By: Paul Carter, Leader of the Council

Roger Gough, Chair of the Kent Health and Wellbeing Board

To: County Council –18 September 2014

Subject: Health and Social Care Integration in Kent

Summary: This high level paper summarises the case for health and social care integration, setting out why this is needed to improve the quality of care for all. This work is currently being led by the Health and Wellbeing Board. Case studies of the work being progressed across Kent are also included. Members will also receive presentations from some of Kent County Council's partners.

RECOMMENDATIONS:

County Council is asked to:

(1) Note the progress made in health and social care integration.

1. THE NEED FOR INTEGRATION

1.1 Unsustainable pressures on the health and social care system are building. These demands often manifest themselves in the acute hospital sector but addressing them requires a response from the whole system.

1.2 As more people are living to older age with more complex long-term conditions demands for health and social care will continue to rise. These pressures cannot be absorbed simply by doing more of the same.

1.3 This is not just a question of economics. Health and Social care needs to be reformed to offer people much greater individualisation of services and more control over what and how the services they need are provided.

1.4 Neither is this just about our hospitals. Primary care needs to change. GP's need to be at the forefront of reform, with much more healthcare provision in primary care. For every neighbourhood there should be a team around the patient led by the GP with access to a full range of professionals, including specialist care. Services closer to home will be provided by multidisciplinary teams that will have preventative as well as responsive components to them (see paragraph 6.3 and the North Kent case study on Integrated Primary Care Teams).

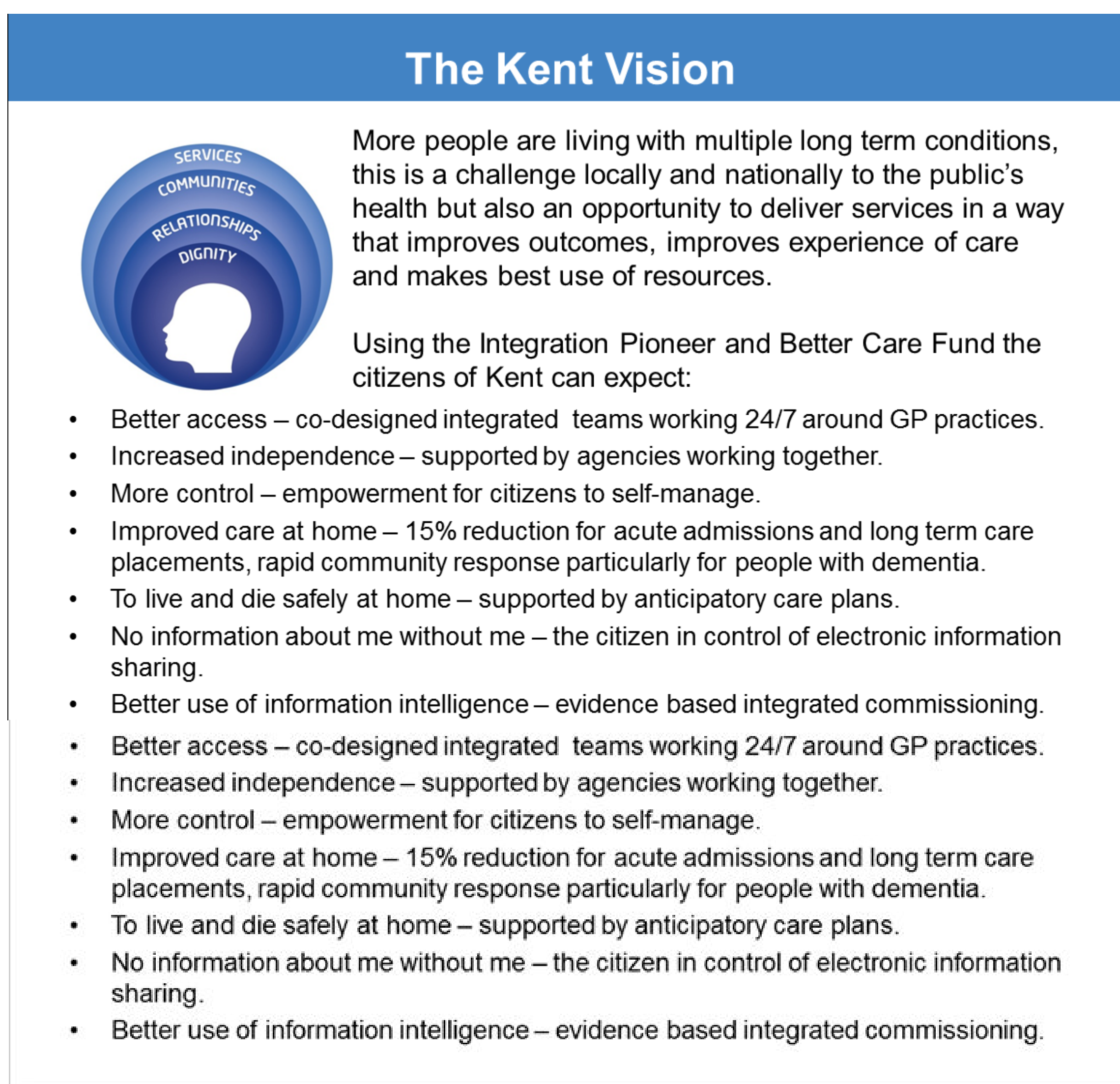
1.5 Acute hospitals will need to change. In future they should do less but be more specialised, giving the best care for those that need to be in hospital but also reaching out into the community. "Hospitals without walls" should become the norm offering specialist care to patients with complex problems in their own homes and the community rather than an expensive hospital bed.

