KENT PUBLIC HEALTH OBSERVATORY

Kent Joint Strategic Needs Assessment (Kent JSNA)

Kent 'Health and Social Care Integration Pioneer (HASCIP)' JSNA Chapter Summary Update '2014/15'

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Kent Health and Social Care Integration JSNA Chapter Update 2014

Introduction

The Health and Social Care Integration Programme (HASCIP) is about the delivery of the model of services for successful integrated care. Since 2012 HASCIP has been working across Kent within clinical commissioning group (CCG) areas to implement a programme with the objective of "Making life-changing improvements to the experience and outcomes of people using health and social care services in Kent". The vision, strategic objectives and outcomes were based on the agreed compact between Kent County Council, Kent Community Health NHS Trust and Kent and Medway Partnership Trust to work together to implement integrated health and social care in Kent.

This was based around the long term condition model of care focusing on:

- risk stratification
- care co-ordination
- self management

In November 2013 Kent was successful in becoming one of fourteen national Integrated Care and Support Pioneers with the aim of delivering integrated care and support at pace and scale by 2018. This has resulted in the reframing of HASCIP to the pioneer programme supported by the 23 partners involved in developing the Kent pioneer submission.

Integrated Care and Support Pioneer Programme

As an integration pioneer, Kent supports the vision as outlined by The Narrative in Integrated Care and Support, Our Shared Commitment (Department of Health 2013): "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

In Kent this means developing services with the citizen at the centre, with services wrapped around what is important to them:

By 2018 we want to achieve an integrated system that is sustainable for the future and crosses the boundaries between primary, community, hospital and social care, with services working together, alongside voluntary organisations and other independent sector organisations. There will be improved outcomes for Kent's 1.5 million population.

Our plan involves building on existing joint working, whilst recognising that we need to increase the scale and pace of what we want to achieve. We want to do some things differently. Within the Kent Integration Pioneer Programme we have identified a number of specific outcomes which we want to achieve in five years to achieve whole system transformation and result in integrated commissioning of integrated provision. These are:

Integrated Commissioning:

a Together we will design and commission new systems-wide models of care that ensure the financial sustainability of health and social care services in Kent. These services will give people every opportunity to receive personalised care at, or closer to, home to avoid hospital and care home admissions.

b We will use an integrated commissioning approach to buy integrated health and social care services where this makes sense.

c The Health and Wellbeing Board will be an established systems leader, supported by clinical co-design and strong links to innovation, evaluation and research networks. Integrated commissioning will achieve the shift from spend and activity in acute and residential care to community services, underpinned by the JSNA, the Year of Care (YoC) financial model and risk stratification. We will have a locally agreed tariff system across health and

social care commissioning based on the Year of Care funding model. This will allocate risk adjusted budgets, co-managed and owned by the integrated teams and patients.

d We will see integrated budget arrangements through Section 75 agreements as the norm, alongside integrated personal budgets.

e New procurement models, such as alliance, lead provider, key strategic partner and industry contracts, will be in place delivering outcome based commissioned services.

Integrated Provision:

a We will develop a proactive model of 24/7 community based care, with fully integrated multidisciplinary teams across acute and community services with primary care playing a key co-ordination role. The community/primary/secondary care interfaces will become integrated.

b We will have a workforce fit for purpose to deliver integrated health and social care services. To have this, we need to start planning now and deliver training right across the health, social care and voluntary sectors.

c An IT integration platform will enable clinicians and others involved in a person's care, including the person themselves, to view and input information so that care records are joined up and seamless. We will overcome information governance issues. Patient held records and shared care plans will be commonplace.

d We will systematise self management through assistive technologies, care navigation, the development of dementia friendly communities and other support provided by the voluntary sector.

e New kinds of services will bridge current silos of working. Health and social care staff will "follow" the citizen, providing the right care in the right place.

The integration pioneer programme is delivered via the Integration Pioneer Steering Group an informal working group of the Kent Health and Wellbeing Board.

The Better Care Fund

As part of the 2013 spending review, the Better Care Fund (BCF) was developed to support the implementation of integrated health and social care through the development of a pooled fund for 2015-16. The Kent BCF plan was submitted to NHS England on 4 April 2014 http://www.kent.gov.uk/social-care-and-health/health/health-and-public-health-policies/better-care-fund-plan Through the Better Care Fund citizens in Kent can expect to see:

- better access: co-designed integrated teams working 24/7 around GP practices
- increased independence: supported by agencies working together

- more control: empowerment for citizens to manage themselves
- improved care at home: a reduction for acute admissions and long term care placements; rapid community response particularly for people with dementia
- to live and die safely at home: supported by anticipatory care plans
- “No information about me without me”: the citizen in control of electronic information sharing
- Better use of information intelligence: evidence based integrated commissioning.

Kent is using the Better Care Fund to further the transition to whole system transformation. The value of the Better Care Fund across Kent is £27m in 2014-15 and £122m in 2015-16. Kent as a pioneer, however, wants to go further than this and by 2018 be considering the Kent £ across the entire health and social care economy.

