Salford Together
Annual Report 2014/15

A Partnership between Salford City Council, NHS Salford Clinical Commissioning Group, Salford Royal NHS Foundation Trust and Greater Manchester West Mental Health NHS Foundation Trust.
The work has been led through three key workstreams:

- Community Assets - working closely with neighbourhoods to develop opportunities and activities where people are better able to support each other and themselves.
- Centre of Contact - a single integrated hub for the co-ordination of social care and community health service provision.
- Multi-disciplinary Groups (MDGs) - where those individuals deemed most vulnerable are supported through co-ordinated care and support plans. The MDGs include GPs, Social Workers, District Nurses, Practice Nurses, Community Mental Health Workers, Community Geriatricians and a representative from the Health Improvement Team.

Teams across the city have worked extremely hard during 2014/15 to bring about and start to embed changes which will provide strong building blocks for the further development of integrated care across Salford going forward.

I would like to take this opportunity to thank Sue Lightup, Strategic Director for Community Health and Social Care at Salford City Council, as the co-chair for the Alliance Board who has championed this programme since its inception, prior to her retirement in June. Also, my thanks go to Alan Campbell, Chief Operating Officer at Salford Clinical Commissioning Group, who too has recently retired but who also with Sue, has given leadership across the city to assist in ensuring the programme became part of the ‘day job’ in providing effective and responsive support to those individuals requiring it.

Though we talk about services and support, it is of paramount importance that we remember this is essentially about promoting health and independence in older people working with all partners, community groups and individuals to realise the potential in each and all of us, to achieve this singular aim.
Salford Together is a partnership between Salford City Council, NHS Salford Clinical Commissioning Group, Salford Royal NHS Foundation Trust and Greater Manchester West Mental Health NHS Foundation Trust.

Salford partners have been working together for over two years to drive the implementation of the Salford Together Integrated Care for Older People programme, through pooled health and social care budgets and joint decision making.

This partnership brings together the work of GPs, District Nurses, social workers, mental health professionals, care homes, voluntary organisations and local hospitals into a more aligned system with the aim of supporting those people who are well and healthy to stay active so they stay healthier for longer, and to help those who have a health or social care need to improve their quality of life and independence, with an overall focus on improving the health and wellbeing of all older people across the city.

Why the focus on older people?
It is recognised that a variety of groups would benefit from integrated care, however for the last 2 years the decision has been to focus on older people. There are a number of reasons for this.

1. Older people account for a high use of health and social care services.
2. Older people often have long term care needs and are therefore more likely to benefit from better care planning and coordination across health and social care.
3. There is good evidence that integrated care for older people can deliver better outcomes, improve experience and result in cost savings.
4. Older people can be socially isolated with a reduced quality of life. Quite often, they receive fragmented care and are not supported to care for themselves.
5. Salford has some of the highest rates of emergency admissions and readmissions to hospital.
6. Salford has some of the highest permanent admissions to residential and nursing care.
7. Salford has too many people receiving end of life care in hospital rather than at home or their preferred place.
8. A significant proportion of health and social care expenditure in Salford relates to older people and this will only increase as the population continues to live longer. Currently in Salford there are more than 35,000 people aged 65 or older and this number is set to rise. It is expected that by 2030, there will be more than 43,000 older people across the city and a large number of these will have long term health conditions.

1 - Salford Together is the logo and branding which was designed to represent the integrated working of all the main partners. This logo was created after extensive professional public consultation. The design uses the S for Salford, with blue at the top of the S which represents the NHS, the magenta at the bottom which represents Salford City Council and the purple in the middle of the S which represents the integrated working of the statutory organisations.
It has a triple aim to:
1. Deliver better health and social care outcomes.
2. Improve the experience of service users and carers.
3. Reduce overall health and social care costs.

Salford Together aim is to transform local the health and social care system, promoting greater independence for older people and delivering more integrated care.