1.6 Simon Stevens Chief Executive of NHS England:

> *"That's the big offer the NHS increasingly has to make to our fellow citizens, to local authorities, and to voluntary organisations. We need a double N in 'NHS' – a National Health Service offering more Neighbourhood health support."*

1.7 This is the essence of the integration of health and social care. In order to improve the quality of services people receive whilst reducing costs and spending public money in a more integrated way we have to deliver the government requirement to reduce acute hospital activity and treat many more people in their own homes and communities.

1.8 Kent has responded enthusiastically to this challenge through its Integration Pioneer programme and with the support of the Better Care Fund. The Kent Vision and how it will change the experience of our population can be summarised in the following:



The Kent Vision

More people are living with multiple long term conditions, this is a challenge locally and nationally to the public's health but also an opportunity to deliver services in a way that improves outcomes, improves experience of care and makes best use of resources.

Using the Integration Pioneer and Better Care Fund the citizens of Kent can expect:

- 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 self-manage.
- Improved care at home – 15% 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.

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- Improved care at home – 15% reduction for acute admissions and long term care placements, rapid community response particularly for people with dementia.
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- No information about me without me – the citizen in control of electronic information sharing.
- Better use of information intelligence – evidence based integrated commissioning.

1.9 Patients and the public should see big differences in how their care is delivered as these programmes, and others like them, are rolled out. The "I statements" contained within the Health and Wellbeing Strategy articulate the type of experience people will have. For example:

- *“I can decide the kind of support I need and when, where and how to receive it.”*

- *“All my needs as a person are assessed and taken into account; I am listened to about what works for me in my life.”*

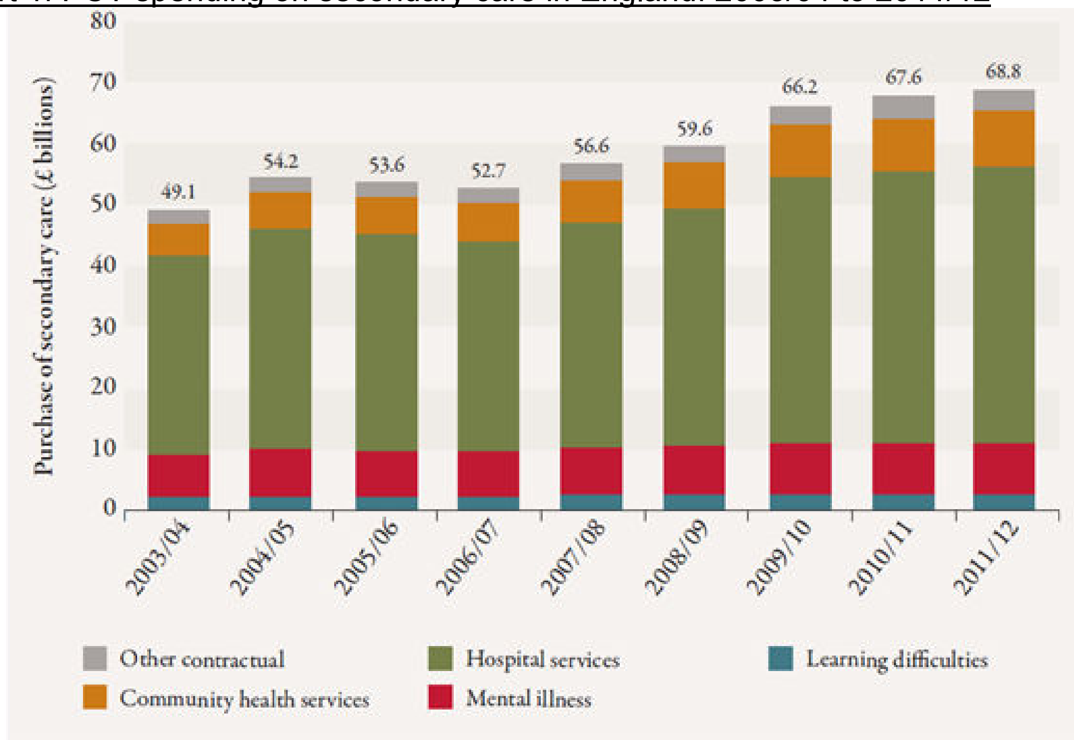
- *“I tell my story once. I have one first point of contact. They understand both me and my condition(s). I can go to them with a question at any time.”*

