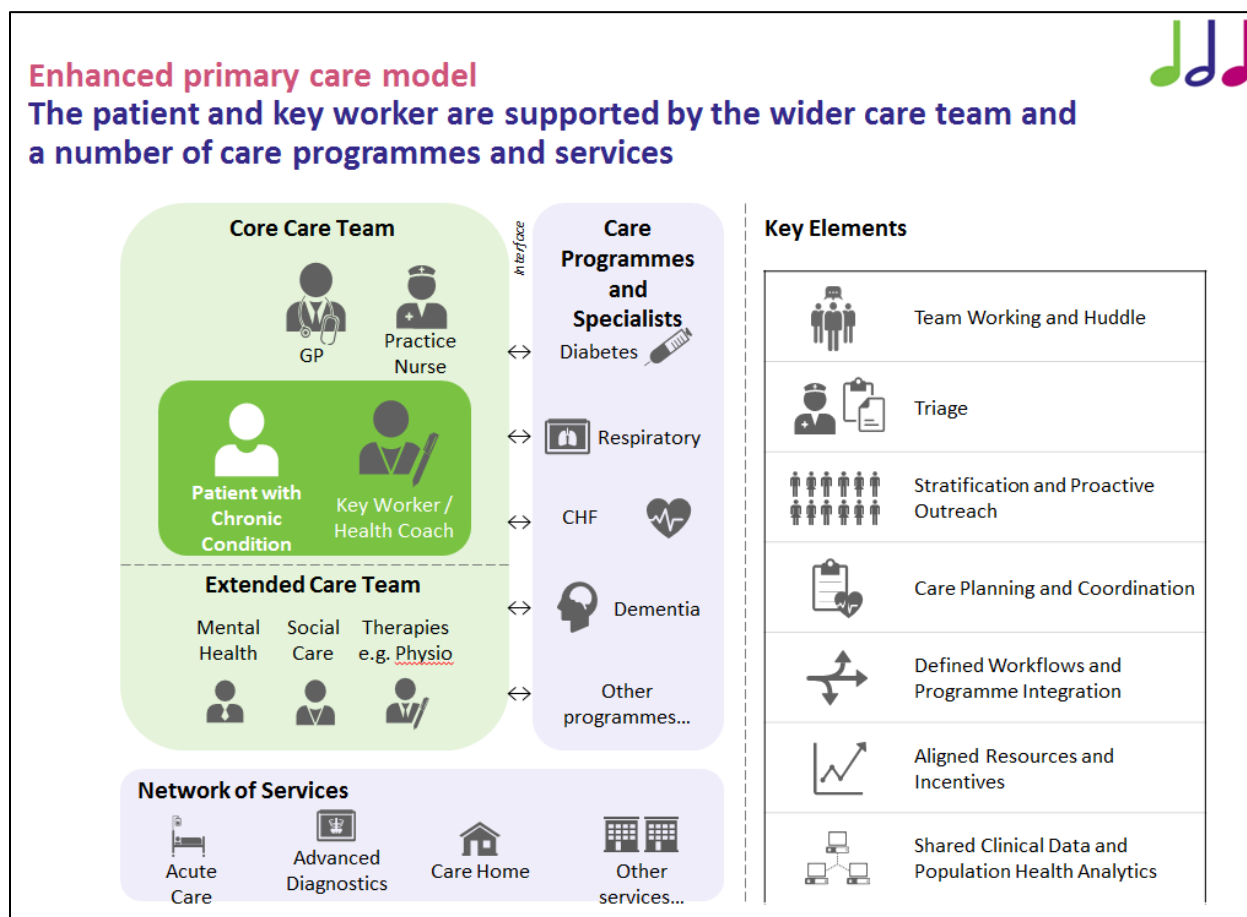

Figure 29: Schematic of Enhanced primary care model [1]

The EPC model is based on the same model developed in the USA by Iora Health. This model is focused on expanding the workforce in primary care. The key aspect is use of the new role of Health Coaches to help build relationships with patients.

The health coaches function as the key part of this model are hired by each practice individually (to allow local choice and adaptation of the model). They tend to be from an administration/receptionist background, although this varies with some former social workers hired by some practices for example. The practice employs health coach directly and the subsequently reimbursed by the Symphony programme for the costs. IP01_2 reports that they have coaches have been extremely engaged and enthusiastic so far.

Of the 18 of the 19 practices in South Somerset currently practising EPC to some extent, some are at a more advanced stage than others. EPC has been rolled out in three waves across the district.

Everyone in the practice is involved in the 'huddles' (once/twice a week), empowering the workforce and up-skilling. Here they discuss specific patients that they think need to be reviewed (IP05_2). The care planning is done by the health coaches, with most of the contact by telephone, but they might also perform home visits or accompany to visits of health services too:

> "so the care planning is a process. I've learned that we have to be quite specific with our language. Care plans are kind of Word documents, or templates. Care planning is a process of empowerment of a patient, to take control of their own health, and wellbeing, and coordinate all the services around them. There's kind of case management planning, which is just organising the medical stuff they need. And we generally don't do any of that in the huddle, that is done outside by the health coaches, or by a health coach in conjunction with a GP, or if the patients are under the complex care hub, they're doing it for us." (IP05_2)

The new model of working has allowed some practices to fundamentally re-arrange primary care working systems, for instance, being able to give more time to the patients who need it:

> "we're able, now, we changed so much that we can give whatever time we think to the right patients...So we've actually gone a bit further and moved to a sort of, entirely on the day system. Everything that comes in on the day gets dealt with on the day. We don't have bookable appointments in advance...But we do have people being contacted by the practice in advance, and routine conditions are kind of separate to that. So if someone calls up in the morning, and they've got a mental health issue, I can have a quick chat with them, and then say, come in a bit later on, maybe give them a 15 minute appointment, or a half an hour appointment. And we delve into the first time, and then follow up. It just means that I'm not getting a ten minute slot with someone that needs longer time" (IP05_2)

> "Primary Care has to adapt because if Primary Care doesn't get it right patients will end up more in Secondary Care and more money will have to be diverted from Secondary Care away from Primary Care or away from education, away from independence...I think as I said this makes sense that, you know, for a GP, it doesn't matter how complex you are, everybody gets 10 minutes. It's logical that someone who is really, really complex, is having multiple admissions with all the services not joining up, you know, 10 minutes is not adequate. Whereas, 10 minutes for a child with mainly an ear infection is - but at the moment the medical system deals with them in the same way and we are just trying to readjust that." (IP06_2)

As well as health coaches, another part of EPC is about up-skilling primary care, bringing in new roles/specialists to work alongside the primary care team. Interestingly, this is disease-specific, rather than focusing on multi-morbidity, with the idea generally to take the pressure off of GPs. The specific conditions to target were selected from what primary care feels would alleviate pressure:

> "And then, you've got, kind of, the skill mix part of the puzzle, which is identifying new services, or services that exist within an acute environment, or a community environment that could be brought into the GP practice, to provide a new model of care...So, the ones that we've done are respiratory hot clinics, where a respiratory nurse specialist will lead a group of clinics that GPs can refer into… We've also done virtual clinics for diabetes, and they're basically multidisciplinary team meetings, where a consultant from the acute environment will go into practices, and will review a group of patients with the practice… And then, the third one, which we've just completed our first phase of, is muscular skeletal assessments." (IP07_2)

Both complex care and EPC models share a co-ordination role, a single point of contact, helping patients manoeuvre through the system, plus a different relationship with the patient through health coaching training (IP03_1). Patients appeared to appreciate this:

> "More for the fact that I would have one doctor that would know all about my conditions and she could reach out to the other people that could help me, you know, so…Well, I could phone up at any time and I could speak to either a receptionist, keyworker, even the doctors have picked the phone up at times. It doesn't matter what is wrong with me, I can discuss it with them. If I need a doctor's appointment, they can make one at the surgery for me and they can…if it's something to do with, say, the diabetes and they think I need a review, they will arrange all of that for me. So it is, as they have said, one body of people I can go to that has access to everything I need." (IP04_2)

Both models are moving towards less doctor contact, and more contact with lower qualified allied staff that have more time for relationship building, with the doctors having more of a consultant role:

> "if you phone up the surgery it depends if they think you need a doctor or if they think it's just going to be a prescription or you see the practice nurse. It's not often you actually see a doctor, but with the Symphony Health I know they're there all the time, yeah." (IP04_2)

> "we've got people who can now spend the time with them, to really find out what it is that they want differently" (IP05_2)

In terms of multi-morbidity, similarly to the Salford programme, complex social needs rather than specifically complex conditions was seen as the main commonality perceived by staff working on the programme. Mental health was once again seen as a particularly difficult disease type, however. In addition, acceptance when a patient is at the end of life/never going to get to the place that they were was seen as a difficulty, and one that made the patients frequent presenters to secondary care, in need of the extra management:

> "generally speaking the patients managed by the Complex Care Hubs are those with three or more long-term conditions or frequent hospital admissions, tend to be the most fragile healthwise, but also have very complex social situations. Those managed purely in tier three can be those who are much more activated and those who perhaps have one or two long-term conditions. But that's a bit of a generalisation, you know? People are people and it's about giving people the service that best meets their needs, so right place, right time, right person…in terms of tackling the underlying cause, which is very rarely a medical issue, it's most frequently issues around loneliness, social isolation, anxiety, mental health issues, such a widespread anxiety and depression issues, confidence issues, a whole range of things that can't be changed overnight. That takes time to work with individuals and their families and their carers…I think the most challenging individuals are those with severe and enduring mental health issues, so anxiety, depression, dementia, no problem, personality disorders, those type of things" (IP03_2)

> "Not necessarily GP needs, maybe more multiple, social, financial needs, rather than the medical side. Because the medical side is reasonably easy to do…they've probably got some conditions, but that's really not the most important thing to them. And turning up that support system, support network, care packages, communication with various different organisations that are involved in their care, it's the non-medical stuff, that falls apart less often. And therefore, they don't go into crisis so often." (IP05_2)

"We then worked out that just because you've got three more conditions doesn't mean that you need to be, your medical condition is particularly complex. It's a lot to do with the psychological and social aspects surrounding patients… Looking at it from the biopsychosocial point of view, so we are often dealing with problems that are very complex. It's not that their general practice has failed them or not been able to manage them, they don't fit into the box, you know, they don't fit into the system we have in the NHS – they fall between it. A lot of what we do is we have to develop new ways of approaching it or managing it and involve other specialities and bringing people together and coordinating social care and psychological and voluntary along with the medical as well…What is quite evident is actually they've got a chronic health problem that's deteriorating but nobody is really having those conversations. They are constantly feeling unwell, they are constantly feeling they need to be in hospital and of course they never get better, so they think the hospital has not done it right so they go back in and do it again. It's being able to have the intervention and being able to talk through and explain that actually it's a naturally progression of the condition and that's where life is now and improving quality of life." (IP06_2)

"social needs are one of the biggest problems. And we already know that there's a gap in provision of social care. And I've seen that at the discharge end, and I guess I'm seeing that at this end, which is kind of prior to admission. And it's really difficult because we don't have the resource to, you know, we're not a social services organisation." (IP08_2)