**Aims**

**INTEGRATED CARE PROGRAMME**

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<tr>
<th>Aim</th>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
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<tbody>
<tr>
<td>Achieving greater independence and improved wellbeing for older people in Salford by integrating care within communities</td>
<td>Create greater independence and resilience within communities through the increased use of local assets</td>
<td>Map existing assets within both neighbourhoods</td>
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<td>Help older people navigate services and support themselves through the use of new technologies and the creation of an integrated care hub</td>
<td>Engage older people to identify those assets that are most valued</td>
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<td>Increase access to local community groups</td>
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<td>Expand befriending and volunteer support</td>
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<td>Develop inter-generational support through working with local schools</td>
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<td>Increase prevention and early intervention</td>
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<td>Deliver a structured approach to population health &amp; wellbeing, with targeted support to those most at risk and their carers, through multidisciplinary working</td>
<td>Implement solutions that support self care</td>
<td>Implement assistive living technologies</td>
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<td>Develop an information portal and directory of services / support</td>
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<td>Rationalise the number of points of contact for older people</td>
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<td>Provide structured support post discharge from hospital</td>
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**Alliance Board The Leadership Team**

- **Steve Dixon** - Chief Finance Officer, Salford CCG
- **Karen Proctor** - Head of Performance and Commissioning Support, Salford CCG
- **Alan Campbell** - Chief Operating Officer, Salford CCG
- **Paul Newman** - Lay Member, CCG
- **Hamish Stedman** - Chair, Salford CCG
- **Keith Darragh** - Assistant Director (Safeguarding, Quality and Business Strategy), SCC
- **Jennifer McGovern** - Assistant Director / Integrated Commissioning and Personalisation, SCC
- **Councillor Connor** - SCC
- **Dave Clemmett** - Assistant Director / Operational Services, SCC
- **David Herne** - Director of Public Health, SCC
- **Neil Thornton** - Director of Finance and Corporate Business, SCC
- **Charlotte Ramsden** - Strategic Director for Adult and Childrens Services, SCC
- **David Dalton** - Chief Executive, SRFT
- **Ian Moston** - Director of Finance, SRFT
- **Melanie Walters** - ICP Programme Manager, SRFT
- **Jack Sharp** - Executive Director of Service Strategy and Development
- **Chris Evans** - Interim Divisional Managing Director for Salford Health Care, SRFT
- **Liz Calder** - Associate Director of Strategy, SRFT
- **June Roberts** - Assistant Director of Nursing Adult Community Services, Intermediate Care, Palliative Care Team, Integrated IV Service and Salford Care Homes Practice, SRFT
- **Anne Williams** - Non-Exec Director, SRFT
- **Elaine Inglisby-Burke** - Executive Nurse Director
- **Ismail Hafeji** - Director of Finance and IT, GMW
- **Gill Green** - Director of Nursing and Operations, GMW
- **Penny Evans** - Head of Operations, GMW
- **Dr Paul Bishop** - Strategic Partnerships and Planning Clinical Lead CCG / Co-Chair Alliance Board
- **Jenny Walton** - ICP Clinical Lead and LMC Representative
As described in the introduction there are four statutory partners to Salford Together, Salford City Council, NHS Salford Clinical Commissioning Group, Salford Royal NHS Foundation Trust and Greater Manchester West NHS Mental Health Foundation Trust.

There are however, many more organisations and community groups and local Salford citizens who are actively involved in working hard on integrating health and social care services across Salford.

These include but are not limited to:

- Age UK
- Citizens Reference Group
- Barton Ladies Group
- Care homes Sector
- Chamber of Commerce
- Citizens Advice Bureau
- City West Housing Trust
- Community Pharmacy
- District Nurses
- Domiciliary Care Providers
- Fire Prevention Service
- General Practitioners
- Great Places
- Helping Hands
- Home Improvement Agency
- Inspiring Communities Together
- Local hospitals
- Citizens Reference Group
- Mental health professionals
- Pendleton Together
- Salford Community Leisure
- Salford CVS
- Salford Multi-Faith Forum
- Salix Homes
- Social Workers
- Unlimited Potential
- Your Housing Group
- Other third sector organisations

A key component of the programme has been listening to local citizens, and involving them in the co-production of the programme. Older people have been engaged through two complementary approaches:

**The Citizen Reference Group (CRG)**
This formal structure was established as part of the ICP programme. The group of local older people are supported through a development worker and meet monthly to look at aspects of the programme – acting as a critical friend. Members engage with areas of work which interest them and act as ambassadors for the programme by sharing key messages from the programme with their own networks.

**The community asset work stream**
Project group have engaged with older people through the network of partners who attend the monthly meetings (housing providers, development workers, third sector organisations, health workers and Salford City Council).

Older people are invited to take part in workshops and focus groups to understand what is important to them to support their own health and well being.