- *“I can see my health and care records at any time. I can decide who to share them with. I can correct any mistakes in the information.”*

1.10 People should have much more of their care delivered at, or near, their home and should go to hospital only when it is the best place for them to receive treatment, rather than the default option. There will be “a team around the patient” centred on their GP who they can trust to meet most of their care and support needs. Information will be properly and appropriately shared between the professionals involved with the knowledge and consent of the patient with agreed care plans capable of being accessed by those involved to ensure continuity of care.

2. THE NEED TO REDUCE SPENDING ON CARE IN ACUTE HOSPITALS

Chart 1: PCT spending on secondary care in England: 2003/04 to 2011/12[1]



2.1 Hospital activity continues to increase year on year. In 2012/13, emergency admissions increased by 1.8% and a further 0.4% in 2013/14. The figures for outpatient attendances are 3.9% and 7.5% respectively for the same two years. As can be seen in the above chart, the trend in spending on secondary care in England has continued to be upwards.

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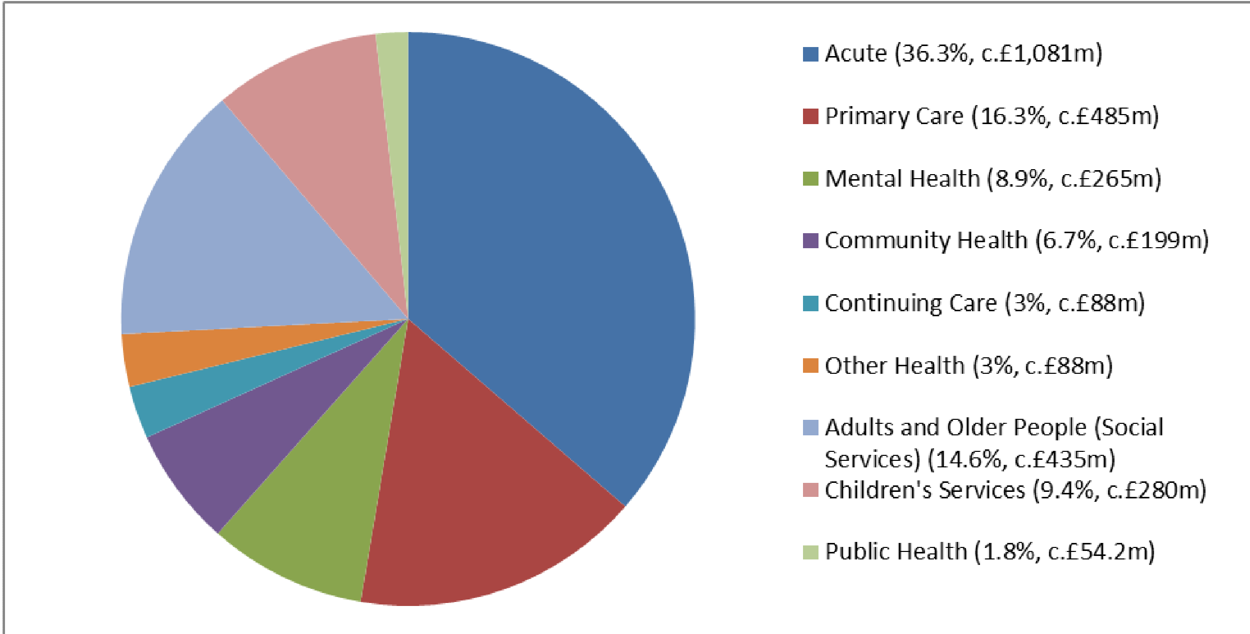
[1] Nuffield Trust, *The anatomy of health spending 2011/12,* March 2013.