"I think anxiety and depression are huge and I certainly didn't realise how much that impacts on a person's health and wellbeing and, you know, some people can have three, four long term conditions and can manage quite well, somebody that could have anxiety and depression could have one long term condition and it's, you know, they don't manage at all" (IP09_2)

The majority of the patients treated (especially in complex care hub) have previously been on a care plan in any case, but the health coaching approach is described as more patient-centred:

"I mean, all of our patients had, sort of, care plans which we either wrote when I was working here on the wards, you would, sort of, have set care plans that you would take out and you would just fill them in with the patients and then, again, when I worked for partnership, they had electronic care plans that we just, you know, wrote in for that person, but I feel that these are person, you know, they are about the person and it's the first time that I've ever probably done that, involving the patient really…And then it's just not what…you know, previously it's, kind of, what you think and you write it

down, you wouldn't necessarily consult the patient about, where that's where this is very different" (IP09_2)

4.2.2. Self-management interventions

Supported self-management is a key goal of the Symphony programme, together with personalised care planning [4]. The 'Patient Knows Best' ICT platform was initially seen as a key tool to enable this self-management (with added input from carers/family members), allowing the patient to access their care plan at any time, and take ownership of their medical record (see section 4.5). Further support and coaching is offered through the new roles of 'Care Coordinators', 'Key Workers' and 'Health Coaches' (see section 4.2), offering better co-ordination of care with a single point of access when needed and support and coaching for both patients and carers in order to better understand and manage their own conditions and to access support in the community [2]. The closer relationships with voluntary and community organisations, and provision of a directory of services in the local area provides further support for patients and carers to take control of their own health and care needs.

Self-management is seen to be primarily about patient education, their acceptance of their current situation and how best to stay at home in the community and accomplish their own goals, as well as linking to local groups/services/ practice group visits. This is primarily led by Health Coaches, and is likely to take time to implement fully:

> "So, I guess it's about, initially, it's about them goal setting, so, what are their goals, are their goals realistic. So, say you've got somebody that's got COPD, and they used to do aerobics, you know, is that still feasible, or actually, do they need to set some new goals. And then, it's about working with them on how they can achieve those goals. And I guess, telehealth is around self-management. And then, it's, what we've talked about is, moving forward, doing more assessments with them, to look at things like, you know, maybe their diet. So if a care coordinator, when they've got a diabetic, and somebody is surrounded by sweets, you know, they might say, you might want to cut down on the sweets." (IP08_2)

> "So it's finding out really what do they understand about their long term conditions and then it's what can they do then?" (IP09_2)

> "If it's right for them, how do you enable them to become an expert patient, and drive it themselves. Tough to do, takes time." (IP05_2)

However, self-management is seen as a new way of working, and the patient's ability to cope with it will vary (by patient and over time), some may not want to be involved:

"So our respiratory nurse and diabetes nurses now go out to primary care and they're a lot more proactive in making sure that patients understand what it means if they're diabetic, what they've got. Asthma or COPD, and understand that actually if you've got COPD and you keep smoking your risk factors are much higher than to have really life limiting lung disease. The same with diabetes, lots of people don't understand. If they don't get the sugars under control they can lose their feet, their toes, their sight. And by the time they realise it it's a bit too late.   So the bottom of the triangle that I talked about, that bit where it's self-management, the key role there is about doing everything we can with the patients so that they're activated to manage their own health and they stay in that bottom one and they don't move up. And if they're in the middle part of the triangle then again it's about working a bit more intensively with them, because what you don't want them to do is to go up to the top part of the triangle through anything that they have or haven't done themselves." (IP02_2)

"Perhaps some people who are in the last few months of life, it's not the best time to start changing and shifting from a culture of dependency and biomedical to trying to encourage self-management but for some people it's exactly the right thing in the last few months of life. They finally get some control over something, so it's really difficult to do any sweeping generalisations. One level one person isn't the same as another level one. One person with eight comorbidities who's terminally ill with cancer is very different from somebody else. The whole thing is it's person-centred and individual so trying to categorise people doesn't work." (IP03_2)

"So, in secondary care, we tend to tell people what they should do. So they come in and we tell them, we're going to do this, this, and this. Whereas, this is more of a, how are you going to, how are we going to work with you, how are you going to manage your condition, and what are your goals. And that's a completely - so, coaching patients, and trying to help them manage their conditions - it's a completely new approach." (IP08_2)

"The way I look at it is they're the professionals. If there was anything I didn't want to do, I would never be forced to do anything. But they've taken control of my illnesses, they're the professionals, they know best, really, so I'm quite happy in that, I suppose, cocoon of being cared for." (IP04_2)

"And if I'm being really honest, some patients respond really well to it. And I guess, no different, some people that decide that they're going to go and eat healthy, go to the gym, and improve their health, 'cause they choose to do that. Rather than somebody being told, you need to lose weight, and eat less, and do more exercise. So I guess there's been the two" (IP08_2)

Nevertheless, care plans are seen as a key step in shared decision-making, and include escalation plans, which are though to re-assure and empower the patient:

> "So it's making the patients feel empowered. Whereas they might panic, now, and think, I need to phone 999, it's about going through…feeling a bit in control. And also, knowing what's normal for them." (IP08_2)

4.3. Leadership & governance

As described above, the new relationships are encouraged through both co-location of multiple services in the newly formed care hubs, and multidisciplinary working through individual assessment and care planning (i.e. case management) of multi-morbid patients. These collaborations, and closer physical workings are designed to allow ease of co-ordination of care, with a more comprehensive and holistic assessment of the person's needs, while maintaining continuity of care through a single care coordinator and personalised input through key workers. Further collaboration occurs at the planning level, with all stakeholders involved in the Programme Board, sharing contractual responsibility and payment through a shared budget and capitated, outcome-based contract for the services provided.

The programme receives national support to attempt to overcome legal/regulatory problems through both the Vanguard and PIONEER programmes.

Beyond the health and care stakeholders, the programme works together with local voluntary organisations and communities, helping people to access support in their areas, providing a directory of services, and supporting communities to support their residents [1].

The vision and leadership from the top has been seen as a key enabler of leading the way as a Vanguard:

> "I think, In [name], you've got a leader that is, that has seen the issues on the horizon, and knows that, as a small district hospital, you know, to cope in the future, we need to do things differently. And has, essentially, been brave enough to want to innovate. Because as a Chief Exec, probably just sitting, and doing the status quo, is the easier. Because with innovation and change, comes disruption, and you get people that really don't like those changes. So I think you need those innovators, those people that are prepared so shake things up. And I think that he's been quite pivotal in doing that. And, again, with the support of some key people from primary care, so people like [name], you know, who think, who equally have maybe seen the writing on the wall in primary care, and think, we need to do things differently, and joining up" (IP08_2)

For the staff involved in the programme, there has been a recognised need to build clinical leaders for the future that understand integration, and potentially different training needs for them:

> "And that's one of the conversations I've been having on this national programme about how do we build board level and nurse leaders for the future for integrated care organisations, because they need to have that breadth of experience.   We've talked about things where there's almost like a… If you had the vision you could identify key leaders for the future and actually they could do six to twelve months in different organisations to get a bit of an understanding around the different… And that could be in social care as well. So that you have a greater understanding of how difficult…or how to unblock some of those barriers for relationships." (IP02_2)

A hierarchy remains, but the professionals are looking to work in a more team-oriented way, with clear roles and each professional wanting to work to 'the top of their license':

> "I: And for the huddles, is there a clear leader?
> R   Yes, it's usually the extensivist, but it could be one of the others, but they all have their own roles because they're all on different systems so it's not hierarchical but usually someone is keeping it to time and making sure that discussions don't go on and making sure decisions are reached. It's always a clinician" (IP03_2)

> "The difference for me in a role is that instead of dealing with things that are quite straightforward for me through to very complex with patients, I spend most of my time - not all my time - working on the most complex.   One of the philosophies is that everybody works to the top of their licence, you know, why would I be doing something someone else who costs less money could be doing?   If, you know, my job has changed, I'm dealing with much more complex stuff, but then I think that's better for the system." (IP06_2)

> "it's kind of traditional. If you liken it to a ward, it's almost like consultants…Or, doctors, nurses, healthcare assistants, but it's just slightly different, as in, they're health coaches. And your care coordinators, rather than a, I'm gonna come and look after you today, it's, how are we gonna help you look after yourself, so that's a slightly different approach… But I think some of what I'm doing, as well, is looking at roles, so that people are really clear what their roles are. Because there is, sometimes, a bit of a crossover, so you might end up with a care coordinator that's ended up doing health coaching. Or, I think, sometimes, the extensivists end up doing things that the care coordinators do. You know, so it's about being clear what their roles are" (IP08_2)

As a new service that sits between primary and secondary care, it appears to have been difficult fitting the governance of the complex care hub into the traditional system:

> "From a Hub perspective, probably just where it sits. So, originally, the Complex Care Hub sat within the acute hospital, essentially, and then, it's moved across into Symphony Healthcare Services. And it's that way, where you're almost offering primary care, but it's one step up from primary care, but it's not quite secondary care. So some of the governance, sometimes, we are trying to apply secondary care governance, and risk management, to what is essentially more of a primary care service. And an example of that might be a piece of equipment, so we might want to use a piece of equipment for one of the patients, and we would apply secondary care principles around, oh, we need to calibrate it, you know, and that piece of equipment costs £400. Whereas, in primary care, they use a piece of equipment that costs £70. So it's that changing the mind set" (IP08_2)

There also appears to be a general problem in the NHS, regarding information governance and the development of IT linkage:

> "And until we solve information governance…information governance is an enormous problem for the NHS, and social services… Within health and social care there should be an agreement that your data can be shared amongst health and social care unless you opt out of it. But at the moment there's lots and lots of very complex, very complicated information sharing agreements of level one, level two, level three that have to be signed and sealed with everybody and his dog really. So that doesn't help, that's created quite a few blocks for us and I think there's a poor understanding of information governance out there as well. So people don't really understand what it is they're signing on or refusing to sign. And most patients, the vast majority of patients really don't care. As long as they get looked after they really don't care who sees their information. And as long as it's stored and used in confidence and correctly, then we really need to get passed all of that, having to have all this information sharing agreements." (IP02_2)

4.4. Workforce

New professional roles (more unusual/novel in the UK's NHS context) include the 'care coordinator' role, and the 'key worker'/'health coach' role. Care coordinators are tasked with working with patients to arrange care and developing a single plan for patients' health and wellbeing, different from their current multiple care pathways in usual care [7] (a more classical case manager role, perhaps). Key workers/ health coaches appear to play a more personal role

with patients, building relationships and providing ongoing support [3]. The key workers are supposed to act as the 'first point of contact' for patients, helping them access other support [7], and to act as health coaches to assist patients and carers with self-management support [7] – to help them understand and manage their own conditions [2].