Older people have taken part in the wider lessons learnt events, taken part in presentations on the ICP and worked with health professionals to coproduce tools which support older people to stay healthy and well.
healthy  Informed  Involved  mobile  Secure
Active  Happy  Supported
Independent  Motivated
Connected
For Salford Together, our focus is on promoting wellbeing and independence for everyone aged 65 and older, looking at both the individual and the environment.

For the individual, four levels of support and need have been identified, with an emphasis on supporting citizens to maintain their independence and wellbeing and when intervention is required it is at an early stage and coordinated across health and social care teams to ensure proactive and appropriate support is received.

The four levels are set out below:

**LEVEL OF INTERVENTION BASED ON NEED.**

Further detail and progress to date is described in the Improving Health and Wellbeing section on page 14. The five main workstreams have been summarised below:

2. Centre of Contact.
4. Housing Workstream.
5. Care Home and Supported Living Workstream.

Focus starts on prevention through completion of wellbeing plans, progressing through to advanced and end of life care planning as appropriate, supported by care services.

Standards are put in place to standardise the quality of care across the City.
ANNUAL REPORT 2014/15

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

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

Multi Disciplinary 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.

SALFORD’S INTEGRATED PROGRAMME.

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

1. Local community assets
2. Centre of Contact
3. Multi Disciplinary Groups

The wellbeing plan
The ‘Wellbeing Plan’ was developed with older people, to support them to help themselves and others understand what is important to keep them healthy and well, now and in the future. The Wellbeing Plan is based on the NHS Five Ways to Wellbeing:

2020 targets - what and why?

Emergency admissions and readmissions
- 19.7% reduction in NEL admissions (from 315 to 253 per 1000 ppn).
- Reduce readmissions from baseline.
- Cash-ability will be effected by a variety of factors

Permanent admissions to residential and nursing care
- 26% reduction in care home admissions (from 946 to 699 per 100,000 ppn).
- Savings directly cashable but need to be offset by cost of alternative care (especially increased domiciliary care)

Flu vaccine uptake for Older People
- Increase flu uptake rate to 85% (from baseline of 77.2%)

Proportion of Older People that are able to die at home
- Increase to 50% (from baseline of 41%)

Quality of Life, Managing own Condition, Satisfaction
- Maintain or improve position in upper quartile for global measures.
- Use of a variety of individual reported outcome measures

Additional local measure selected for Better Care Fund
- Diagnosis of Dementia against estimated prevalence rates - BCF.
Our Achievements in 2014/15

- Integrated Care Board transitioned into the Alliance Board May 2014.
- Alliance Contract: Section 75 pooled budget arrangements in place from April 2015. Pooled budget of almost £98M, made up of services largely commissioned for older people by Salford City Council and Salford CCG, which includes some services provided by the third sector and independent providers.
- The Alliance agreement was signed off by all partners in October 2014.
- Salford Together branding introduced to represent partnership between the four partners.
- Multi-disciplinary Groups are now active in all neighbourhoods in Salford.
- Salford 65+ population has been segmented, using the risk stratification methodology, developed as part of the neighbourhood collaborative work.
- An electronic shared care summary record has been developed in the hospital electronic patient record which can be accessed by hospital, community, mental health, social workers, GPs and practice nurses for those patients under their care.
- The Centre for Contact was established in November 2014 when Single Entry Point for Intermediate Care collocated with the Adult Social Care Contact Centre.
- Dedicated housing workstream established which includes housing partners, Fire Prevention Service, Helping Hands, Home Improvement Agency, and Hospital Aftercare Service.
- 4400 Older people living with 2 or more long term conditions are assisting in evaluating support provided by health and social care in Salford. The 2 year long evaluation is being undertaken by Manchester University with funding from the National Institute of Health Research.
- Wellbeing plans were launched in Autumn 2014, following co-design with community organisations and older people.
- Age UK Salford with Salford Royal were jointly chosen as one of five Malnutrition pilots across the country. The initiatives taken forward during the pilot have been fully adopted within the Salford Together programme.
- We recruited a development worker and volunteer co-ordinator to support the community asset work.
- Carried out a number of small projects which are now being scaled up, including tech and tea, eating well in later life and improving access to physical activity.
- Carried out community asset mapping across neighbourhoods.
- The ICP/ICO Stakeholder Event Development Day held on the 26th March 2015 had approximately 140 attendees. Overall the feedback showed continued optimism and support for the benefits of integration and progression to even closer working as part of an ICO. The images below over were drawn by a scribe at the event, and assist in summarising key points discussed on the day.