2.2 The trend in spending on primary care services has been in the other direction to the point where less than 10% of the NHS budget is spent on GP services (excluding prescribing) yet more than 90% of patient contacts in the NHS are dealt with by GPs. Funding for GP services has been decreasing in real terms since 2010/11, falling by 1.2% on the previous year in 2011/12 and a further 0.5% in 2012/13.[2]

2.3 While there has been an increase in the amount of money spent on community health services, there has not been a fundamental shift of activity away from acute settings.

2.4 This national picture is replicated in Kent. Adding together the commissioning programme budgets of the seven Kent CCGs, NHS England's spend in the county and gross expenditure by KCC on adults and older people, children's services and public health, the combined budget for Kent is approximately £3 billion. The chart below sets out an estimate of what proportion of this global sum is spent on different areas. As can be seen, the largest single area of spend is the acute hospital sector, which receives a little over a third of the total (and accounts for just under half the total NHS spend).

Chart 2: Indicative Shares of Combined Health and Social Care Spend



2.5 As explained further below, the treatment of older people in acute hospitals is likely to consume an ever increasing proportion of the health and care budget. A 5% reduction in the money spent on the acute sector currently would realise around £54 million to spend on other services. However, consideration would need to be given to maintaining the sustainability of the acute sector. The push towards improved integration is in part an answer to this challenge.

[2] Nuffield Trust, *Into the red*, July 2014

3. THE AGEING POPULATION

3.1 While the overall population of Kent and Medway is estimated to increase by 5.4%, the population of those aged 65+ is likely to increase by 25.5% and for those aged 85+ the increase is expected to be 34.1%. While it is good news that people are living longer, there is still a gap between the life expectancy of people in the richest compared to the poorest areas of 17 years nationally and 14 years across Kent. In addition, the consequence of this demographic shift towards a population which is proportionately older is that many people will also have multiple and complex long-term conditions as they age. This in turn has an impact on the health and care system as the following national estimates set out:

- One quarter of the population (just over 15 million people in England) has a long term condition such as diabetes, depression, dementia and high blood pressure – and they account for fifty per cent of all GP appointments and seventy per cent of days in a hospital bed

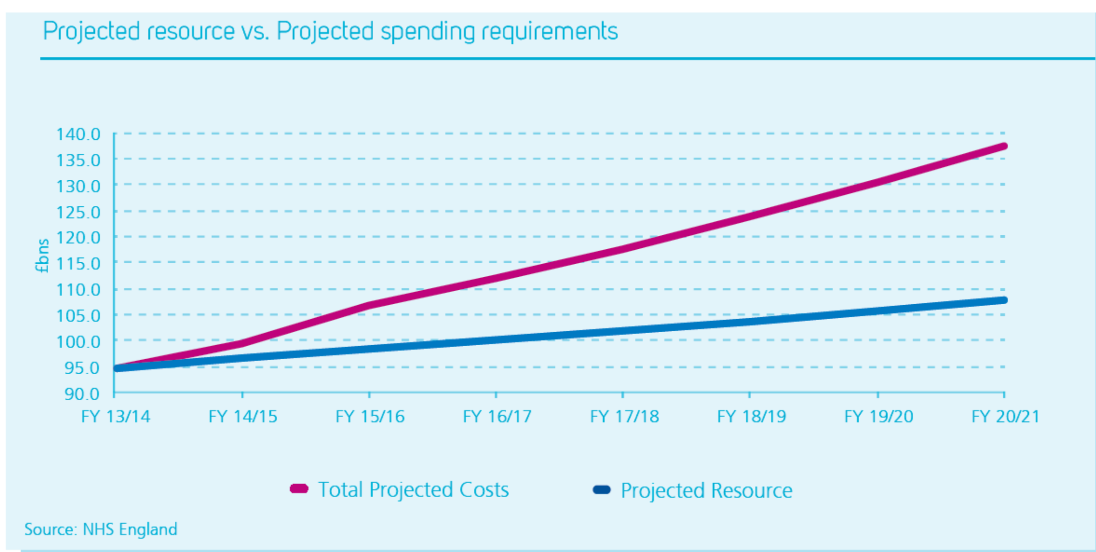
- Hospital treatment for over 75s has increased by 65 per cent over the past decade and someone over 85 is now 25 times more likely to spend a day in hospital that those under 65