Many of the new roles, e.g. extensivist GPs and health coaches, have been adapted from programmes in America and elsewhere, but the professionals are still adapting the roles to themselves and their own context:

> "well it's a role that we've taken - I mean extensivists exist in America and it really I think it just means that you're following the patient from the community into the hospital. We use the term because it became quite complicated saying the hub GP and their own GP - so to use the word extensivist. I think it, you know, we are developing the role, I mean it's popped up a few places around the country, but it's kind of a new role. The extra skills we are learning on the job around preventing admissions and allowing earlier discharges, so we are, kind of, upskilling in certain areas medically, but we are obviously not consultants – still generalists and focussing more person centred care in health coaching, but we also look after the patients that are in the community." (IP06_2)

The need for new roles is linked to the wider sustainability of the system (see macro level section), e.g. to the shortage of GPs and need to diversify the workforce:

> "So part of that is how you make primary care more sustainable as well, the need for more training places for primary care and GPs, maybe some different models of working for primary care. Which is why we've got these acquired primary care practices now and we're looking very closely at the skill mix and the staffing model around that. And the traditional one's been very top heavy with GPs who are very scarce and very expensive. And we're actually saying that we think that things could be managed with a lot more nurse practitioners and EMPs, which is like paramedic backgrounds, those kinds of roles would work really well in primary care. And again, replicable and scalable. So we're trying to develop a best value for money staffing model for primary care, look at practice lists of about 10,000 and we're just working on that at the moment." (IP02_2)

Currently, although the extra work is paid for, the service is still something extra for the GP to do, and they are breaking even, without profiting from it:

> "there's massive pressure on our day to day, because my time is taken out, doing this stuff, as well. So, Thursday, erm, this afternoon, now, although the funding is there to cover it, there's nobody, there's physically nobody I can call and employ to come and cover my work. I have to go, after this, and do it...And we don't make money out of it,

we less than break even out of doing this. So it would be much easier for me to just stay in my practice, and see who comes through the door, and carry on, than it is to do this. So that's a pressure on us." (IP05_1)

New ways of working for more established professions e.g. GPs, nurses, hospital medical staff, and social workers, therapists, pharmacists etc. also appear to be relevant. This comes from closer professional working, through multidisciplinary teams in the treatment of patients, co-location in the complex care hubs, and new patient-centered care model [1]. Additionally, these groups have all fed in to the development of the new care approach [6], perhaps affecting how they interact and communicate with each other. They are also represented on the Programme Board, controlling budgets and the new capitated contract together, which may offer even more opportunity for roles to have changed, including working relationships [3].

All those involved in the Hub, and the health coaches in EPC received a 2-day training course in health coaching at the beginning of the programme, and they are now training their own trainers to deliver the programme to new recruits:

> "We organised and we've all had two days worth of health coach training which gives you different techniques to base it around more person centred help with allowing patients to identify goals which have to be identified by them and be important to them. Then working around and working with them and coaching them to be able to achieve them." (IP06_2)

For the new roles, particularly the unregistered roles, such as health coaching, moving forward there is the need to develop new competency frameworks and develop clear career pathways and progression that shows they are valued (IP02_2, IP06_2).

There has also been a potential unmet training need identified, particularly around mental health, although the generally more patient-centred approach of health coaching is felt to help towards addressing this:

> "I do think it is a bit of a gap in that the vast majority of people that have been recruited to the teams, I won't say everyone but I would say the vast majority because I'm not sure of everybody's background, their predominant involvement has been anxiety, depression, dementia, learning difficulties, not schizophrenia or whatever, but we have had patients with schizophrenia and a whole range of other mental health issues, bipolar disorder...So I think people have been surprised that by taking that person-centred approach how unscary mental health issues are because it's just a continuum, for the majority." (IP03_2)

> "for us it would be really good to have further training around, you know, that, kind of, mental health and depression and anxiety, because it does affect people

differently. Yeah, that's one of the things that I've definitely seen...If they go into crisis, we can talk to the, kind of, mental health team, but there's not, kind of, much in between, they have talking therapy which is a six week course and it looks around how patients can take control of their long term conditions and there's, sort of, counselling, but it's just, kind of, finding the right approach for a lot of these patients, because a lot of them say that they feel let down by the mental health services, that there isn't anything and nobody cares and they're, kind of, just left, well, we've tried everything and we don't know what else to do with you so, you know, off you go." (IP09_2)

Job satisfaction for those directly involved appears to have increased:

"it feels like you're doing stuff that is satisfying. Like, talking about being able to spend half an hour with somebody on the initial, sort of, mental health assessment. And then you can work on low level, kind of, cognitive behavioural stuff that you just never would have time for before. It's great to be able to do that." (IP05_2)

"I think, you know, what's one of – probably the best thing about the job for me is that I work in a team which in Primary Care GPs are often in a room on their own and you might not see anybody else all day other than patients. You don't have a team approach, you feel like you need to do absolutely everything and you spend a lot of your time doing stuff that realistically other people could do. It's quite a big shift and it feels quite difficult to do and let go initially because we always do, holding onto it all - but it's really great sitting down next to other GPs and colleagues on a desk next to them and being able to talk through things whenever I need to." (IP06_2)

"I've always loved, from the moment when I came into this job, when I saw it advertised and it was, sort of, person centred care and I thought, oh, yeah, how lovely that would be to be able to work in an environment like that and, yeah, I love coming to work every day and I think that now having the, you know, that knowledge, experience and, you know, the training it's just a really satisfying job to be able to support patients in this way to be able to stay living at home independently and, you know, we can, sort of, just cross all boundaries to help pull in what support that they need and it's amazing." (IP09_2)

However, for those not directly involved, there is perhaps a delay in awareness of what the programme is and does:

"Whether the consultants on the ground, they probably don't see it happening that much...In terms of, how does it impact what they're doing? They might be looking for, well, how does the complex care service impact on what they're doing, or they might not realise what happens outside, they're not watching it that closely. But actually, my

health coaches are ringing up and trying to find out what's happening with our patients who are inpatients, so they should be, if they do do inpatient care, they should be seeing that. Or the coordinating outpatient appointments, and follow up, and not letting it happen if it doesn't need to, so they might see that. But the time it takes for them to come across it might be too long." (IP05_2)

4.5. Technologies & medical products

The new ICT applications appear to focus on four key areas:

1. Risk stratification to identify complex patients
2. Professionals' data access
3. An online patient record
4. Telehealth

Risk stratification to identify complex patients

In planning, the United Health's RISC tool, "a patient-level predictive modelling tool developed by United Health, UK, to assess the risk of patients having unplanned hospital admissions within a 12-month period" [4], would be used to select patients for inclusion. It uses ICD10 and Read codes in the patient's records to categorise Episode Treatment Groups (ETGs), containing 49 chronic conditions from the 586 ETGs analysed [4]. The RISC tool was used in initial evaluation to select the multi-morbid group to focus on (those with 3 or more conditions).

However, in practice there has been movement away from purely using data to select patients to manage. It is used to some extent, but more reliance is placed on their own 'Symphony score', and staff knowledge of the patients and what care would best serve patient needs. Data for symphony score comes from EMIS and hospital data, and is then checked by GPs. This score is also what determines whether the patient is discussed in the huddle (see Service Delivery section, 4.2):

> "the three tiers are beginning to evolve, it's not a strict criteria of referral in or not referral in. It's who would best have their needs met by that service. The main tools used are, obviously there's the dataset but that's not refreshed that often. There's the AUA, avoiding unplanned admissions data, the top two per cent. There's also we've got something called the Symphony Scale which kind of is the equivalent of the American Worry Score which basically captures the team's concerns about individual patients…So everybody in the team can feed in information, and escalate them up and that's how the patients are chosen. It's about data and people knowledge as well, from the people who are directly involved in dealing with them. So you can't say, oh, well, it's only strict

criteria, which makes it a bit more fluid and a bit more difficult to identify but more responsive as well." (IP03_2)

"so there's two data sets that are used. One is a data set that is pulled out of the EMIS system that practices use. And it takes information about comorbidities, et cetera. It also, then, maps against...I'm trying to remember what the...all of our practices report into a central system, which is pulled together by the Commissioning Support Unit... there's a report that they have to generate, each month, I believe, that then goes into a central system. So that, again, does a kind of risk analysis against patients. So, the Symphony stratification pulls together a risk assessment that's been built specifically for Symphony, and a risk assessment that's been done in this other system. Puts them both in a template, does a calculation across the two, and then gives each patient a score...it's a useful tool, but it is just an indication of what you might need to think about. The critical part of this is actually layering on additional thought, and information, on top of that, to say, what is the clinical input here; what does the GP believe… there are stories of GPs looking at their stratification and saying, this patient scored a ten, you know, we've got some admission data here that shows they're being admitted regularly, or they're attending A&E regularly, but they weren't on my radar… And on the flip side, it'll identify patients, as I said, earlier, that would appear high risk by the data, but actually, the local knowledge says, they're actually managing their health quite well. So, it's only part of the mix… But when you look at the big number, where do you start from. If you've got a population of 13,000 patients for a practice, how do you start identifying which patients to go for. It's quite a slow process if you just do it out of what you know. And actually, to have some data analysis is a helpful start to the discussion. And of course, some practices might use that, you know, give that more weighting than others" (IP07_2)

Professionals' data access

There remain numerous data systems that the professionals need to use to enter and extract data from. The hub initially tried to develop their own system, but there were numerous problems with interoperability. The problem is thought to require national intervention, at least in setting compatibility standards. However, the CCG are locally attempting to use incentives to make a start to easing this issue. The complex care hub is also using the primary care system, EMIS, to manage in the meantime:

"for some reason the NHS doesn't seem to have got itself together, to have got one care record. So everyone's using different systems. There's lots of talk about interoperability and the fact that all these systems can be interfaced with each other, but then it's never that easy. And there's information governance and all the stuff that goes around that…

so the CCG have got…commissioners have got a CQUIN, which is a quality improvement incentivised payment thing going at the moment to try to get us have a shared care plan across Somerset. So all of the healthcare providers have to try and work to that. If it happens in my lifetime I'll be ecstatic. Because it's what's needed, it's just difficult to bring in… EMIS is doing a lot but not all GPs use EMIS. That's one of five or six big players within primary care. So I think the Government needs to be really clear about interoperability and all of these. They have to have interfaces, they have to be able to join things up so that patients can view their records online. And we are a long way from that at the moment…I won't be around in ten years' time. If we've cracked it by then I'll be very surprised, because we've been trying to crack it for years. And I've been involved in some very big projects with IT companies that have gone a long way down the line and then they've fallen apart, backed off. So it's unfortunate I think, the Department of Health and the Government needs to be a bit more prescriptive with all of the private organisations that are out there developing stuff." (IP02_2)

 "Bane of my life – we've developed a system ourselves here, well the IT system have called Symphony Notes which started in very much one form and I think it's completely transformed. That was me and my team working with the IT people of what we wanted. Basically the notes now has the huddle sheet which is basically the mainstay of what we do every day and it enables us to have a quick note of where a patient is and ability of one member of the team to handover to another member of the team what's happening. We can also record our activity on there so we can look at service and how much time we are spending with patients, what travelling. That wasn't shareable with general practice, and it wasn't, you know, part of the patient's own health record, so now we have EMIS where we can do a joint view. We have what is called the clinical support module, so we have the patients on our system and we add our notes and the GP can add their notes and if you in joint view you can see joint notes. We can see all the patient's GP notes with their consent. We have got access to RIO which is the community services IT system, so we set up as a service there so we've got access to the district nurses, the rehab team, mental health team. We can get the hospital notes, we can access the hospital system and look at discharge summaries, blood results, x-ray results, outpatient letters. The only thing we can't easily access is Social Services because I think there's are still paper written, but the whole idea was that we were the one place that could see all the information…It means there are lots of different systems and it is difficult and it is clunky…What we do is we write the Symphony Notes just because at the moment the huddle sheet is there…We write it in there and then we copy and paste it into the EMIS which is the main record, so those are the two things we work on" (IP06_2)

"they have to input into, or, they have to use about five systems…but they're having to duplicate information, and they're also then having to access other systems, like the system that they use in the community. And that is definitely an issue, in terms of resource, and time taken up." (IP08_2)

Online patient record

The 'Patient Knows Best' platform (http://www.patientsknowbest.com/) describes itself as "the world's first patient-controlled medical record" [9]. The platform is designed to empower patients to take control in managing their own care, while simultaneously enabling clinicians to share information and better engage with patients [9]. In the Symphony programme, both the patient and any named carer/family member can access the online record and care plan, in line with the goals of the programme that patients and their carers take increased ownership of their health and care.