Milestone Calendar 2014/15

Update from the individual workstreams and programme sub-groups can be found in ‘Improving health and Wellbeing’ section.

**February**
- Initial submission to Better Care Fund agreed through Health and Wellbeing Board.

**March**
- Malnutrition Taskforce (1of 5 sites).

**May**
- Integrated Care Board became the Alliance Board.
- Alliance Agreement -£98.7 M health and social care spend for 65+ in a section 75.

**June - July**
- Salford Together branding.

**July - January**
- Business cases developed and approved to support the model and implementation.

**September**
- BCF refresh submitted & approved.

**March**
- Cabinet visit from policy advisors
- Salford Together website
- ‘CLASSIC’ National Institute for Health Research - Manchester University, evaluation of the programme, now recruited their patient cohort.
**Finances and Service Plan**

**FINANCIAL INVESTMENTS 2014-15**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount (£)</th>
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<tbody>
<tr>
<td>Investments in new responsibilities and demographic pressures</td>
<td>215,000</td>
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<tr>
<td>New model of care in the community - Community Geriatrician and Elderly Care Physicians</td>
<td>12,000</td>
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<tr>
<td>Integrated Care Programme costs</td>
<td>556,000</td>
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<tr>
<td>Shared Care Records</td>
<td>140,000</td>
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<tr>
<td>Centre of Contact – additional investment</td>
<td>139,000</td>
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<tr>
<td>Community Assets</td>
<td>24,000</td>
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<tr>
<td>Multidisciplinary Teams – GP Backfill</td>
<td>111,000</td>
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<tr>
<td>Multidisciplinary Teams non-GP Backfill</td>
<td>169,000</td>
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<tr>
<td><strong>Total spend 2014-15</strong></td>
<td><strong>1,336,000</strong></td>
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Part of this process has been to self-assess Salford’s position using AQuA’s ‘Leadership for Integration’ framework.

The ‘Leadership for Integration’ framework identifies eight domains that play an important role in the effective integration of care within an economy. Each domain is scored on a 1-5 scale (1 being the least developed, 5 being the most progressed).

The December 2014 self-assessment was completed by 16 representatives from the partner organisations.

Overall, there has been an improvement in the scores for all eight domains, with most improvement in ‘user & carer experience’, ‘workforce’ and ‘service redesign’. This would appear to reflect the move to implementation and rollout of the model, which has included recruitment of additional staff and ‘new ways of working’ for the Centre of Contact and the Multidisciplinary Groups. Although the scores for ‘leadership’ and ‘culture’ have both improved, there is quite a degree of variation in individual scores. It is unclear whether this reflects a perception that about how the overall programme is currently functioning against position on ‘the journey’ or whether this is a product of different interpretations of the scoring criteria.

**CLASSIC**

Is the NIHR funded evaluation of the Salford Integrated Care Programme (NIHR HS&DR 12/130/33). It is a research programme which incorporates:

- A cohort of over 4000 elderly people from Salford.
- Process Evaluations of the ICP at both system wide and MDGs/Centre for Contact levels.
- Health Economics Outcomes.
- Health Coaching within the ICP Centre for Contact.
- PPI work with elderly Salford Residents.
The period up to March 2015 saw the setup of the Cohort with the assistance of NWEH’s FARSITE and 33 of the 50 Salford GPs. Over 13,000 surveys were mailed out to elderly people in Salford between December 2014 and March 2015 and 4380 (34%) responded.

This response forms the baseline for the cohort which will be followed up 4 times in the period up to September 2015.

CLASSIC also looks at how the SICP was set up and well as the results. The system wide Process Evaluation involved 22 face to face interviews with staff from the ICP and 22 observations of stakeholder meetings. The initial findings from this research have been presented at the Health Services Research Network Conference (Nottingham, July, 2015).

CLASSIC has been informed by Public Patient Involvement work with a team of Salford volunteers. The elderly people assist the research team by giving their opinions on the nature and roll out of the survey and also any sub projects within CLASSIC. The PPI team met the

CLASSIC team for the first official meeting at St Frederick’s community Centre on 25th March to discuss our survey responses and approaches to elderly residents to take part in further research.