- The number of older people likely to require care is predicted to rise by over 60 per cent by 2030

- Around 800,000 people are now living with dementia and this is expected to rise to one million by 2021[3]

4. THE £30 BILLION FUNDING GAP

Chart 3: Projected Funding Gap[4]



4.1 'The NHS Belongs to the People: A Call to Action' was published in July 2013 and was intended to help frame a realistic and honest debate about the future shape of the NHS. Rising demand at a time of flat funding alongside the introduction of new

[3] Estimates taken from NHS England, http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/
[4] NHS England, '*A call to action*', July 2013

technologies will result in a funding gap of up to £30 billion by 2020/21 if services continue to be delivered in the same way. This is the equivalent of approximately 22% of projected costs in 2020/21.

4.2 With the NHS treating around 1 million people every 36 hours, the scale of the challenge of maintaining sustainable health service should not be underestimated. Overall, life expectancy in England increased by 4.2 years between 1990 and 2010. Along with this, the NHS has made significant improvements in reducing premature deaths from heart and circulatory diseases. However, England does not perform as well as other European countries for other conditions. Within England there are wide variations in the quality of service provision, as well as life expectancy. As set out elsewhere in this paper, the NHS also faces the challenge of an ageing population.

4.3 'A call to action' is not about restructuring the health sector, but rather about doing things differently. Preventing disease in the first place, for instance, would significantly reduce premature death rates. Early diagnosis and appropriate treatment of disease can also reduce premature deaths as well as reducing the need for expensive interventions.

4.4 NHS England are clear in their paper that doing nothing is not an option as the health service will not be sustainable if everything carries on as before.

5. PARITY BETWEEN PHYSICAL AND MENTAL HEALTH

5.1 In February 2011, the Government published its mental health strategy, *No Health Without Mental Health*. This emphasised giving equal weight to both physical and mental health, with mental health outcomes being seen as central to the three outcomes frameworks. The implementation framework of the strategy suggested that local mental health needs should be reflected in JSNAs and JHWSs.

5.2 The idea of parity of esteem between physical and mental health is not new, but was made an explicit duty on the Secretary of State through the Health and Social Care Act 2012. In March 2013, the Royal College of Psychiatrists published a report into achieving parity, writing that a "parity approach should enable NHS and local authority health and social care services to provide a holistic, 'whole person' response to each individual, whatever their needs."

5.3 A key part of the approach in Kent is the Six Ways to Wellbeing Campaign which seeks to share the knowledge of the six themes for positive action. Kent Public Health aspires to help the population to adopt behaviours that can improve and sustain their mental wellbeing; these behaviours fall into the following themes of the Six Ways to Wellbeing campaign:

1. Connect with the people around you
2. Be active
3. Give
4. Keep learning
5. Take notice
6. Grow your world

6. THE NEED TO WORK DIFFERENTLY

"We need to stop treating people as a collection of health problems or treatments. We need to treat to them as individuals whose needs and preferences should be seen in the round and whose choices shape services, not the other way round."
- Simon Stevens, NHS England Chief Executive.

6.1 The key point of the 'call to action' is that the health and care system needs to do things differently and change the status quo. There is a need to embrace new technologies and treatments, with services delivered in a different way with less focus on buildings and more on patients and services. Kent's participation in the Integration Pioneer programme and Better Care Fund are examples of how different approaches are being developed to meet the challenge locally.

6.2 Following 'a call to action', the Better Care Fund was created out of existing monies, supporting the full integration of services by 2018, with challenging targets to be achieved by 2016. The intention of the BCF is to complement the work that KCC had already begun and will continue through its Pioneer work.

