Appendix 1

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To: FSC Directorate Management Team – 21 December 2011

Subject: **HEALTH AND SOCIAL CARE INTEGRATION PROGRAMME**

Classification: Unrestricted

Summary: The purpose of this document is to update DMT on the Health and Social Care Integration programme's progress and to ask for confirmation of the strategic direction.

FOR DECISION

1. Background

1.1 "Integration" can mean different things to different people. For the purpose of this report, integration is defined as the assimilation of organisations and/or services into single entities, allowing for greater transparency between partners as well as enhanced benefits for service users (particularly those with complex needs).[1]

1.2 The Health and Social Care Integration Programme (HASCIP) started up in December 2010 in response to a mandate from the Kent Adult Social Services Strategic Management Team. This mandate was given following discussion between KASS Directors and the PCT Cluster Chief Executive.

1.3 The scope of the programme includes OPPD services. Learning Disability and Mental Health (under 65s) are not within the scope of this phase of the programme.

1.4 The programme will deliver integrated adult community health and social care services for the residents of Kent. The benefits:

- Deliver better co-ordination of care
- Provide better experiences and improved outcomes for individuals and their families
- Enable people to have more choice and control through underpinning integrated services by a personalisation ethos
- Deliver efficiencies by improving productivity and managing costs

1.5 There are a number of drivers for this work to be done:

- It is the right thing to do. Co-ordination of care for people with complex needs and long-term illness is poor. Improved care co-ordination can have a significant effect on the quality of life of frail elderly people with multiple long term conditions. Highly integrated care systems that emphasise continuity and co-ordination of care are associated with better experience by the recipient.

[1] Integrated Care Network. Bringing the NHS and local government together. Integrated working: a guide. London: Integrated Care Network; 2004

- Policy drivers include the NHS White Paper "Equity and Excellence: Liberating the NHS" and the Government's Response to the Future Forum.
- Locally, "Bold Steps for Kent"[2] aspires to integrated health and social care provision with new kinds of providers entering the market.
- The Bold Steps Delivery Framework priority 2 is "Support the transformation of health and social care in Kent" and priority 15 is "Improve services for the most vulnerable people in Kent".
- Significant efficiency savings need to be delivered by health and social care organisations. The KCC Access and Assessment related savings attached to this programme for 2013/14 and 14/15 are £4m.
- The FSC – Adults Transformation Programme 2012-15

2 Policy context

2.1 The NHS White paper "Equity and Excellence: Liberating the NHS" identified:

- integration of health and social care could be enabled through the roll out of personal health budgets. PHBs will transform NHS culture and improve outcomes for individuals by putting people in control of their own health care choices.
- The key role for the Health and Wellbeing boards will enable the integration of health, social care and children's services, including safeguarding and across the wider local authority agenda.
- Local authorities will have a new responsibility to promote the integration of health and social care, public health and other local services and strategies.
- It is essential for patient outcomes that health and social care are better integrated at all levels of the system.
- Local authorities new functions will help unlock efficiencies across the NHS, social care and public health through stronger joint working.

2.2 Kent County Council's strategy "Bold Steps for Kent" describes a future picture of integrated health and social care provision for the county. The Kent Community Health NHS Trust (KCHT) has also shown its commitment to this aim.

2.3 The "Kent Health Commission" has recently been established by the Leader of the council. A paper, the "Kent Health Vision" will be presented to the Secretary of State for Health this month (December 2011), which will include key recommendations for what the current health reforms could and should mean in practice, using activity in Dover as an exemplar. This report will support KCC and NHS partners in a range of activities, including developing integrated services at a local level. After December, the second phase of work will test and develop recommendations.

2.4 Andrew Lansley, Secretary of State for Health, says in "The Government response to the NHS Future Forum report" (June 2011) that there is an overwhelming case for a new kind of health system where people's health and social care needs aren't treated separately and where local councils have a real say over decisions in the NHS.

[2] Bold Steps for Kent, p6. states "We will work with GP consortia to encourage new healthcare providers to enter the market for health services in Kent. This will drive up standards, provide competition, increase choice and drive greater value for money for GPs and patients. We will work to join up and integrate health and social care service provision to reduce costs and demand that could be avoided - for example, by joining our assessment processes."