The period up to April 2015 saw CLASSIC making good progress to the foundations to complete the planned evaluation of three core SICP outcomes:

- Increasing satisfaction with the care and support provided to older people.
- Increasing proportion of older people feeling supported to manage their own conditions.
- Improving quality of life for users and carers.

The next phase of CLASSIC will involve the Health Economic evaluations of the MDGs and a Health Coaching sub project for up to 250 elderly patients in the Centre for Contact.
Improving Health and Wellbeing

Focus on work themes.

Community Assets

- The community asset work stream project group has a membership of 35 people from organisations across Salford who all bring different skills and knowledge. The network includes a wide range of partners ranging from mature people, Salford City Council, Salford University, Housing providers, Local Businesses, Charities, Social Enterprises, and Third Sector organisations, all working across a number of areas including housing, volunteering, befriending and Leisure and Health Improvement connections.

- Community asset model:
  - A Sally Friendly City - the commitment of the city to support older people to stay healthy and well.
  - Sally Standards and Sally well being plans - the commitment by older people to support their own health and well being.
  - A set of tools developed by and for older people based in local neighbourhoods - the commitment of community and deliverers to support older people to stay healthy and well. The model developed by the community asset working group looks to address the barriers which effect older people and increase the risk of social isolation, loneliness or depression.
  - The barriers identified are: Limited physical activity, lack of access to information, not eating well, not engaged in activity. By addressing these barriers we will be able to:
    - Reduce emergency admissions.
    - Improved quality of life for users and carers.
    - Increase the proportion of people that feel supported to manage own condition.
    - Activity during 2014-15
      - Limited physical activity – Step up classes.
      - Not eating well – Malnutrition tools.
      - Lack of access to information - Tech and tea.
      - Community asset mapping – Salford Together Development Worker.
      - Volunteering – Salford Together Volunteer Coordinator.
      - Engagement of older people.

- Initial investment saw a Salford Together Development worker hosted by Inspiring Communities Together and a Volunteer Co-ordinator post, hosted by Salford CVS.
Improving Health and Wellbeing

Rapid Response referral came in to the newly collocated Intermediate Care Single Entry Point.

The clinician and social worker looked at the information and discussed with the referrer (GP). The response was a temporary increase to the current support package. The outcome for the service user was that the increase to the current support package was instant; under the previous system this would have involved a Rapid Response triage, Rapid Response attendance and then a referral to the Adult Social Care Contact Team.

Benefits —
The new pathway enabled an immediate solution for the service user and saved approx. 6 hours of professional time and up to 1 day for the patient.

Centre for Contact
The Centre of Contact will deliver a joined-up approach to health information, advice and support for health and social care.

The Salford population, Salford Together staff and clinicians will be able to access help and advice through a web portal or over the telephone. While the rest of the integrated care programme is aimed at older people, this element is for the use of everyone in Salford, regardless of their age.

Progress to Date:
- Intermediate Care Single Entry Point, the Adult Social Care Contact Team and District Nurse Administration teams are now co-located and will be renamed S.I.R.P. (Salford Integrated Referral Point).
- CareFirst and ELMS (Equipment Loan Management Service) integrated into CITIZEN – the Council’s Customer Relation Management System, as part of the Software Solution.
- Health Coaching being developed, in conjunction with the CLASSIC research programme and Hitachi as a commercial partner.
- Out of Hours work stream started, to ensure better join up of exiting services, including Care on Call.
Multidisciplinary Groups (MDGs)

A neighbourhood Multidisciplinary Group or MDG, is a group of health care workers and social care professionals who unite as a team to ensure the planning and implementation of person-centred care and its delivery for individuals who require support. The groups include:

- A GP and/or Practice Nurse.
- Social care worker.
- District Nurse.
- Mental health worker.
- Administrator.
- Pharmacist.
- Community Geriatrician.
- Health Improvement Service representative.

The Integrated Care Programme (ICP) Multi-Disciplinary Groups (MDGs) & Care Coordination Operational Procedure—was devised and implemented in December 2014. The purpose of the operational procedure was to describe for MDG members, the six essential elements and process of the model required to deliver person-centred care for people requiring a level of care co-ordination between health and social care services to promote wellbeing and independence. The six elements are:

1. A holistic assessment of health and social care needs.
2. Joint working, risk stratification and decision making with all organisations/agencies involved in order to deliver person-centred care.
3. Regular MDG reviews to plan person-centred care, review and amend care and to signpost to community support as required.
4. The appointment of a named Care Coordinator.
5. The development of an electronic summary Shared Care Record to enable essential information to be shared between statutory agencies.
6. An agreed Shared Care Plan within the Shared Care Record based on Multi-Disciplinary (MDG) working.