6.3 Services closer to home will be provided by multidisciplinary teams that will have preventative as well as responsive components to them. Integrated teams will provide active support in the community to enable patients to take control of their own care. In local areas this could potentially mean that integrated care is provided through community health, mental health, and social care teams, with GP leadership. Where necessary, the services will be responsive and provide an integrated 24/7 service that has a full range of out of hospital urgent health and social care services to support individuals in the community and avoid hospital admission. This would also mean that there will be increased support to help people at the end of their life to die in the place of their choice and with dignity.

7. PUBLIC HEALTH

7.1 Many of the long-term conditions that generate a large amount of health care for individuals, such as diabetes, coronary heart disease, are the result of unhealthy lifestyles. It has been calculated that around 80% of deaths from major diseases, such as cancer, are attributable to factors such as smoking, excessive consumption of alcohol, poor diet and lack of physical activity.

7.2 The preventative role of Public Health will be crucial to reducing demand for health care by enabling people to live healthier lives, stay healthy for longer and reduce the health inequality that increases the impact of poor health in our more deprived communities. This includes better public mental health and a critical role in improving the health of children, starting at conception and maternal health in pregnancy.

7.3 Public health has another key role in supporting the health and social care system through information and data analysis, identifying major priorities (through the Joint Strategic Needs Assessment) and helping GPs and others understand the particular characteristics of the populations they serve.

8. CHILDREN'S SERVICES

8.1 Over the coming years Kent will also see a much greater integration in services for children from pre-birth to 19. In October 2015 Health visitors will become a part of the public health responsibilities of Kent County Council, and will complement the responsibility to support breast feeding, and reduce smoking in pregnancy. KCC is in the process of developing a joined up preventative services approach for 0-19 year olds. Meanwhile, a new School Health service specification is currently being developed with the intention that a new service is in place by April 2015.

8.2 In addition, Kent has been successful in our expression of interest for the Transformation Challenge Award 2015/16 with a bid focused on 'Improving Children's Services through Integrated Strategic Commissioning'.

8.3 In April 2014 the Department for Communities and Local Government announced a £320m Transformation Challenge Award to help councils transform the way local services are run. The 2014-16 Awards aim at helping Councils 'go further and faster sooner' in their transformation with a focus on developing public-focused services, reducing costs, and redesigning business practices and service delivery.

8.4 The expression of interest noted that Kent County Council and the seven Clinical Commissioning Groups work to support the same families. We have the same aspirations: improve outcomes, target resources to support families to help them become resilient and independent. However, we currently have diverse commissioning processes.

8.5 The proposal is to develop an integrated, strategic, approach including effective pathways for children and families across the early help and social care agenda, services and governance processes.

8.6 The benefits of this approach should be improved outcomes for children and families as a result of ensuring more targeted access to services for those who need them most, reductions in duplication and repeat interventions from more efficient pathways, and efficiency savings for commissioning organisations through the development of integrated commissioning approaches.

8.7 We are now working to develop a full bid for Transformation Challenge Award funding with partners by October 2014.

9. CASE STUDIES

9.1 The following case studies illustrate some of the work being carried out across Kent:

9.2 NORTH KENT

a. Integrated Discharge Team

The IDT is an initiative commissioned by the DGS CCG and includes the Kent Community Health NHS Trust, Darent Valley Hospital, KCC, IC24 (out of hours GP service) and the Kent and Medway NHS and Social Care Partnership Trust (mental

health trust). It is designed to ensure that patients receive the most appropriate treatment delivered by the most relevant health care worker in the most appropriate setting, all the time. This will help avoid admissions, ensure patients are managed to reduce their length of stay and enable those who are medically stable to leave hospital as early as possible. The IDT brings together nurses, doctors, therapists, pharmacists, case managers and mental health specialists working across hospital and community settings.

Since its inception there has been:

- A decreasing trend in emergency admissions seen from December to February.

- A reduction in the number of patients having to wait more than four hours in A&E since January 2014.

- An improvement, since November 2013, of timely access to specialist mental health assessments out of hours from 20% to 48%.

On average over 50% of patients have been discharged going home with an enablement service since January. So far no one receiving a service through the IDT has been placed in residential care.

b. Integrated Primary Care Teams

These teams operate in the community and bring together community nurses, social care workers, mental health workers, specialist services, pharmacists, outreach hospital specialists, palliative care nurses, paramedic practitioners, with GPs at the centre coordinating and organising people's care. These teams are designed to ensure that as many of the patient's needs are met in the community thereby reducing demand on hospitals. The first phase of this programme will begin on 27th October 2014. Integrated Primary Care Teams will provide:

- Flexible 7 day provision, with a named GP for patients aged over 75 yrs, and will service neighbourhoods with a population of 20-40,000.