Current Outcomes

The Health and Social Care Integration Programme has produced a number of outcomes across Kent:

Proactive Care started in April 2012 in South Kent Coast Clinical Commissioning Group (CCG) locality. Each patient on the programme receives a holistic package of care aimed at improving the management of their long term condition (LTC), including improving their confidence to self manage after the programme. Patients are supported by a multidisciplinary team (MDT) including GP, community matron, health care assistant, physiotherapist, occupational therapist, pharmacist, health trainer, care manager and mental health professional.

Evaluation from the first cohort of 134 patients demonstrated:

- a 15% reduction in hospital A&E attendances
- a 55% reduction in non-elective admissions
- a reduced admission risk score for 37% of the cohort
- total saving to date of £225,938
- EQ-5D assessments completed to date showing 75% of patients reporting improvement in functional quality
- plus, 86% no longer anxious about their condition, from a baseline of 46%.

West Kent Integrated Rapid Response Service (RRS) has seen well over 4,000 patients since its launch in November 2014. The majority of interventions are admission avoidance and supported discharge. Case reviews demonstrate that the scheme is enabling patients with more complex needs to remain at home through enhanced decision making. Key to the success of the enhanced ERRS is collaborative working between health, social care and ambulance services providing a fast response to patients. The service particularly targets people aged 75 and over. It includes clinical treatment, rehabilitation and support which link with reablement programmes, and focus on enabling a person to stabilise and regain their independence and help them to remain safely at home.

North Kent Integrated Discharge Team: in October 2013, Kent Community Health Trust (KCHT), Darent Valley Hospital (DVH) and Kent County Council (KCC) agreed to provide a multidisciplinary Integrated Discharge Team (IDT). This helps avoid hospital admissions, ensures patients are proactively managed to reduce length of stay and enables patients that are medically stable to leave in good time.

The IDT is made up of nurses, doctors, therapists, pharmacists, care managers and mental health specialists working across the acute and community settings. Key outcomes to date:

a A decreasing trend in emergency admissions seen between December 2013 and February 2014.
b A reduction in the number of patients having to wait more than four hours in A&E since January 2014.
c More than 50% of patients, on average, are going home with enablement, including equipment, since January 2014.
d Since November 2013, timely access to specialist mental health assessments out of hours has improved from 20% to 48%.

Health and Social Care Co-ordinators based in two CCG areas (West Kent and Canterbury) help co-ordinate activity around (MDTs) and between GPs and community services. In Canterbury the current service has had over 3,363 contacts, with 1920 A&E attendances avoided and 1443 admissions avoided. The cost saving to the local health economy has been identified as over £200 thousand. In April 2014 the service moved to extended working hours. This included co-locating at the local acute site at weekends.

Dementia Friendly Communities Kent has worked within local communities through intergenerational work between schools and care homes for people living with dementia. This includes the creation of dementia diaries, connecting people through iPads and working with schools on intergeneration projects.

Year of Care: as an early implementer, Kent has outlined the potential savings that could be achieved through delivering whole system transformation (see the chapter on Year of Care).

Kent Innovation Hub: the Kent Innovation Hub is a network of local, national and international organisations across health, social care, the voluntary sector, industry and academia. It shares good practice, tackles key challenges and aids the development and implementation of solutions for service change at pace and scale. The innovation hub was launched in December 2013 and has had a number of events. These have included participation in an international event on teletechnology, hosting an online questionnaire on the Better Care Fund, launching a Tweet chat on information governance and, most recently, a Tweet chat on shared care plans. The innovation hub has provided a mechanism to engage the public and others in helping establish an integrated health and social care system and in barrier busting .

Key work streams that have begun within the pioneer programme include:

Information Governance: the Integration Pioneer Steering Group is exploring the practical barriers to information sharing and the steps that can be put in place to resolve these. Kent is mapping data sources for shared system-wide intelligence and will be continuing the development of shared data for commissioning.

Workforce: Kent is exploring the "art of the possible" in terms of future workforce requirements alongside establishing a fit for purpose workforce. This includes establishing system leadership and the innovative development of "leadership of place", looking at local leaders within services, teams and on the frontline.

Self Management: Kent has a Personalisation Steering Group delivering an action plan on self care, including establishing a methodology for self care within integrated service provision and using technology to enable people to maintain independence and access a shared care plan.

Barriers to Integrated Care and Support

Kent is committed to exploring how the barriers to successful integration can be removed. It is already working in partnership with national partners and other pioneers across several areas such as information governance, contract design and shared care planning. Identified barriers that Kent is currently looking to tackle are:

- communications between services, providers and patients so patients know, through a variety of media, who to contact and what services to access
- contract design: any inability of commissioners and providers to agree a common contracting model will hinder the spreading of clinical and financial risk
- flexibility, tariff and pricing: there is a need for new models to be implemented
- information governance for patient held records and work across multiple partners
- IT platforms need support to find lasting solutions to infrastructure differences
- developing additional funding streams.

Ongoing Delivery within Pioneer

As part of the implementation of the Better Care Fund each CCG area has detailed delivery plans for the integrated schemes within each BCF plan and will have a governance structure to support implementation

The implementation of a BCF will be supported by Kent Integration Pioneers)with regular reporting to the Health and Wellbeing Board on progress and outcomes.

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