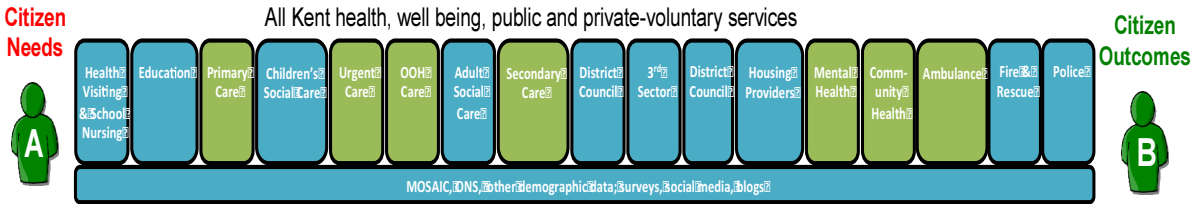
| | |
|---|---|
| From: | Roger Gough, Cabinet Member for Education and Health Reform |
| | Robert Stewart, Head of Kent Integration Pioneer Programme |
| To: | Kent Health and Wellbeing Board |
| Subject: | Proposal for establishing an intelligence-enabled integrated commissioning support capability |
| Classification: | Unrestricted |

## Our current situation – the challenge

The challenges that health and social care commissioners have to solve in provision for citizens are increasing at a rapid rate with growing populations living longer, with more complex needs against a backdrop of increased pressures on funding. The pace and scale of this challenge are crystalised by two recent studies by NHS England and The Local Government Association which have looked at the trend of the gap between demand and funding. Both studies conclude that, even taking account of known efficiency measures, by 2021, local authorities and CCGs in England will be facing a combined funding gap of between **£19b and £27b** per annum. For Kent, this roughly translates to a gap of between **£560m and £800m** per annum.

Both studies have concluded that this will necessitate material losses in levels of care, support and services. Therefore commissioners need to become more enabled to transform the behaviour of the 'whole system' to intrinsically create better outcomes, improved experience of services at lower overall cost.

This requires a **capability** to look at the journeys of different groups of citizens across all services over various periods of time, understanding how interactions between services are affecting outcomes and costs. This is illustrated below where we would want to understand what happens in the 'A to B' journey of citizens and the impact service utilization has on outcomes:




By understanding these journeys, health and social care commissioners will be able to:

- Truly understand the impact of all health and public services, their interplay and behaviours upon the outcomes for citizens
- Think cross-agency and cross-agency budget to identify the most effective ways of co-ordinating investment to create more value for money towards short, medium and long term outcomes
- Understand behaviour of citizens and adapt the behaviour of the system to enable them to participate in their optimal outcomes

## Our complication – we do not have the capability to meet the challenge now

The capability, as described above, seems like something we should already have. Indeed,

there are increasingly sophisticated yet pragmatic ways in which commissioners are trying to transform the 'whole system' now:

- **Local Integrated Commissioning Teams** (CCGs and Social Care) planning changes to positively alter the flow, care settings, costs and outcomes for different cohorts of patients

- **Integration Pioneer:** multiple initiatives to create better integration, coordination and behaviour across the 'whole system'

- **Better Care Fund:** planning for specific change in dynamics and activity flows between health and social care services

- **Facing the Challenge:** transforming the provider landscape and implementing planned changes across care pathways

All these initiatives require the capability to baseline the current behaviour of the 'whole system', predictively model/plan changes and then assess the impact of change in terms of new behaviours of the whole system, impact on citizen outcomes and overall costs. At a time when so many commissioned and non-commissioned changes are occurring, we also need to be to discern the effect of one change from another.