- Proactive and responsive care, improving people's experience, delivering better care outcomes, reducing health inequalities and making better use of care resources.

- A focus on keeping people well and supporting patient's self-management, using a risk stratification and prediction approach to determine those at the highest risk of hospital or long term care admission or re-admission, and those who are regular users of other services.

- Joined up services to support those with Long-Term Conditions and with complex care needs.

- Increased use of advice, information, guidance, enablement, rehabilitation and telecare thereby supporting the Adult Social Care Transformation programme.

9.3 WEST KENT

a. Anticipatory Care Plans

Critical to the success of any more integrated approach to providing the care people need is the availability of the necessary information about the patient and their care to those that need it at different times.

The Care Plan Management System project is being led by West Kent CCG in close liaison with KCC and the Kent Integration Pioneer Steering Group. The goal is to provide person-centred digitised care plans that are shared across all care professionals involved in a person's care and accessible by people and their families (always subject to the person's explicit consent).

Initially the project will focus on care plans for people with long term conditions, the frail elderly and people needing end of life care. The project involves professionals from both health and social care, starting with a jointly agreed specification of requirements and moving on to implementation.

This project is designed to change the way services are delivered, driven by the need for integrated care and the West Kent Mapping the Future 5 year strategy. The IT system will be a key facilitator. Implementation will be in phases, starting with a small scale but live system establish cooperative working and demonstrate the benefits of the changes. The first phase is due to start on 2nd March 2015. It is anticipated there will be 2 further phases over a two year period

b. Enhanced Rapid Response Service

This service targets people aged 75 and over and includes clinical treatment, rehabilitation and support, whilst linking with re-ablement programmes, and focusing on supporting people to stabilise from an acute event, regain their independence and helping them safely to remain at home.

Key to the success of ERRS is the collaborative working between Health, Social Care and Ambulance Services and by providing a fast response to patients who need assistance unexpectedly.

Since November 2013 the service has seen well over 4000 patients.

The majority of interventions enable unnecessary admissions to hospital to be avoided and support safe but earlier discharge from hospital.

Case reviews are demonstrating that the scheme is enabling patients with more complex needs to remain at home due to improved decision making via a multi-disciplinary team of medical practitioners, paramedics and clinician.

9.4 EAST KENT

a. Ashford and Canterbury - Health and Social Care Coordinators

This service has been enhanced in 2014 to provide extended availability including co-locating with acute hospital services at weekends. The Health and Social Care Co-ordinators:

- Help coordinate activity with Multi-Disciplinary Teams and between GPs and community services.
- Have had over 2300 contacts with patients resulting in 700 A&E attendances and 140 admissions being avoided.
- Have produced cost savings to the local health economy estimated at over £200,000.

b. Ashford and Canterbury - Community Networks

Community Networks are part of a five year vision that care will be delivered as close to where patients live as possible and that services will be jointly commissioned with Social Care colleagues. Community Networks will be centred around groups of GP surgeries with local doctors taking a leading role in co-ordinating the services their patients require having access to a full range of medical and support services in the community.

This will mean that:

- Local residents will be able to access a variety of services across their local area, which meets the specific needs within their community.
- Closer integration of services will be provided out of hospital, available 24/7, and co-ordinated with specialist expertise in hospitals, among mental health providers and in related forms of care.
- Attention will be given to care that is preventive and proactive with the aim of supporting people to remain independent for as long as possible and avoid the unnecessary use of hospitals and care homes.

Ashford and Canterbury CCGs and KCC are keen that community networks are developed hand in hand with our local population, who will ultimately use them. The first step in this process is to understand what services are already available in each of the networks and assess them against the need of the local population. Ashford & Canterbury CCGs & KCC Social Care colleagues are running two events to facilitate this in early September.

c. South Kent Coast (Dover and Folkestone) - Prime Ministers Challenge Fund

In October 2013, the Prime Minister announced the £50 million Challenge Fund to improve access to general practice and test innovative ways of delivering GP services.