Progress in 2014/15

- Rolled out MDGs across all neighbourhoods using a phased approach in 3 waves.
- Recruited 3 x MDG Coordinator posts and provided training in order to facilitate MDGs in localities.
- Electronic Shared Care Record went live in November 2014, giving access to Mental Health, Social Care and GPs to SRFT’s Electronic Patient Record ensures that activity recorded for a patient can now be shared with additional community services. This includes rolling out a training programme for the staff across the 4 partner organisations and negotiating access. Approximately 1400 shared care records have now been completed for level 3 (Needs More Help Sally) patients.
- Development and sign off of a Data Sharing Agreement across the 47 partner organisations with further development to look at 3rd sector organisations such as Age UK who provide a hospital aftercare service.
- Further engagement with additional GP practices across the city.
- Developing tests of change to share information regarding patients who live on boundaries with neighbouring areas; i.e. Bolton, Warrington, North Manchester et al.

This procedure has now been implemented across all 7 neighbourhood MDGs and is due for evaluating and updating shortly.
Improving Health and Wellbeing

The housing work stream brings together partners from health and housing.

**Housing**

This includes providers of social housing (e.g. City West, Together Housing, Salix and Great Places) as well as a representative from the City Council who works in the area of people living in their own homes and privately rented housing.

The group has recently recruited members from the Fire Prevention Service, Helping Hands, the Home Improvement Agency and the Hospital Aftercare Service. The group aims to strengthen the links between health and housing to improve the care that older people receive.

**Care Home and Supported Living Workstream**

The Care Home and Supported Living Workstream is focused on the 'needs a lot of help' level, for people who require a high level of support from health and social care services either in extra care facilities or residential or nesting care homes.

The aim of the group is to support the improvement of the quality of care on offer in care homes and supported accommodations and decrease the variance in quality across providers in the city.

**Progress in 2014/15**

- **Health & Housing Strategic Partnership Group formed.**
- **Housing work stream now linked into the CCG flu group.** Tests of change carried out by the group have enabled the development of an action plan for the 2015/16 flu season. Helping Hands and the Home Improvement Agency have promoted the flu jab across their services.
- **Worked with Lombardy Court to carry out a ‘deep dive’ on data relating to falls, isolation, loneliness, equipment and the well-being plan in order to effect change.**

- **Managing Falls in Extra Care.** Following a successful test of change. Mangar Lifting cushions and training are now in place in all of the extra care facilities. Data is being collated by each care provider on usage and impact on reduction of calls to NWAS.
- **Volunteering in Care Home Pilot.** Project. Work took place during 2014/15 to develop this scheme and two care homes are now participating on this pilot project. This project is being supported by Siobhan Foley - Volunteering Co-ordinator (Older People) Salford CVS as a test of change with a view to rolling out to more care homes which do not have in house Activity Coordinators. This test will also link with the START art lottery funded project for art activities in care homes.
- **Age UK Discharge and Reablement Service access to SCR.** Work is progressing with Age UK, Discharge and Reablement Service, with a view to giving them access to input their assessments on to the ICP Shared Care Record. Patient profiling is underway of the patients that this service works with, in order to better understand this group.
• Care Homes Training Database. The workstream has collated information on the range of free planned and bespoke training on offer to care homes, with a view to having a more coordinated approach to the training offer in the future and to identify any gaps in provision, in order for care homes to meet the training requirements in the revised care home service specification. It also aims to identify the training that care homes buy in from private providers.

• Salford Advance Care Planning Document has been jointly developed with the Dementia Champions Group. This document is based on the national Preferred Priorities for Care (PPC), called Planning My Future Care. This document will be launched in 15/16 and will be used by all the Salford providers.

• Medical Advance care Plan. The Salford Care Homes Practice has developed and implemented a Medical Advance Care Plan.

• Discharge Communication. Improved personalised discharge info is now being entered onto the discharge summary to assist patients and carers in the transition to home from hospital.

• Risk Stratification. The Salford Care Homes Practice has READ coded all of their patients as Level 4 sally, N approx=1116.

• MDG meeting with CHP and GMW now embedded in routine practice and can evidence early intervention and referral avoidance.