In practice, however, there have been a number of difficulties with this. Uptake is poor, and the platform requires duplicate entry from professionals, which means it quickly gets out of date. As above, EMIS is seen as a good alternative (although, Viewer cannot be edited). It is seen that it is important to set the groundwork for this kind of patient access now though, as future generation will expect everything to be electronic:

"Well Patient Knows Best we are not using so much at the moment purely because of just organisational use. On the Patient Knows Best is the idea is that the care plan sat there, the patient can access it, we can access it on lots of different services with their consent can access it. The trouble we have is that the information at the moment that is put in is put in by hand by clinicians and medication and we do not have the capacity to go and check that the GP hasn't changed medication, so it becomes a potentially unsafe record." (IP06_2)

"So it's not ideal for us, which is why we're looking at an EMIS care plan. Because that would be easier for us to get everyone. Because lots of people have got EMIS Viewer, so the emergency department at Yeovil Hospital has got EMIS Viewer and Taunton's hospital are getting that." (IP02_2)

"The difficulty is that they've still got that patient mindset of having things done unto them. And actually we've only got about ten patients that use that service. Most of them say I don't have a computer, I don't have access to it. I wouldn't know what to do with it. Can you print it off? And they have a paper copy. So I think the use of IT down the line will be much greater, that's why we need to get off the mark now and start to have systems that are single systems that aren't over complicated, that when we get to mine and your generation being in their 70s and 80s and 90s" (IP02_2)

In addition, the complex patients who would potentially have most to gain from access to their records, are perhaps those least likely to use it:

> "Complex care hub – the reason we haven't pushed it too much was that very low uptake - some patients are very frail. I think a massive benefit is in EPC - you've got younger people coming through, you are trying to be much more proactive. The other big issue is the patients we are really trying to target have got low activations, PAM scores of one and two and these are not the people who are going to use an app or want to do it. They are going to be your threes and your fours who are very activated already. That's a bit of an issue with it – is whatever technology you use you are going to have to work quite a bit to get maybe people who are busy and, you know, the type of people who haven't got time for their health for whatever reason – they could be busy lifestyle, family problems/issues - are also the people who are not going to readily update a care plan on an IT system or use an app. Yet they are the very people who would benefit the most from it, so that's where coaching comes in." (IP06_2)

Telehealth

Telehealth is used by the complex care hub (so far, around 45-50 patients (IP09_2)), to keep track of vital signs and alert staff to any changes that might require escalation/ follow-up:

> "I've got the telehealth, which is the…it's connected by Bluetooth to Yeovil hospital, and I just put it on in the morning, tell them how I was yesterday and take my stats, and it all goes through so they've got a daily record of how I'm doing. So, if, say, my oxygen levels really dip low, they would soon pick it up, yeah." (IP04_2)

> "we've also got telehealth, that support. So we've got patients who are on telehealth in their homes, and each morning, the extensivists review the telehealth and see if there's any flags, like, if somebody is on...I'm trying to think. If somebody is on some sort of medication that they need to, you know, where fluid balance is an issue, if they've lost six pounds in weight that might flag some medication change. So they get them to weigh themselves, do their blood pressure, and so on. So, telehealth has been hugely supportive, actually, at keeping patients at home" (IP08_2)

4.6.   Information & research/monitoring

To date, there has been one published report [8], and one peer-reviewed journal article (based on the same report) [4]. These relate to the initial evaluation of the data held in South Somerset, used to identify the target group for the ICC programme. They describe the data set

held in South Somerset, as well as the methods and results of the initial analysis led by the University of York, which looked at the relative drivers of healthcare cost in the area.

The Symphony Project originally built a large dataset comprising information about each anonymised individual in the South Somerset population, linking health and social care data together, as well as information on costs, morbidity and demographic characteristics [4]. For the initial analysis, the data were derived from various primary sources all of which cover twelve months from April 2012 to March 2013, 114,874 people are included. The dataset has three key features:

1. "Anonymised data are available for each individual in the population about their utilisation of health and social care. Utilisation data for each individual are linked across eight broad settings of care:
   a. PC: primary care episodes and prescribing
   b. IP: acute inpatient & daycase
   c. OP: acute outpatient
   d. AE: acute accident & emergency
   e. MH: mental health
   f. CM: community care
   g. SC: social care.
   h. CC: continuing care"
2. "Costs have been calculated for each individual according to the type of care they have received in each setting. These calculations generally reflect the costs to the commissioner of procuring care of a particular type."
3. "Demographic characteristics are available for each individual, including age, gender, socioeconomic measures, and indicators of morbidity." [8]

As detailed above, the initial analysis concluded that multi-morbidity and not age is the key driver of costs, and so this is the group that the ICC programme focused on (rather than frail elderly, another possibility the programme was exploring at early planning stages) [3]. The key purpose of the analysis was to identify "groups most suitable for pooled funding arrangements that might facilitate integrated care" [4]. The group of 1500 patients with 3 or more conditions was felt to provide a sufficiently large risk pool for financial management [4].

Andrew Street, professor of health economics at York who led the initial analysis is quoted as saying the dataset available is "up there with the best" due to the wide data linkage, and population coverage for the area of interest [6].

Going forward, one of the documents describes an 'outcome set' that has been formulated from the insights of stakeholders (see Figure 30) [3].

Figure 30: Development of 'outcome set' for Symphony programme [3]

There are a number of outcome measures of interest, that the programme is currently recording, including:

> "Number of bed days, average length of stay, 30 day readmission, avoidable emergency admissions, precautionary emergency admissions, patients admitted multiple times, excess bed days, avoidable A&E attendances, confidence to my own health, received enough support to help self-managed long-term conditions, have a written care plan, care plan regularly reviewed, patient access to GP and nurse, online services, GP referrals, mental wellbeing, the Warwick-Edinburgh Mental Wellbeing scale, patient activation measure [PAM], patient satisfaction experience, and number of contacts made." (IP03_2)

As the programme is health coaching/self-management oriented, there is particular emphasis placed on the patient activation measure (PAM score) (IP02_2, IP03_2, IP06_2, IP09_2). This may be because of the expectations of what can measurably be changed, particularly in the short-term, where the major changes needed (particularly in terms of utilisation and costs) are likely to take a long time to achieve:

"And again, we want to start doing things like the PAM score, the patient activation measure with the patient's enhanced primary care as well. So there's loads to do. I think the difficulty with a lot of this is you won't be able to demonstrate huge benefits in reduction of patients turning up in EDs and in hospitals and needing expensive treatments for some years to come. So it's getting NHS England and other places where really they're desperate to try and make savings now for the NHS to understand that the cost savings and the benefits might not be apparent for another three, four, five years." (IP02_2)

"If you're changing a culture and expectation and people are managing their own health better, it's going to take time, particularly for those who are less at the top of the iceberg already who were perhaps only using services relatively a small amount of time, to start to see a reduction in that is going to take longer to see. Starting to see a whole mindset shift in both clinical staff and the patient population, starting to see a greater uptake in terms of local voluntary sector services, starting to see changes in commissioners in terms of commissioning those sort of voluntary sector, peer support, all those types of services that provide that low level support rather than them going from one financial year to another and hanging on by the skin of their teeth, so having a more sustainable community that helps people manage their own health, that's going to take a lot longer, which is why we're not measuring it." (IP03_2)

"But it's probably gonna take two or three years to make the change. And we're asking the question at one year, and you won't see it. Because, even as the first practice to do it, we've only really been fully functioning for two, three months, in reality. So we haven't even done twelve months of action, yet." (IP05_2)

"it was never gonna be a model that, after two years, was gonna be up and running, and successful. It was always a five year plan. Because you're trying to do two things. You're trying to bring the people up here, on the top of that kind of triangle that four per cent, you're trying to work with them, to maybe bring them back to a level where they're managing their condition, moving forward. But equally, what we're doing in enhanced primary care, is taking that next level of, moving the people that would be next to go up to become that four per cent, and working with them, in a different way, with health coaches, to stop them becoming those patients of the future. And that's never gonna be, so it's never gonna be a quick fix, because with complexity, you know, it's not an A&E, where you patch people up, and send them away. So it needs time, so you kind of need to be patient. Because in healthcare, we always want instant results, we want to see the data, we want to see that, straightaway, we're making a difference. And actually, for some of these, it's gonna be a slightly longer game. Where we've worked with them, and your potential patient is starting to come in here because

their condition is out of control, has been managed by enhanced primary care here, and actually, they've not reached that point." (IP08_2)

However, there are some indications that the programme is heading in the right direction (although the robustness of the analysis to date is not yet detailed):

"And also, where people look at the wrong stuff, people - inevitably, it comes down to, well, are you reducing admissions. It was one of our 55 aims, but it's not the main one...Are we improving person centred care - that's the main one. Are we hitting the right places, is quality going up - those are the main ones. Balanced, of course, by, is it cost effective, and not, is it cheap - it's not cheap…Cost wise, we definitely cost money, everything we're doing is costs, you will see no savings for a long time...But quality wise, I reckon, it's through the roof." (IP05_2)

"Well, certainly the data that we've already seen has seen reduction in hospital admissions, reduction in length of stay, increase in patient activation measure, more appropriate admissions and more appropriate GP attendances, and people still go for flu jabs and things like that." (IP03_2)

There is a lot of evaluation now being conducted at the site, but generally interviewees were positive about this, seeing it as serving a function of proving effectiveness, and as expected as part of a trailblazing Vanguard site:

"I mean I think what we're doing at the moment is entirely scalable and replicable, and the key bit really is to demonstrate…get that evaluation data out and demonstrate that it actually does work." (IP02_2)

""I see it as positive and I try and say to the team, you know, that these evaluations have to happen, because, you know, we need to know whether we've got it right and what we need to change" (IP09_2)

"But that's the nature, when you're going to be a vanguard, you know, you have to go into it knowing that you're gonna attract that type of attention." (IP08_2)

4.7.   Financing

The Symphony programme has started out with the implementation of the care models, discussed above, but is currently planning organisational changes to support this. An 'Alliance' contracting model (in which all of the providers involved are represented on a board that holds a single contract with the commissioner) has been at the centre of the Symphony programme from early planning, thought to be a key enabler of integrating care [6]. This way all

organisations in the Alliance are working to the same contracted objectives and share the risks. This has led to the formulation of the IACO (described in section 4.1), and has influenced the organisation of the programme. The plan to use an Alliance contracting model was designed to "spread the risk and share any gains between all providers" [6]. The ambitions are to eventually roll this out across the county [6].