The problem is that we do not have this capability now. Historical circumstances have made this difficult:

- **Information Governance** constraints make providers and commissioners reluctant and weary of pooling health, social care and public service data together for fear of patient confidentiality breaches

- **Timescales to gather and join up data** - notwithstanding the above information governance issues, it can take weeks and usually months to gather relevant datasets before any analysis can begin

- **Traditional technologies as used in 'Data Warehouses'** require complex pre-design (agreeing how all universal data must be stored and agreeing naming conventions) and very expensive technology architectures meaning it is very costly to store large amounts of data. These technologies find it hard to analyse non-structured data which could provide crucial system and citizen behaviour insights. Overall traditional data warehouse these solutions can take many months and, often, years to implement

- **Skills and talents spread across different teams and best use of capacity**. We have highly talented and innovative teams such as Public Health, Business Intelligence and analysts across CCGs, social care and, especially, **provider organisations**. We are not always able to pool the resources against our most important 'whole system' priorities and often do not have 'enough left' to adequately measure and assess and learn from the

  impacts of changes

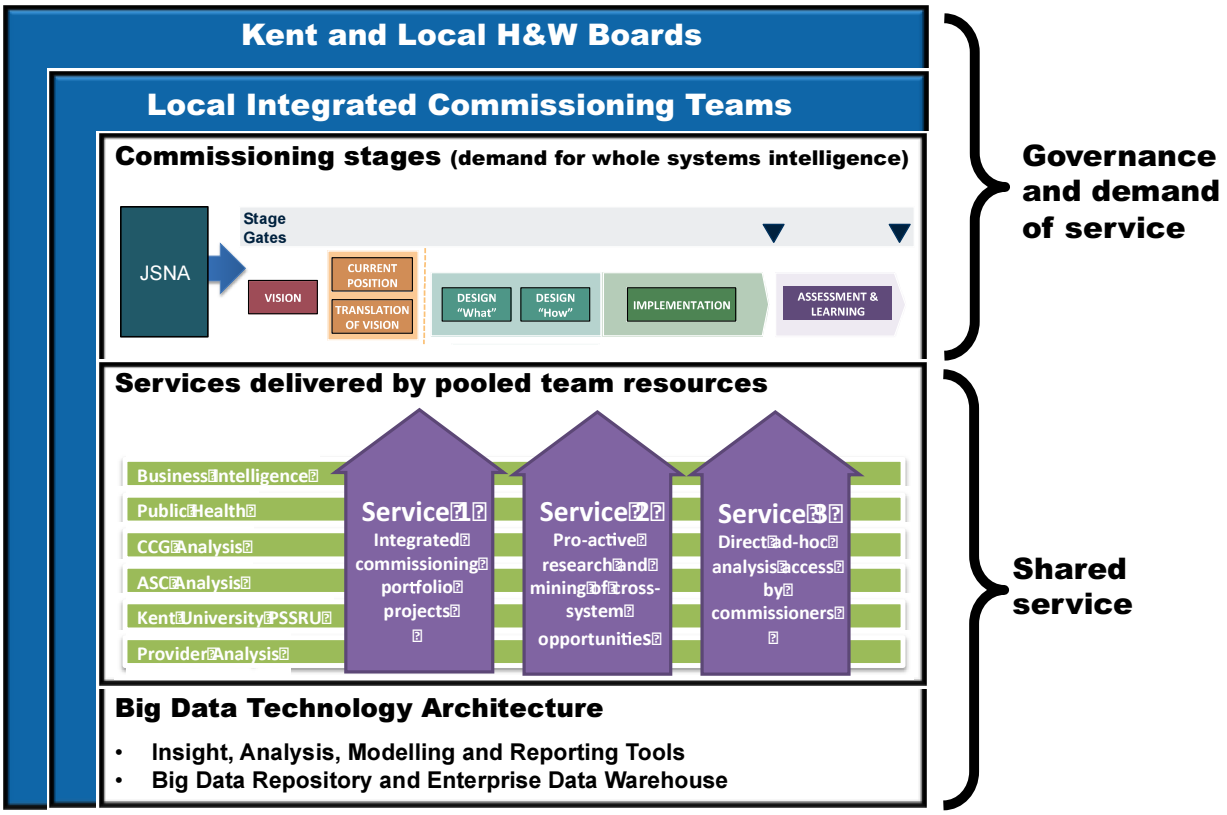
## The solution – establish an intelligence-enabled integrated commissioning support capability

We need to establish an intelligence-enabled integrated commissioning support capability through bringing together our resources.

The design of this shared service capability addresses the problems outlined above and creates the functionality that commissioners need to more radically transform the whole system at a far faster pace and scale to meet the funding gaps.