Care Homes Quality Assurance Development Group

As a result of some of the qualitative issues identified in Care Homes through the work of the Care Homes and Supported Living Workstream, at the request of the Steering Group a new meeting was established within the ICP early 2015 to oversee the development of an integrated approach and system for the performance and quality monitoring by care homes.

This has been established in the context of the revised Care Homes contract offer and service specification. The ICP has set money aside to pay the sector a quality premium if they meet the standards set out in the revised service specification.

It was identified that there was no local mechanism for measuring this so the group has been tasked over the next 12 months to develop an integrated assurance process and to identify what market support is required to enable the providers to meet the agreed specification and KPIs. The group meets on a bi weekly basis and has now agreed a draft set of KPIs, which will shortly go out to wider marker consultation.
Improving Health and Wellbeing

www.malnutritiontaskforce.org.uk/prevention-programme/

In 2014 Salford was chosen as one of the five pilot sites in a national programme funded by the Malnutrition Task Force (MTF) to address malnutrition across the city.

Salford has one of the highest admission rates related to malnutrition in the county and in the North West.

The Salford Malnutrition Task Force includes staff from Age UK Salford, Salford Royal NHS Foundation Trust, Salford Clinical Commissioning Group, Salford City Council and Greater Manchester West Mental Health NHS Foundation Trust. The programme is designed to raise awareness of the signs of under nutrition and to develop tools to ensure older people receive the right level of support to keep healthy and well.

During 2014/2015 the task force has:

• Developed a Malnutrition Care Bundle which includes:

  1) A Salford nutritional armband©, which signposts adults with a BMI of <20kg/m² to the Salford Age UK website nutrition section by a QR code. This nutrition section on the Age UK Salford website contains public, service user and carer literature on how to identify and self-help for unplanned weight loss. The dietary information leaflets on the Age UK Salford website were written by Salford residents and dietitians.

  2) E-learning package for carers on malnutrition and dysphagia.

  3) Access to assisted shopping trips to local supermarkets.

www.ageuk.org.uk/salford/news-campaigns/malnutrition-prevention-pilot

http://www.salford.gov.uk/sctp-elearning.htm
Flu

27,908 seasonal influenza jabs delivered to over 65s in 2014/2015
Increase of 188 in comparison to 2013/14

Re-ablement

1,026 people going through re-ablement services

Community Assets

No. of events held – well being training network elected members older person champions. 4 older people presented at The North West elected members older person champions network.

No. of older people attending events - 50 older people attended drop in session at Tesco to find out about well being plans. 4 older people presented at The North West elected members older person champions network.

No. of events held – well being training (14 different organisations attending), peer review run by GMPH looking at community resilience.

No. of staff recruited - 1 Salford Together development worker

No. of projects developed with older people in community assets workstream - (Sally Standards, eating well in latter life, Salford Together logo, intergenerational tech and tea project, age friendly city draft model)

No. of older people attending events - 50 older people attended drop in session at Tesco to find out about well being plans. 4 older people presented at The North West elected members older person champions network.

No. of events held – well being training (14 different organisations attending), peer review run by GMPH looking at community resilience.

MDGs

7 MDGs in operation across 5 neighbourhoods.
Recruitment
- 2 x administrators
- 7 x District/Community Nurses
- 6 x Social Care Advanced Practitioners
- 3 x Mental Health Workers

Community Assets

No. of events held – well being training network elected members older person champions. 4 older people presented at The North West elected members older person champions network.

No. of older people attending events - 50 older people attended drop in session at Tesco to find out about well being plans. 4 older people presented at The North West elected members older person champions network.

No. of events held – well being training (14 different organisations attending), peer review run by GMPH looking at community resilience.
The task force held a very successful celebration event on the 18th March 2015 at Albert’s Restaurant in Salford.

Celebration Event
With over 80 people in attendance from a range of statutory services, third sector, service providers and representation from the National MTF team and Age UK England. The event showcased the work and progress to date of the task force over the last 12 months and promoted the range of public health and service provider products that have been produced.

There were over 60 pledges from attendees on how they plan to take this work forward and these have been formatted into a word cloud and will be following up 6 months after the event.