A capitated outcome based commissioning (OBC) contract is planned to be the primary method of payment [1]. This type of contracting moves from a process to an outcome focus [6], as the name suggests. The Symphony programme define this type of contract as "The results people care about most when seeking treatment, including functional improvement and the ability to live normal, productive lives (ICHOM, 2013)" [1]. The outcomes are said to start from the perspective of the patient, to challenge the cultures and not the structures, and aim to make best use of capped resources [1]. Figure 31 illustrates how the programme envisions commissioning being aligned through the incentives of the OBC [1].
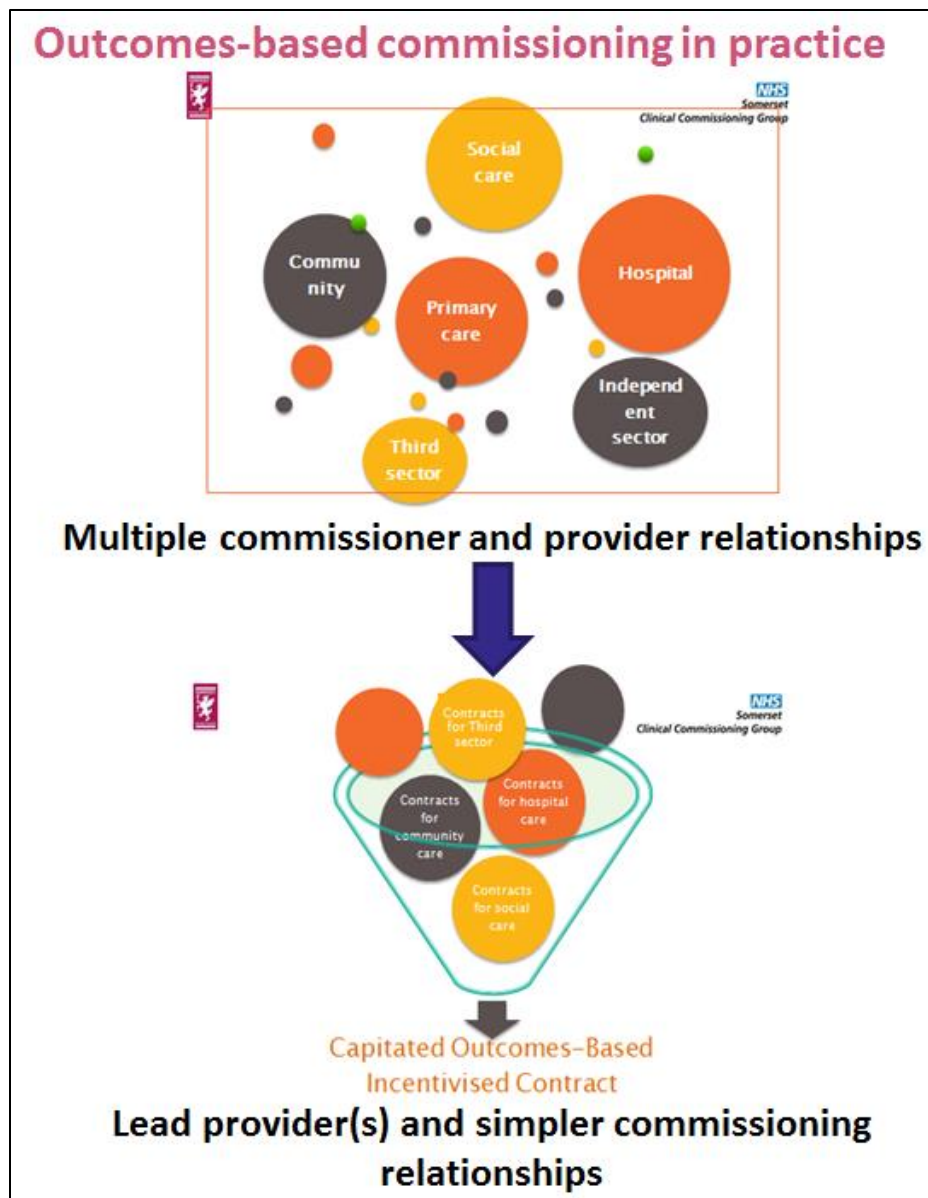
Figure 31: Illustration of outcome based commissioning through a capitated outcomes-based incentivised contract [1]

A risk-adjusted (based on multi-morbidity) budget has been planned to pay from, and incentivise improved quality at reduced cost [6]. Figure 26 (p.6) shows the organisational management of this budget, with the IACO as the budget holder. The budget is most simply calculated from "Budget = number of people x average cost" [3], with the model from the early evaluation work (based on multi-morbidity level) used to calculate the 'risk adjusted' model for projection to future years, and for specific segments of the population [3,4]. This sharing of budget should in theory allow targeting of resources to parts of the system where they can make the most difference to patients [5]. The programme states that, "shared budgets and incentives reduce costs", and savings can then be reinvested where need is greatest [1]. Figure 32 shows the projected impact of these projected savings [1].
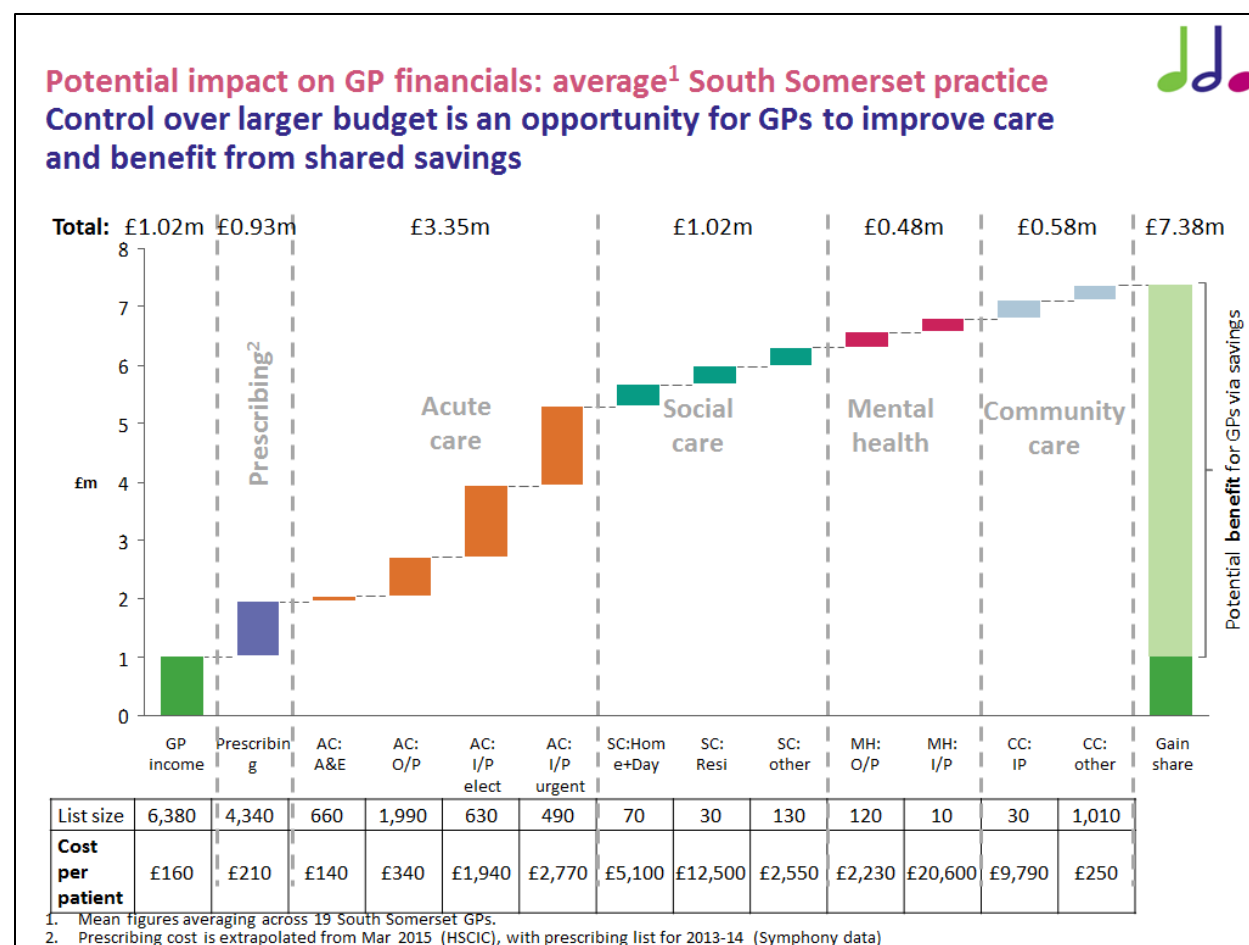
Figure 32: Estimated impact of projected savings [1]

While the IACO is currently still in development, similarly to the Salford programme, funding and organisational integration are seen as key to delivering efficiency savings in the future. The IACO is planned for implementation in 2017/18 (IP07_2):

> "Now what that will hopefully do is prevent duplications. So instead of everybody doing a little bit of something and none of it being joined up you'd be able to say right, this is the bit, around when they're in hospital, before they go into hospital, when they're in hospital and when they come out of hospital, or when they need long term care, how do we manage that across the whole of Somerset? Rather than individual little organisations providing that, and providing it in a bit of a fragmented way." (IP02_1)

> "that's really, that's the next piece or the puzzle. So in order to ensure that the funding, and the care models, can be delivered in the most effective way, we need to look at what would be the structure of an organisation that would support that best. And what the team are working on for South Somerset, is an accountable care organisation that could then receive funding in, and commission services in its team. And what that

enables you to do is to remove some of the silo working...Rather than having multiple commissioning levels of a bit of physiotherapy commissioned from the acute trust, a bit of it commissioned from the partnership trust, and a bit of it commissioned from an interface service that's run by a GP practice. So, those three things, all getting different amounts of funding, for different things that might not be in the patient's interest... So if you look at an accountable care organisation, they would then be able to say, actually, you know, what we should do is, rather than the physios being an interface here, put them into practices, and let's do assessments straight off the bat. So you take out GPs, and you take out the interface, and you just put an immediate assessment of the patient. And if that patient needs to go onto acute care for an operation, they do that. If they need to go into self-care, they do that. If they need to be given a physio treatment programme, then, they can do that. So, it starts to break down some of those barriers, and it enables you to look at where do you best deploy your teams. And of course, as pressure changes across the system, you can change how you work...it facilitates team working...So, it becomes an organisation that is the interest of the patient, it puts the patient back in the centre." (IP07_2)

The Symphony programme has employed OPTUM (United health) to help with setting up the IACO and OBC. The current stage that the programme is at is showing how the contracts will work in detail (work ongoing). The programme takes on any practice that wants to be involved. Initially involved was a single 2-person practice that were tired of being NHS-led. A former GP-owned company that provides primary care services, Pathways Healthcare Ltd (a group of 4 GP practices, plus a walk in centre based at Yeovil hospital), was bought by Yeovil hospital to help with the creation of the planned structures. This company was renamed Symphony Healthcare Services Ltd (in April 2016). Core GMS/PMS payments continue to run straight to practices, but other funding options will run through Symphony Healthcare Services Ltd. Four more practices have subsequently committed to integrating (estimated completion in August/September 2016). Importantly, it has been decided that Symphony Healthcare Services Ltd will not be set up to compete with other practices in the area. They want other primary care in the locality to remain viable. Therefore, they offer similar payment to salaried GPs etc, at the going rates in the local area (IP01_2).