The main elements of the shared service capability (shown in the diagram below) are:

- Use of the capability is **governed** and **prioritised** by Local and Kent H&W Boards. An agreed portfolio of commissioning investigations/projects will be turned around quickly. These projects will support various stages of the commission cycle as commissioners deem fit
- Three types of **shared service** (across CCGs and Social Care) will be available to the Boards: 1) whole system investigations and projects as prioritized by the Boards; 2) Pro-active identification of major whole-system opportunities through collaboration with CCGs, Social Care and various *providers; 3) Ad-hoc, direct access to the pooled whole-systems data and insight tools by commissioners
- The above three services are delivered by **existing resources and talents pooled** from teams such as Public Health, Business Intelligence, CCG Analysts, ASC Analysts, CSC Analysts, *Provider Resources. The teams will work in a matrix fashion, focused on the purpose of the capability, on the prioritised projects and pro-active investigations
- The findings and recommendations from the services are **continuously reported** to H&W Boards, Local Integrated Commissioning Teams and the Kent-wide strategic programmes
- **'Big Data' Technology**. Is used to rapidly assemble large and varied sources of data from providers and external sources and perform analysis and predictive modeling of changes using sophisticated 'Big Data' tools. **With this technology, implementation and insight development timescales are a matter of weeks and not months/years**



* In terms of Provider Resources, we have engaged directly with Kent Police, Kent Fire and Rescue, District Councils, IC24 (Out of Hours Provider), SECAmb (ambulance service provider), Kent (Kent and Medway NHS and Social Care Partnership Trust) and KCHT (Kent Community Health Trust). All have expressed a strong desire to share data and resources. Furthermore Kent University PSSRU has expressed a strong desire to participate as part of this capability offering free resources and expertise and, potentially, some funding (we are in negotiations).

## Proposed implementation approach, costs and additional benefits

In terms of the proposed implementation approach, all Commissioning Accountable Officers have been asked to prioritise the first 10-15 'whole system' projects that the capability should be used for. The results of this prioritisation (and the expected scale of benefits) will be complete by the time of this Board Meeting and presented to the Board for endorsement.

It is proposed that the capability is implemented on a trial basis for 6-9 months at the end of which we can evaluate whether and how to embed the capability based on learnings.

The estimated implementation costs are around £200K for the trial period. The implementation period would be around 2 months. All of the costs are 'one-off' and mostly associated with implementing the 'Big Data' technology and integrating very large, diverse datasets from across multiple providers. Given the capability will be a shared service, **it is proposed that the cost is equally divided amongst participating commissioning organisations equating to around £20K to £25K each**.

Beyond the direct commissioning benefits from the 10-15 projects, this pilot will also:

- Accelerate Kent's pace of pragmatic Integrated Commissioning, using meaningful and important projects that will result in local interventions
- Experientially inform our other efforts in achieving commissioning maturity e.g. "Towards a strategic commissioning authority"
- Provide an intelligence platform that will enable us to **assess**, **deepen** and **accelerate** the impact of the Kent Integration Pioneer and Facing the Challenge programmes

There are **Information Governance** implications in being able to pool such diverse datasets and purposefully use them in the way this capability will need to do. We have secured positive interest from the Department of Health to see how the Kent Pioneer Programme (and this specific capability, as part of it) could be supported. We are due to meet with Mark Davies, who is drafting the next Information Governance legislation for Parliament, on 5th August to secure the necessary support. It will be very powerful to have this discussion with them with a mandate from this Board.

## Recommendations:

The Health and Wellbeing Board is asked to:

I. Ratify the purpose and design of the Intelligence Led Integrated Commissioning Capability

II. Endorse the top 10-15 priorities that have been selected by Commissioning AOs, as will be presented on the 16th July

III. Offer further ideas or suggestions on funding approach

| | |
|---|---|
| IV. | Approve, in principle, the inception of the pilot subject to confirmation of costs and funding approach (these will be determined by the choice of the 10-15 pilot period projects) |

Report prepared by: Shakeel Mowla, MD LBD Partners, shakeel.mowla@lbd-partners.com