Project Sustainability
The 12 month pilot project with support from national Age UK and an AQUA affiliate officially ended at the end of March 2015. However the group have committed to continue this work. In February 2015 a bid was submitted to the Health Foundation for funding to create a post and process to evaluate the effectiveness of the suite of products.
Risks
• The Programme fails to deliver against its planned improvement measures, risking receipt of some performance related funding from the BCF.
• Other, interdependent strategic change programmes (Greater Manchester Healthier Together and Primary Care Strategy) fail to deliver to planned timescales.
• Full range of Adult Social Care statutory functions and responsibilities may not be fully recognised to manage risks to vulnerable people.
• The cost of delivering the revised service model is greater than assumed in the financial model or there are ‘double running’ costs.
• Sign up to the Avoidable Admissions Enhanced Service is optional and could affect the roll out/engagement of the MDGs if viewed in a negative way.
• Partners not engaged in supporting Sally to complete wellbeing plans.
• Lack of engagement from the services involved.

Challenges
• Shortfall in recruitment of staff in primary care, district nursing and social care may cause difficulties in effectively delivering the model across primary and community services.
• Maintaining older people in community based settings may compromise the safety of clinical care provided or delay access to necessary specialist hospital based services or nursing/residential care.
• The introduction of the Care Act will result in a significant increase in the cost of care provision from April 2016 onwards, which is difficult to estimate at this stage. This will impact on the sustainability of current social care funding and plans.
• Ensuring the planned health and social care savings within the ICP pooled budget are fully realised.
• Providing an integrated IT solution that could auto-populate from existing operational systems used in services, to avoid duplication of work and reduce workload.
• The key challenge for the community asset work stream is being able to evidence the impact the work is having on improving lives for older people against the key aims identified through the Integrated Care for older people programme. The community asset approach is developing evaluation tools by working with Manchester University along side collecting case studies and individual stories of peoples journey.
• Staff and the public place too much unnecessary demand through the centre of contact instead of using other internal channels of communication available.
• Approximately 80,000 dwellings in Salford are privately owned or private rented whilst only approximately 30,000 are social housing. This creates a challenge in terms of reaching and effecting change in the most vulnerable of our older people in Salford.
The next stage of the programme is the development of the Integrated Care Organisation, which will follow the process and timescales outlined here.

**Looking forward:**

<table>
<thead>
<tr>
<th>PHASE ONE</th>
<th>TO MAY 2015</th>
<th>Due Diligence &amp; Formal Decisions (OBC)</th>
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<tbody>
<tr>
<td>PHASE TWO</td>
<td>MAY - SEPT 2015</td>
<td>Shadow Governance, Commissioner and Provider</td>
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<tr>
<td>PHASE THREE</td>
<td>BY END OF 2015/16</td>
<td>Establish commissioning system Create Integrated Care Provider Organisation</td>
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<tr>
<td>PHASE FOUR</td>
<td>2016/17</td>
<td>Evaluation / Review / Planning for the next stage</td>
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</tbody>
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Salford Together has been selected to be involved in the National Vanguard Programme, which will provide additional opportunities in Salford to redesign services, to become more timely, responsive, and create an environment where communities are connected and supported.

Citizens of Salford will be encouraged to take responsibility for their health and wellbeing, and the health and wellbeing of their communities. Salford Together will provide an environment where taking this responsibility is enjoyable, rewarding and self-promoting.
### Glossary of Terms

<table>
<thead>
<tr>
<th>TERM</th>
<th>DEFINITION</th>
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<tbody>
<tr>
<td>MDG</td>
<td>Multi-Disciplinary Group</td>
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<tr>
<td>MDT</td>
<td>Multi-Disciplinary Team</td>
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<td>ICP</td>
<td>Integrated Care Programme</td>
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<td>BCF</td>
<td>Better Care Fund</td>
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<td>SCR</td>
<td>Shared Care Record</td>
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<td>SCP</td>
<td>Shared Care Plan</td>
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<tr>
<td>RISK STRATIFICATION</td>
<td>A statistical process to determine detectable characteristic associated with an increased chance of experiencing unwanted outcomes</td>
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<td>PERSON CENTRED CARE</td>
<td>The Health Foundation has identified a framework that comprises four principles of person-centred care:</td>
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<tr>
<td></td>
<td>1. Affording people dignity, compassion and respect.</td>
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<td></td>
<td>2. Offering coordinated care, support or treatment.</td>
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<tr>
<td></td>
<td>3. Offering personalised care, support or treatment.</td>
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<tr>
<td></td>
<td>4. Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.</td>
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</table>
How to improve your food and drink intake if you have a poor appetite