Currently, the programme has relied on the short-term, pump-priming provided by Vanguard funding. However, less money being provided than was applied for, and the short-term nature of the funding are thought to bring some perceived risk, particularly for a programme that will quickly have to become self-sustaining, but, as above, where any cost-saving benefits are likely to take years to arise:

"The idea is that they become obviously self-sustaining but they save sufficient money, so at the moment my understanding is that vanguard pays for the health coaches in

primary care, and pays for the extensivists, care coordinators and the keyworkers in complex care." (IP03_2)

"I mean that's difficult. Vanguard funding was for three years. So we've had the second year's funding this year, and actually all of the vanguards got less than they were expecting. We absolutely did, we got 50 per cent less than we were expecting. That's meant we've had to cut some of the things we wanted to do. That means that our chances of demonstrating those benefits more quickly are reduced, but that's fine, we're used to things like that in the NHS. We have to do what we do with what we get." (IP02_2)

"There's a worry I guess about next year's funding. We don't know yet what we'll get and there is a committed service and recruited staff. So we have obligations as an organisation right now for a service and pay and patients and staff, and we need to make sure that what we get through next year is able to continue that. Because again, the cost savings that we think our organisational and operational programme will deliver won't probably be apparent or won't start to become apparent until the end of the next financial year. So that does bring pressures." (IP02_2)

"when you look at, sort of, funding streams, there's always a niggling voice in the back of people's heads - I would say, probably not within the Symphony team, but perhaps, a wider basis - a niggling voice that says, what happens when the funding runs out. And the answer, from my point of view is, well if the funding runs out, we keep going, because this is what we need, you know...the funding is there to pump prime this as a project, and make the change happen quicker, you know, but the change still has to happen. So if we're to cope with the pressures that we've got in acute, and primary care, and secondary, and community care, et cetera, we have to change. And we have to change the model of what we're doing...And we believe that this is somewhat of the solution to the problem. But it needs to scale a lot more." (IP07_1)

Again, similar to the Salford programme, the independently contracted nature of primary care appears to make it difficult to manage change, despite primary care being at the centre of the new model. The programme has formed Symphony Healthcare Services Ltd, owned by the hospital, as a possible way to better manage this change. However, not all GPs are keen to change their business relationship:

"In amongst all of that you've got the other difficult issues with primary care, which primary care is individual private practice. We've got some integrated practices now within the NHS that they belong as part of our organisation. And that's making things easier. But there are huge amounts of different organisations and different trusts and the commissioners for Dorset and Somerset, and then all the individual private practices

for primary care that make it trickier. We're desperately working very hard to build up those trust and relationships so that we can start to work much closer with them." (IP02_2)

"No, we haven't got any plans to integrate. We're an independent partnership.
I: And you're quite happy with that arrangement, yeah?
R: Yeah…As is." (IP05_2)

Integrating practices is also seen as a way to sustain primary care, especially in a rural area where recruitment of GPs can be more difficult. They are also seen as the easiest way to pilot change, rather than signing independently contracted practices up without yet having proof of concept:

"Symphony Healthcare Services, what we're doing is we've got three practices at the moment, three that were all going to fail, all that were not profitable… Sorry, that's not true. Two were not profitable, one of them was. But where the practice…the GPs that were partners were leaving and there was no one to take over. We've taken those on and we're in negotiation with another seven to ten practices… The five year forward programme said that practice lists needed to be somewhere between 30,000 and 50,000 patients to be really sustainable going forward and to deliver primary care in a new and different way. We are aiming to have around about 60,000 in those patients lists if we get the practices that we're in negotiations with at the moment, so that we can do that… it's about developing new ways of working within primary care. It's about making it sustainable and it's about the fact that we want to provide a back office function. So things like HR and IT, because we can do that with economies of scale, rather than them all dabbling and doing a little bit. And some of these practices are singlehanded GPs with four other members of staff. Well, you can't expect them to have that level of expertise. Especially around governance and all of those kinds of things. So I think it's an opportunity for primary care and for those that don't want to lose their… I mean we're very clear within SHS that we keep the individual practices' profile and personality, but they form part of our group. So they can either do it through joining something like SHS, or they can join together and become like the co-operative of GPs. Or they can do it with other big companies like Modality. So I think it is just the way that primary care has to go and what we want to do is manage that as sensitively as we can so that we provide the right services for the patients at the end of the day." (IP02_1)

"One aim is to make a responsive primary care system. We have, with the integrated practices, instead of having no practice at all, and five or six failed practices, we've got integrated practices, who are ready and willing, I think, to make changes to what they're

doing. So, again, the impact is on a responsive primary care system, that's able to do what you want it to do." (IP05_2)

"If I'm really honest, if I could start from scratch, I would integrate some practices, so I would have the integrated practices…as your start. And then, you would have introduced a model of complex care, whereby you have enhanced primary care, and complex care, working together, as a model. And you would kind of get it right there, and then, as practices integrate, you would roll out the complex care model to them. Whereas, I guess, what we've done is, complex care came first, the Hub, followed by EPC, followed by integrated practices. So what we're trying to almost go back and do is, we're looking at working very closely with one of our integrated practices, to kind of maybe drill down a bit more, and see how we could work more closely with the enhanced primary care team, on one model of care. Also, encompassing a nursing home that the GP surgery looks after. And trying to do it as a quality improvement type approach, whereby, we can take - you know, that kind of small, let's get it right, here. Because then, again, as we integrate practices, or not, or if the practice says, I'm interested in working differently, we can go, this is how we did it. But we can kind of make those mistakes with one of our own practices. So, if it was…yeah, I would kind of start with the integrated practices, and then, I would bring in a model of complex care." (IP08_2)

The current independent GPs are paid for the extra work on the programme, but are not making a profit from it, as it does encompass extra work:

"so the fact is, you're doing work every night, answering emails every day, and it's another session funded by that. So it's funded. And as part of implementing the new care models, as well, we have, as a programme, funded practices to do this, upfront money, to say, this is gonna be more work for you, this is gonna bring costs, you don't need to spend money on, in terms of time of what you're gonna do - that's not a real cost, but it's understanding that's what, GPs are businesses...And like I say, breaking even, probably." (IP05_2)

4.8. Implementation process

4.8.1. Historical information

The main goal to start the programme originated from analysis of current and future challenges to the local health system. Key challenges to secondary care were thought to include: unscheduled care, complex co-morbidities, discharge planning, generalised vs specialist services, integrated care, comprehensive care closer to home, and resources including space,

finance, time and workforce. And, for primary care were though to include: patient demand, long term conditions, seamless care, competition vs continuity of care, autonomy vs scrutiny, call for action, and resources including time, finance, and workforce. The overarching goal was to shift care from secondary to primary to preventative [1].

The case for change centered on the recognition of demographic changes driving costs in the local health economy and across the NHS. The NHS's plan, the 'Five Year Forward View' called for new care models to meet this need, and one such care model is now being piloted in South Somerset as part of the resulting NHS England sponsored Vanguard programme. A drive towards increased patient-centered care is believed to improve care received and the cost-effectiveness. Shared budgets and incentives are further believed to reduce costs, where savings can then be invested where need is greatest [1].

The programme, like many others in the NHS which has encouraged this approach, has been prepared from the bottom-up. In planning the programme, the initiators (organisations involved in health and social care in the local area - the five key players were Yeovil District Hospital Foundation Trust, Somerset Partnership Foundation Trust, Somerset County Council, Somerset Clinical Commissioning Group and the South West Commissioning Support Unit [6]) sought ideas from people with lived experience and current frontline staff, reviewed national and local publications, held one-to-one interviews with people with long term conditions, and facilitated events with people, carers, and frontline staff (see Figure 33) [3]:

> "I was in at the beginning when they were deciding…I was invited to take part at a huge group meeting in Yeovil...this was to decide what people with multiple conditions would like from GPs, that would make their lives easier, and the one thing that stood out was people wanted one doctor that knew about everything to deal with them. It was nice that I was part of that, and then a couple of years later it was developed into Symphony Health." (IP04_2)
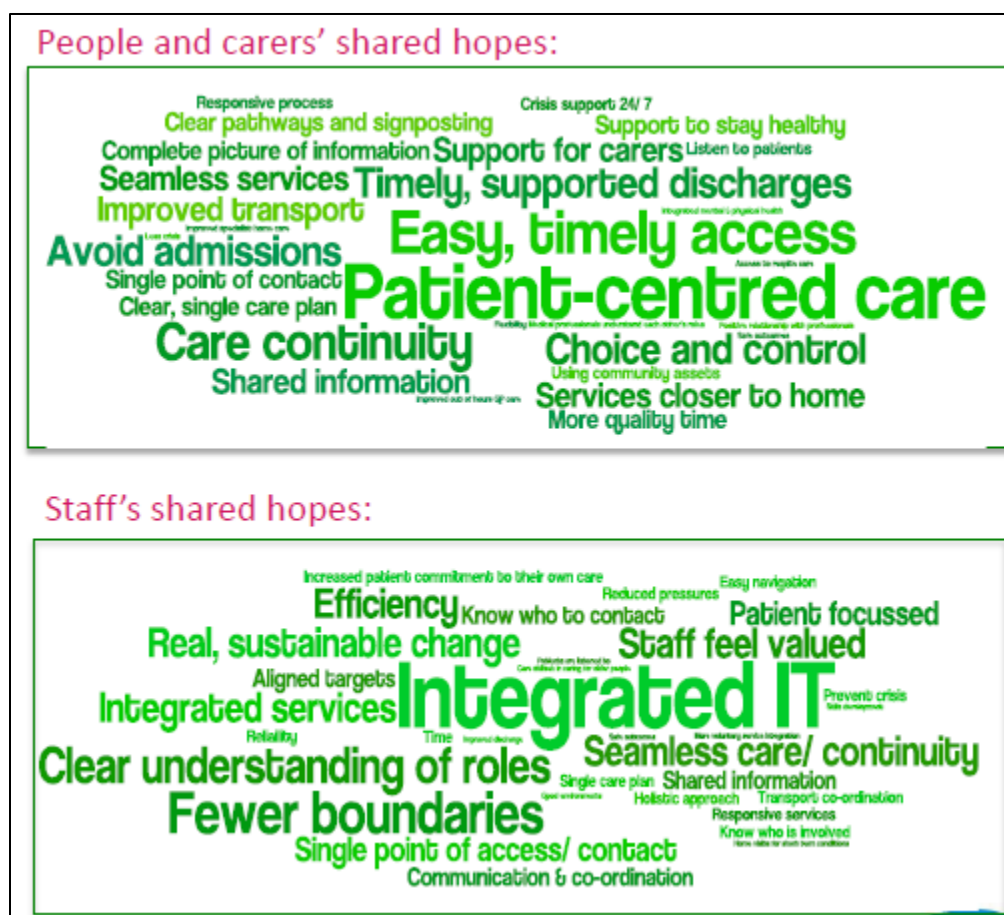
Figure 33: Highlights of People and carer/Staff shared hopes from initial consultation events [3]