2.5 The response also goes on to state that:

- Clinical Commissioning Groups will have a duty to promote integrated health and social care around the needs of service users. e.g. by extending personal health budgets and joint health and social care budgets, in light of the current pilots *(note, KCC and NHS Kent and Medway have started this work with the DH and are one of 18 pilot sites nationally. Integrated personal budgets will be piloted in Dover from February 2012).*
- The NHS Commissioning Board will promote innovative ways to integrate care for patients e.g. by encouraging CCGs to work closely with local authorities.
- The experience of care for too many patients is fragmented between different parts of the health service and between the NHS and social care or other services. There are huge opportunities to make services more integrated, building on the many examples of good practice that already exist.
- Health and Wellbeing Boards will have a stronger role in promoting joint commissioning and integrated provision; they can also be the vehicle for "lead commissioning" for particular services (where functions are delegated to them).

3 Evidence base for integration

3.1 There is a large body of evidence supporting the move to deliver integrated health and social care and also supports some successful approaches to follow.

3.2 A Kings Fund report (May 2011) "Transforming our healthcare system: ten priorities for commissioners"[3] supports the need for integrated community health and social care services. The 6th priority recommended is the creation of integrated health and social care teams which can deliver better care co-ordination, improve clinical and social care outcomes and deliver better experience of health and social care services. The Torbay model, which is based around alignment to GP practices supports people with complex needs well.

3.3 The results of the Torbay integration model included:

- Pooling of budgets helped created wider range of intermediate care services
- The appointment of health and social care co-ordinators improved care through harnessing the contribution of all team members
- reduced use of hospital beds
- low rates of emergency hospital admission for people aged over 65
- minimal delayed transfers of care
- reduced use of residential and nursing homes (although an increase in use of home care services)
- Increase in uptake of direct payments for social care

[3] Available at http://www.kingsfund.org.uk/publications/articles/transforming_our.html

3.4 Another Kings Fund paper which explores the Torbay model in depth makes a number of recommendations:

- Base any strategy on the benefits being sought for service users / patients. Specify them in advance and communicate them constantly.
- Use GP registration, not home address to allocate work to integrated teams
- Establish joint governance early
- Use the evidence base to overcome cultural, political, financial and organisational difference. They're not deal breakers.
- Engage middle managers and clinical leaders from the start. Develop non-silo management arrangements. Locate teams together.
- Tie in intermediate care and hospital discharge to the integrated system
- Make sure everyone understands what is meant by the term "integration"

3.5 "Where next for the NHS reforms: The case for integrated care" (Kings Fund, May, 2011) cites earlier research (Curry and Ham, 2010) which concluded that "significant benefits can arise from the integration of services, particularly when those are targeted at those client groups for whom care is currently poorly co-ordinated".

3.6 One British article (2010) from the International Journal of Integrated Care that attempts to capture some of the key themes from the literature on learning so far is entitled "Integrated team working: a literature review"[4]. Recommendations include the need to focus on the management of multi-professional teams, that considerable investment of resources are needed to implement successfully and that there is a need for clear standards for monitoring the success or failure of integrated teams.

3.7 Cornwall County Council and its partners have recently created integrated health and social care "hubs", incorporating an integrated single point of access and co-location of health and social care staff. As an example of early learning, recent performance activity reported a 25% reduction in numbers of referrals entering the system during the first three months, achieved through sharing the first point of access.

3.8 There is little available information to evidence savings associated with integrating health and social care – this is one of the areas of interest for the NHS Future Forum Integration work stream (due to report in December, not available at the time of writing). A recent report by the Audit Commission (December 2011) suggests that integrated working could offer efficiency savings and improve outcomes for people. It will be important to release savings where they are achieved and to have an agreement in place as to how they will be shared between KCC and the NHS.

4 Stakeholder engagement

4.1 Kent Local Involvement Network (LINk) has been engaged in this programme from early on and holds 2 seats on the programme board. They, with a number of other voluntary sector organisations, are also represented on the Communication and Engagement sub-group.

4.2 Two presentation and workshop events have been held, via the LINk, to seek views from members of the public. Kent people have said that services feel disjointed and inefficient because there are separate organisations with different systems, processes,

[4] Available at http://www.ijic.org/index.php/ijic/article/viewArticle/529/1042

agendas, budgets and targets. Furthermore, they said that there is a lack of joined up communication which impacts on continuity of care and can cause them delays in getting the right treatment or service.

4.3 Communication and Engagement officers (Customer and Communities) are supporting the programme by working with NHS partners to set up further public consultation activity.

4.4 Regular briefings and discussions have been held with the Leader of the Council, Cabinet Members and other Members.

4.5 The East Kent Commissioning Strategy Committee (sub group of the PCT board) have already agreed (22nd June 2011) the principle of the integration model for community teams described in the paper below – integrated health and social care teams based around GP practices. As a group, East Kent shadow Clinical Accountable Officers reconfirmed their support of the proposed operating model (see below) at a meeting on 29th September 2011 and for the model to be tested.