These insights were used to guide the work and the evaluation outcome set for the programme going forward [3]. Each of the five initiators (named above) contributed £27,000 to fund the project's development over the initial 12 month development stage [6]. Wider support for the programme in the area appears to be strong, with organisations including: local housing association, Yarlington Housing Group; Yeovil College; and local charities South Somerset Mind and Age UK Somerset said to be backing the project [6].

The multi-morbidity focus (instead of an initially planned frail elderly focus) came from early evaluation work alongside University of York. This work influenced the choice of care model, and choice of starting cohort. It is also seen as a key enabler of implementing a capitated budget, has generated buy-in from clinical staff, and attracted national interest and investment [3]. The main reasons for selecting the group were said to be:

1. "This group of around 1500 patients offered a reasonably high level of predictable cost variation, providing a sufficiently large risk pool for financial management;"
2. "The group incurred costs across all settings, thereby offering the prospect of strengthening links across health, mental health and social care;"

3. "There is an opportunity to reduce inpatient costs, which currently account for 38% of total costs for this group." [4]

The hope is that the programme will eventually extend the arrangements to a larger cohort, including all patients with long-term conditions [4].

There appears to be some previous experience of integration in the ranks of the programme. Two members of the project board were members of the senior leadership team at Torbay Care Trust, which has been a leader in health and social care integration in the UK [6]. Previous integration of mental health and community services has occurred in the area in previous years, and there has also been some work with the county council, and private sector social care providers setting up re-ablement teams for independent living [6].

There has been clear political support, with the granting of PIONEER status in Wave 2 of the government-funded scheme, and subsequently the Vanguard programme (Primary and Acute Care System category – PACS). Both provide support and advice from an integrated care support team at the Department of Health [6]. The schemes also provide additional funding for new care and organisational models (for example the Vanguard provides funding for programme costs, primary care staff and remodelling 'Complex Care hubs'). The CCG is also funded to develop the outcome based contract (OBC)). The South Somerset programme leads the 'Vanguard for Organisational Forms', and a national team work alongside the site to help break down any national level barriers to innovation and other issues encountered [1].

The Vanguard was also a way of beginning to change the system, attempting to address some of the disincentives in the way money flows (e.g. payment incentives in primary care versus secondary care) in the system, for example. A new Symphony Programme Board (SPB) was established to oversee the Vanguard/new models of care. Primary care was seen as the key to make integration work. Therefore, primary care was disproportionately represented on the board. The initial eight members of the board were split between primary and secondary care: four elected by primary care practices (3 GPs and 1 practice manager elected); four from the hospital Trust (including a primary care representative of the hospital board) (IP01_2).

IP01_2 sees the key enabler of the South Somerset integration programme as buy-in to primary care from the hospital board. They have a shared vision of secondary care, basically involving a smaller secondary care system (reducing utilisation of secondary care, and moving as many services as possible into the community). For example, IP01_2 questioned why we need outpatient services (except a small amount of capacity as a step-down service form inpatient), where the majority of their minor operations should be done in the primary care setting. Likewise, many chronic disease specialties could be moved into the community.

The Symphony programme has been designed from the idea of what the implementers would want the NHS to look like if it was designed from scratch. They have talked about how much of health and wellbeing outcomes can be influenced by social and mental health services (they have therefore decided to invite mental and social service commissioners to be represented on the SPB, together with representatives from the voluntary sector – not yet members with voting rights, as they have not committed money to the programme yet) (IP01_2).

The historical relationship in South Somerset between primary and secondary care appears to have been beneficial:

> "historically, we've always had a really good relationship as an acute with our GPs. But I would say we haven't necessarily worked together, because it's, you know, it's kind of two different areas of healthcare… if you had an acute that didn't have a good relationship with primary care, and saw themselves as very much separate, I'm not sure that you would …you have to have your people who are prepared to - I guess, like us - to kind of work through, and kind of complete, finish, or, you know, problems." (IP08_2)

However, co-location of the complex care hub in the hospital at first perhaps led to some mis-perceptions of the service, despite now being seen as positive for working relationships:

> "One of the pluses of the first hub actually being physically located in the hospital was communication with hospital staff. There was no great mandate for it to be in the hospital, it was just that we couldn't find anywhere else that had space that there wasn't a financial issue with that the hospital was willing to contribute the space as part of its funding towards it...so that helped develop relationships between people like the discharge facilitators, the discharge lounge, the frail older person's assessment service, all the different -ology specialists, the inpatient staff, who all had to be educated about what Symphony was as equally did everyone based in the community so community…the Somerset Partnership, all the community hospital staff, the mental health staff, the GPs, primary care, social care, voluntary sector, but there was initially very much a perception that it was part of the hospital, even though both groups of staff, acute and community equally well didn't know what it was, it was referred to by a lot of people as Yeovil and the hospital, even though it was covering the whole of South Somerset and the team themselves regard themselves as much more community based. So there was something about perceptions at that stage." (IP03_2)

> "I wasn't going to do it at first because I thought, I'm going to lose contact with the surgery and they were based in Yeovil, and I thought, because I'm the main driver, it's a long way to go if I needed a doctor's appointment. But I saw [doctor's name] in another appointment and she explained more to me what it was, that I would still have dealings

with the surgery, and it's one of the best things I've ever done was joining Symphony Health." (IP04_2)

4.8.2. Present information

Like in Salford, the scope of the programme has changed over time, with the focus becoming less on the highest risk patients (and less on using risk tools), and more holistically on the system, including preventing future high-risk patients.

"So it is about that triangle, it is about the top bit and what we're saying is that complex care hubs, like we've got here, the model here in the hospital is a very tiny proportion of very, very high need. We think now the middle part of the triangle is a real bit to focus on. That's the bit that's very much more easily replicated and scalable, because that could be done across all over primary care...Because the first part, we were starting off down a journey where actually we were focusing much more on the top of the triangle and whilst that's definitely necessary it doesn't need to be as big a part as we'd first expected. We're really focusing on that middle part and working much closer with primary care." (IP02_2)

"some of it is initially, you know, identifying people through a risk tool, but we are increasingly using admission data, frequent admissions and also using the hospital specialists as well as the GPs to identify. What's much more successful is when clinicians in Secondary and Primary Care identify a patient on a patient to patient basis." (IP06_2)

"I think, before...they were really specific about, I think, it was three or more comorbidities, polypharmacy, high admissions. But then, again, they've had to look at, actually, you might have somebody that meets the criteria of all of those, but is managing their condition really well. You might have somebody that's got one complex, you know, they might have COPD, and they're coming into ED every other week, because they're not managing. So we've had to just be a bit more flexible. So it's a bit more about finding, instead of just getting numbers through, we need to get the right patients. Because it's so important that we are looking at the outcomes. So, you could have 450 patients in the service, tick a box, and say, great, but actually, they might not be the right patients, and we might still end up with the other patients being admitted, so our admission rate hasn't been impacted. Those patients might be going off and booking three appointments a week at their GP. So it's about having the right patients in the service, for the patients' benefits, but also, to meet the outcomes that we want for the service." (IP08_2)

The scope of the Symphony programme has evolved into a full system integration strategy, rather than just integrating primary and secondary care. At the same time, commissioners have been thinking about the Outcomes Based Contract (OBC) in order to have universal incentives (global outcomes) across the system. These are developing slowly. There have been some barriers to what was initially planned. For example, South Somerset is more advanced in terms of integration than the rest of the county, and therefore there has had to be development of two different contracting systems across the county (however, recently – in the last 6 weeks - representatives from an organisation in the East of the county, Mendip, have agreed to come on to the SPB as collaborators). Also, there have been some difficulties in negotiating with the County Council. For example, they have not been allowed to move away from competitive tendering of contracting, meaning workarounds have to be sought to allow the integration envisioned to take place. The County Council are signed up to the Symphony programme as formal partners, but are not in the shared budget therefore. However, they have agreed that they are happy to risk share, and participate in shared care pathways etc (IP01_2).

Some of the original working groups planned as part of the programme have changed slightly, with experience. For example, the hospital now has its own working group dedicated to surgery efficiency. There is also an 'organisational working group' looking at development of the IACO and strengthening primary care. The programme was originally approached by a group of primary care practices in the area stating that they wanted to integrate, and for the Symphony programme to hold the contracts. There have been a number of legal hurdles to try and accomplish this, with new companies being formed to hold the GMS/PMS contracts, and reversibility clauses being incorporated to minimise risk. The result, is that for these integrated practices, Symphony can now be recognised as a single provider, with multiple sites, but only single Care Quality Commission (CQC) responsibilities (IP01_2).

Currently, there is the attempt to make the Programme Board a shadow ACO for now, with hopes to expand to the East of the county in future years. There are some concerns about how this dual contracting might work, however. For example, there is a single Sustainability and Transformation Plan (STP) for the whole county, and it is difficult to see how this aligns with two separate Somerset contracts. IP01_2 also suggested some underlying political issues, e.g. those in other parts of the county questioning why South Somerset is taking the lead on this transformation project. There are also some concerns about Central government input. Some unwanted fiddling with what was planned, plus Vanguard funding at a quarter of what was asked for (and needed for pump priming the implementation of the new models of care) (IP01_2).

There are some additional issues around boundary cut-offs. For example, the Royal United hospital in Bath is not currently involved in the programme, but receives roughly 15% of its referrals from South Somerset practices. They are unlikely to join fully as there are difficulties

for them e.g. this is a small percentage of their total income, and there are at some distance from where the board meets making complete involvement difficult (IP01_2).