4.6 A paper was presented to the West Kent Commissioning Group on 18th October 2011. Implementation of integrated health and social care services in Maidstone and Malling was supported in order to inform future commissioning decisions.

4.7 Locality Steering Groups have been established for all 8 CCG areas now, in partnership with KCC and health providers, so that CCG members can influence the model and its delivery.

4.8 The strategic direction to integrate community health and social care was agreed at the Kent Community Health NHS Trust Board meeting on 24th November 2011. Furthermore, the board agreed to support the implementation on Model A in Dover/Deal, Swale and Maidstone/Malling as part of a first phase of rollout.

4.9 A discussion was held at the KMPT Older Persons Programme Board on 19th October. KMPT are doing an internal piece of work to explore the impact of integration and how their existing services may need to adapt to fit the proposed model and to meet the requirements of the future commissioning intentions for OPMH services.

4.10 A Communications and Engagement plan has been developed and related activities are taking place.

4.11 The programme has been a standing item at Joint Consultative Committee meetings for the past year and informal meetings with recognised trade unions have been established, supported by HR.

4.12 There is a real energy and excitement within health and social care organisations in Kent to deliver whole scale community health and social care integrated provision now, more so than there has ever been in the past.

5 Programme activity to date

5.1 A programme board was established in January 2011. Membership of this includes Kent LINk, KCC, Kent Community Health NHS Trust (KCHT), Kent and Medway NHS and Social Care Partnership Trust (KMPT) and NHS Kent and Medway.

5.2 There are governance arrangements in place with regard to the programme itself, commissioning decisions, and strategic and operational decisions that respective providers need to make. The governance structure is attached with this report.

5.3 Locality project steering groups have been established for all parts of Kent now, so that local dialogue between stakeholders can take place and plans can begin to be made where they are not part of the "phase 1" activity.

5.4 During the period December 2010 to September 2011, the programme was exploratory in nature and focused on options for whole system transformational change through the creation of integrated health and social care provision in Kent. One of the products of this work has been an operational model to be used as a framework to construct new integrated teams. This is attached as an appendix to this paper and summarised in section 6 below.

5.5 From September 2011 to October 2012, the programme is concerned with developing an implementation plan and testing out the operational model through whole systems changes in three "Phase 1" areas – Dover/Deal, Swale and Maidstone/Malling.

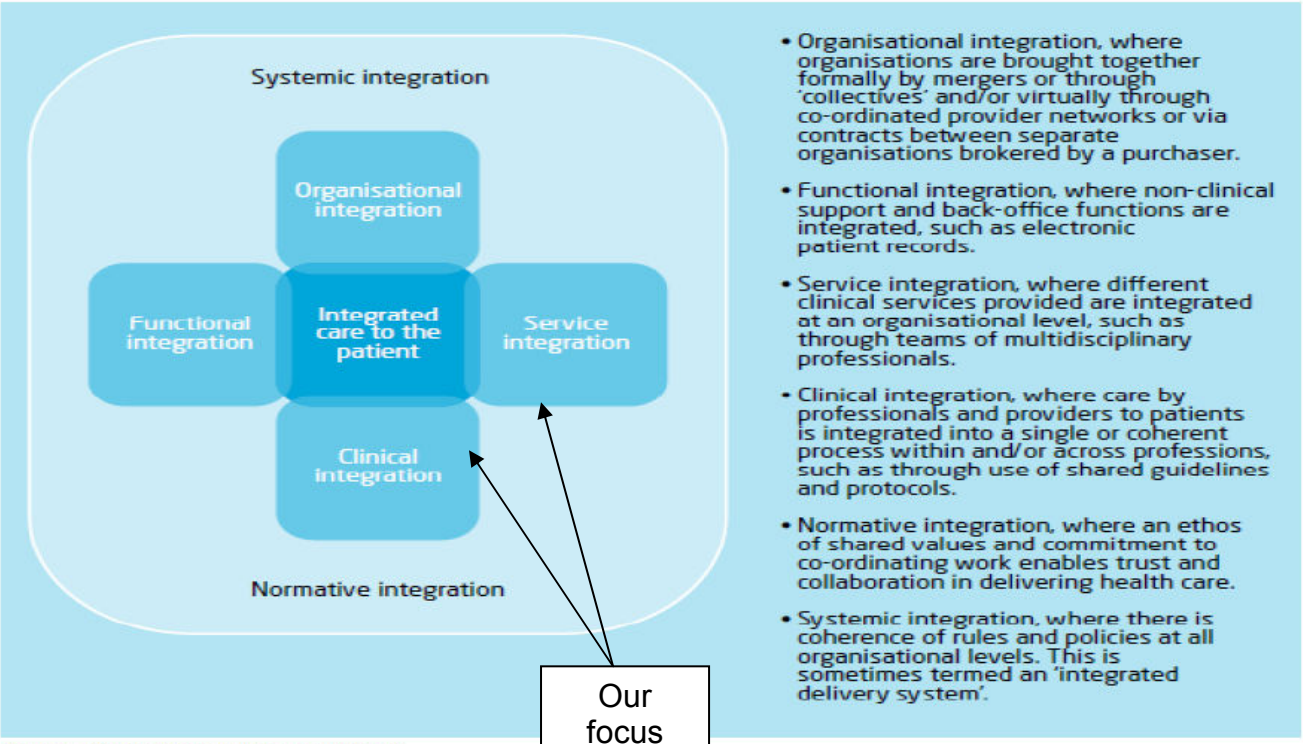
5.6 Milestone for Phase 1 sites are as follows:

- Dover/ Deal and Swale: end February 2012 – SPA established; April 2012 – integrated teams established
- Maidstone and Malling: April 2012 – SPA established; June 2012 – integrated teams established

5.7 The approach being adopted is to focus on delivering service integration (creating multidisciplinary teams) and clinical integration (establishing shared guidelines, processes, protocols). According to the Kings Fund/ Nuffield (2011), these two elements of the "integration recipe" alone could deliver a strong level of co-ordinated care. See figure 1 below.

5.8 A high level programme plan is available and has been included with this report. It details the content of each of the work streams / projects within the programme.

Figure 1 Fulop's typologies of integrated care (from Lewis *et al* 2010)



Source: Adapted from Fulop *et al* (2005)

6 The Operational Model

6.1 Please refer to the "Operational Framework" document in the appendix for details of the models that have been proposed. Specifically, please refer to Model A, which can be found on page 15.

6.2 The model has been through a quality assurance process. It has been shared and discussed through face to face meetings with Sir John Oldham, the DH's national lead for Quality, Innovation, Productivity and Prevention (QIPP) and with Richard Humphries, Senior Fellow at the Kings Fund. Both supported the model, as developed, and agree that this could be a vehicle for delivering some of the challenges that health and social care faces. Sir John Oldham encouraged the mainstreaming of the model, rather than running it as a pilot, on the basis that there is sufficient evidence to demonstrate that integration delivers positive outcomes and supports the management of long term conditions.

6.3 Model A is seen, by most, as the model that bears closest resemblance to the current strategic fit for the current providers of health and social care, with an ambition to move in the longer term to Model B (or variation). This model could see the integration of services currently provided by adult social care (KCC), older people's mental health – dementia (KMPT) and intermediate care/ rapid response, community matrons and primary care nursing (KCHT).

6.4 Model A being used as the basis to develop integrated health and social care services in the three "phase 1" areas: Maidstone and Malling, Dover/Deal and in Swale. The pilots will be established during the early part of 2012, followed by ongoing evaluation, which will be used to inform the development of these types of arrangement in other parts of Kent. Evaluation will include looking at outcomes relating to (i) impact on

service user/ patient experience, (ii) productivity/ use of services and (iii) cost-effectiveness.

6.5 Model A is based on 4 component building blocks:

- 1. Locality based **Single Point of Access team**. This team would deal with self referrals and will be used as a "one stop shop" for referrals from GPs. The service needs to be able to immediately access rapid response services and co-ordinate ongoing health and social care assessment and support.

- 2. Locality based **Integrated Health and Social Care Team incorporating Rapid Response / Intermediate Care and Enablement**. This teams would cover a locality and would work as part of or be aligned to the single point of access. Would manage and deliver rapid and crisis responses.

- 3. **Practice Linked Multidisciplinary Teams** based around GP surgeries. These teams would cater to the needs of people with long term conditions and ongoing social care needs (complex cases). They will co-ordinate care for those people with complex medical and social care needs in order to deliver better outcomes and experiences.

- 4. The 4th building block is made up of other commissioned community health care and social care services, including those provided by the private and voluntary sector.

6.6 Model B shares building blocks 1 and 4, but with a fundamental difference that community health and social care would be delivered through an integrated team arrangement that does not form a distinction between short term and long term conditions management. If Model B were adopted, it is proposed that named individuals from the integrated team would form links with practices.

6. Recommendations

DMT is asked to:

1 AGREE the strategic direction to integrate community health and social care services (OPPD).

2 AGREE the Operational Framework and for Model A to be tested out in Dover, Swale, Maidstone/Malling.

3 AGREE that these first three areas to integrate will be viewed as the first phase of transformation and mainstreaming, rather than to be seen as pilots.

4 DECIDE the frequency for the programme's progress to be discussed at DMT.

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