Although the care delivery models are currently functioning, they are still in a formation stage although things are starting to embed:

> "the first Complex Care Hub staff started a year ago February, the first health coaches started Autumn 2015, and then we had a huge recruitment drive the early part of 2016 to get staffing for the additional two Complex Care Hubs and the health coaches in primary care. So we've got about 15 health coaches now, we've got eight or nine care coordinators, four or five extensivists and maybe 15 or 20 keyworkers. So you're talking about a lot of staff, who've all come into post predominantly between March and July 2016, so you can imagine that the teams are still forming, learning the ropes, going through their training, all that sort of thing. So the model is still evolving and developing." (IP03_2)

> "So, enhanced primary care is basically health coaches in practices, delivering a new model of care. That part of the project was broken down into three waves. Of the 20 practices that there are across South Somerset, 18 are involved in that process. So, you've got wave one and wave two are now live, so we've recruited health coaches into there. Wave one are obviously starting to develop, sort of, normal running of health coaches, and developing a patient cohort that they're working with. Wave two are just getting to the point of having fully recruited, and are starting to introduce health coaches to their patient cohorts...So, waves one and two are live, that's a group of eight and five, which makes thirteen, with five to go live in wave three, which starts, basically, from now." (IP07_2)

> "It almost feels like we're still, sort of, quite near the beginning, but over the last, sort of, couple of months, it feels like things have moved along quite a bit, it felt like it was stood still for a while and then it, sort of, moved, but there's still, I feel, there's still quite a lot of things that we need to, kind of, bottom out really before I can say that we're, you know, sort of...yeah." (IP09_2)

4.8.3. Future implementation/development

Symphony Healthcare Services Ltd as an organisation has some potential future barriers. The aim of the organisation is to make sure primary care services continue to be sustainable in the locality. In order to achieve this goal, they have taken on some riskier practices e.g. three practices with no GP partners, with potential further recruitment/workforce issues. There have been issues with NHS England. For example, with the choice and competition agenda and potentially being seen as monopolising the health economy. There are also issues with the

overall funding agenda of the NHS. Trusts are expected to balance the books this year, but these new models of care are expected to have outcomes in the longer term and not shorter. IP01_2 suggested that we need to have a rethink at the national level of how we want to make savings in the NHS, and that these should be in the long-term rather than short.

Likewise, there are issues with the capacity of social care services. IP01_2 gave the example that currently there were 64 patients in Yeovil hospital who were ready for discharge, however, the social support required to do this safely was not available. If this support was available, the programme could consider decommissioning services and closing these wards. The major programme barriers were summed up as scale, time and money (IP01_2).

There has already been some input from patients, for example through South Somerset Together. However, the next step is for patient representation directly on the programme board. There is currently discussion about how best to do this e.g. through the local Health Watch may be one approach. The programme managers are keen to have a real lay view, and not an over professionalised patient (IP01_2).

Those interviewed felt that the two separate parts of the model still had to be better joined up to each other, to avoid the care hub being a service patients got stuck in:

> "We are developing that now, because now EPC is just beginning to develop. We are looking it at really as a continuum and patients can move backwards and forwards, hopefully not too much" (IP06_2)

> "I guess one of the things I've identified is the fact that we're not really very good at handing patients back. And we need to make sure that we do that in a way that supports the patients, and also supports the GP… we do want to get to one model of care rather than two. It's about how we manage complex patients. And dovetailing from that is, what falls out of that, is things like, you staff your GP surgeries differently, and manage those patients differently, so they don't create such a resource burden onto your GPs, that you may not have many of" (IP08_2)

There also appears to be work to be done in building and developing relationships between those directly involved in the programme, and those not involved in the core team, as these other services/people still remain critical to delivering care to the patients. However, this appears to be developing slowly, as it is something that takes time to embed:

> "Links, improving links with other organisations, like, better access to consultants - it works, but I don't think that's really built into the system yet. So it's working in ways that - because I've been to these meetings, I know the consultant better, and I can just email and ask them a question...It's kind of cheating, it's just 'cause I know him. I need everybody to know a consultant across the whole system, for the system benefit to

work. That's kind of thinking about it with the board role that I have. But for me, it's beneficial." (IP05_2)

"They may still see physicians obviously in the hospital and they may see their own GP or practice nurses for, you know, routine things like diabetes checks or smears or vaccinations.

I: How does the relationship with physicians who aren't directly involved work out? Has it been quite positive still, are they aware of what the service does?

R: It is variable. You know, if I could back and do things again that will be the one thing I've learnt is, you know, the communication, you know, has been difficult. It's difficult to – even if you send emails or letters out to everybody, the pressure of time, meetings. The understanding of what the service does and what it can offer I think, you know, we are still getting there with that. We still have got people at different stages." (IP06_2)

"I think it's, at times, it's been challenging, it's a new, you know, service trying to come in, especially one like this where it's not been done before and, you know, we've had to look at all of the information sharing agreements, you know, right up through and I think now it's…we're starting to, kind of, embed ourselves in different services, but there's still a way to go before, you know, we're there." (IP09_2)

"But like everything that's new, it comes with its risks. And not everybody is up for something new, and we have to work with those people to explain why it's a good thing." (IP07_2)

"Well, the biggest gap is between the acute inpatient teams, and the Complex Care Hub… And, so we're building relations between our extensivists who go up to our medically fit for discharge ward, which has got your complex patients that are here longer than they should be, for one reason and another. And trying to pull patients, rather than wait for them to be referred, it's that pull rather than push… So it's about starting to pull patients, rather than sitting and waiting. Because GPs are busy, and they don't always think - and equally, the hospital consultants, we've started to get extensivists to go up to the ward, because the consultants might not necessarily think, oh, complex care. Because it's a new service, a new specialty." (IP08_2)

4.9.   Discussion

4.9.1. General discussion

Similarly to the Salford programme, in South Somerset the integrated care plan is still evolving, and is currently at an earlier stage of roll-out than the former. Again, adaptations have had to be made from the plan on paper, to the implementation on the ground.

The South Somerset agenda is built primarily around self-management, with health coaching, and prevention of disease progression the main goals in order to run a sustainable system. However, both programmes ultimately see organisational integration as key to the sustainability problem, but this has been slower to implement than the new models of service delivery.

4.9.2. Discussion of the programme in the context of the conceptual framework

Service delivery

The social needs (and mental health needs) of patients are primarily seen to be what makes a patient complex, rather than the number of conditions.

While self-management is a real focus of the programme, there is the recognition that for many of the most complex patients (highest utilisers), this is not an easy ask, and certainly takes baby-steps to achieve any real meaningful change. By offering the added support through the programme that these patients need, there is also the perceived danger of creating dependency, and simply introducing an additional service/replicating others. Many of the patients are at the end of life as well, and self-management may not always be appropriate (although in some circumstances, this extra control will still be helpful for quality of life).

The life goal setting offered through the shared-decision making health coaching approach is seen as a good first step towards self-management, and the escalation plan as part of the care plan may empower the patient and give them some sense of control. However, this approach is not for everyone, and some patients do not like the changed relationship with their care-provider.

There is lots of room for informal caregiver involvement in the programme, and although this tends to be seen as a positive, there were also safe-guarding issues that arose from this involvement.

Leadership & Governance

Positive leadership and historical relationships between providers were again suggested to be key enablers of being able to integrate care.

Again though, there appeared to be some issues with the boundary of the integrated care programme, and there still appears to be work to be done to fully embed the service, and make sure it links well with those providing care outside of the core team.

Workforce

As in Salford, co-location of services was seen as an enabler of relationship and trust formation between professionals and organisations.

The introduction of new, less professionalised roles to primary care and the care hub were seen as positive in allowing professionals to work to their full capacity, and for the patient, in allowing a person with more time than a doctor to lead day-to-day contacts, potentially able to better assess and deal with the social needs.

However, not all patients liked the change in relationship with the GP, seeing it as a 'downgrading' of their importance and a lack of a powerful mechanism for making any changes to their care. There may therefore be a need for wider cultural change before this type of care is widely accepted and adopted.

Financing

While the national funding to pump-prime the programme was seen as necessary for change, the amount and terms it was given with were questioned.

In addition, there were similar barriers with implementing the wider organisational and funding changes which the programme viewed as necessary for sustainability, due to national competitive tendering and governance policies.

Independently owned GP practices were again seen as particularly difficult to integrate, and South Somerset is also attempting to integrate practices into the hospital to try and take some contractual control, as well as supporting sustainability through risk pooling.

Technologies & Medical Products

As in Salford, the macro-level IT environment in the UK made it particularly difficult to implement a single shared record. National-level prescription (at least in terms of interoperability/compatibility) was seen as essential to enable this to work at any scalable level. More attention to the implementation of such systems (e.g. via the use of theory such as the Normalisation Process Theory) is advisable .

In terms of patient interaction with technology, uptake has so far been poor of the system available, and the current generation (elderly and least IT literate) are not seen as those who are likely to be big users. In addition, there appears to be a more general dilemma, as those who are most complex, and potentially have most to gain from access to their own records and

self-management, are also those who are least likely to have the ability to do so. For some, informal carers might be able to help with this.

While use of telehealth is currently developing and seen as positive in terms of being able to keep patients at home, again this requires active participation by the patient to feed in the measurements, so it is again questionable the extent that this would work for the neediest complex patients with little or no informal carer support.

Information & Research

Similarly to Salford, the data-driven risk tool stratification was seen only as a potentially useful starting point for stratification of patients, where GP knowledge was seen as the ultimate deciding factor. The programmes have now introduced their own 'Symphony score' reflecting this move away from purely data-driven selection. Again, they are also moving to targeting those patients primarily in lower risk levels than the highest band, as they feel there is the most room for preventing future admissions/cost for these patients.

4.10. References

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5. Appendix

Interview partner number	Stakeholder	Interview date
The Salford Integrated Care Programme (SICP) / Salford Together		
IP01_1	Manager of the programme	March 2015
IP02_1	Initiator of the programme	November 2014
IP03_1	Representative(s) of the sponsor/payer	December 2014
IP04_1	Representative(s) of the sponsor/payer	November 2014
IP05_1	Physician 1 (GP)	September 2015
IP06_1	Physician 2 (Geriatrician)	September 2015
IP07_1	Informal caregiver 1	February 2016
IP08_1	Informal caregiver 2	November 2015
IP09_1	Social worker	May 2015
IP10_1	Mental health worker	October 2015
IP11_1	Patient engagement worker	October 2015
IP12_1	Health improvement officer	June 2015
IP13_1	Patient	June 2016
South Somerset Symphony Programme		
IP01_2	Manager/ initiator of the programme	August 2016
IP02_2	Nurse/ initiator of the programme	August 2016
IP03_2	Physiotherapist/ initiator of the programme	August 2016
IP04_2	Patient	August 2016
IP05_2	Physician 1 (GP)	August 2016
IP06_2	Physician 2 (Extensivist GP)	August 2016
IP07_2	Project manager 1	August 2016
IP08_2	Project manager 2	August 2016
IP09_2	Care Co-ordinator	August 2016

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