Invicta Health, a community interest company, owned by more than 40 GP practices in East Kent was selected as a pilot and awarded £1,894,267. The pilot brings together 13 practices, in Dover and Folkestone, and will offer extended and

more flexible access to services for 94,940 patients, backed by enhanced community care and specialist services for people with mental health needs.

This will enable patients to book appointments at any of the 13 practices from 8am to 8pm, seven days a week. Outside of core practice hours (8am-6.30pm) patients can access urgent home visits and if required, short-term residential facilities in the community, to avoid hospital admissions.

For patients with urgent mental health needs, this pilot is also introducing a new rapid assessment service delivered by a primary care mental health specialist, either at a patient's home or at their GP.

South Kent Coast is also in the process of developing an Integrated Care Organisation. This is designed to work with all relevant partners to establish the most appropriate form of organisation to deliver a comprehensive and holistic service to ensure patients receive high quality care outside of hospital whenever this is the best option for the patient.

9. CHALLENGES

9.1 Implementing the changes necessary to achieve integration and realise the benefits it can produce will require leadership and co-ordinated action from all involved. There are a number of issues that will have to be addressed if we are to succeed. These include the following:

a) **Complexity:** As a large county of 1.4 million people Kent has a complicated system of health and social care. In the NHS there are seven CCGs, four acute hospital trusts (including Medway), a Mental Health partnership trust, a community health trust and an ambulance trust. The county council commissions public health services (to include child health from October 2015) and social care, and the twelve districts also play an important role. The county divides into three health and care economies based around the major hospital providers in the East, North and West of the county with their associated CCGs. Delivering an integrated system across this area and number of organisations is a much greater challenge than that faced in a unitary authority with one CCG and a single provider trust.

b) **Timescales:** Timescales are tight. Integration needs to be delivered quickly if it is to realise the necessary benefits before the system becomes unsustainable ('A call to action'). In any event we are committed to producing a fully integrated system by 2018. If acute hospital activity levels do not reduce as a result of the integration programme hospitals will be faced with the prospect of less funding as services have been moved into the community, but still having to treat the same, or greater, numbers of patients. We must take care to make sure that the necessary changes do not undermine the viability of our main providers. Similarly we must ensure that in achieving the targets of admission reductions required by the BCF across Kent as a whole we are not distracted by managing issues that may arise through variations in performance between trusts in different parts of Kent.

c) **Managing change:** Changing health services is often difficult as people are very attached to their local hospitals and proposals for changes to how they are

configured, especially if it involves reductions in capacity for whatever reasons are often highly controversial. One way to mitigate this political risk is to implement “double running” of services so that new services are established and proven before older ones that they replace are decommissioned. This is, however, potentially very expensive and money is very limited. The impending general election may also affect developments. Although “integration” is currently the only policy option to deliver better care at lower cost, a change of government next year might lead to different approaches to pursuing integration and a change in emphasis.

d) **Maintaining service quality:** In all of this we must maintain a focus on service quality and the care patients receive. Implementing significant changes to the way services are delivered can have a distracting effect on other parts of organisations’ activity. In particular there is a potential for service quality to be adversely affected when other priorities compete for attention and resources. It is critically important that this is not allowed to happen as the scale and pace of integration is accelerated in the coming months and years and the new CQC inspection regime demonstrates that the regulator will be rigorous in its examination of quality and patient experience as well as clinical outcomes.

e) **Revenue Support Grant allocation disparities.** The amount, per older person, that councils receive varies considerably across the country much to the disadvantage of counties such as Kent. The Relative Needs Formula for Older People (aged over 75 years) allocates £1,957 per head to Inner London Boroughs, £ 816 per head to Outer London Boroughs, £ 978 per head to Metropolitan Authorities and £ 691 per head to Unitary authorities. County Councils receive just £496 per head despite the fact that the proportion of older people in counties is almost twice that of London. The County Council Network is lobbying central government to address this imbalance with KCC actively involved with the Leader acting as CCN Spokesman for Health and Social Care Integration.

Report author contact details:

Tristan Godfrey
Policy Manager (Health)
(01622) 694270
tristan.godfrey@kent.gov.uk

Mark Lemon
Strategic Business Advisor (Health)
(01622) 696252
mark.lemon@kent.gov.uk

Appendices:

Appendix A: ‘I Statements’ from the Joint Health and Wellbeing Strategy

Appendix B: The NHS – A Basic Reference Guide

Background Documents:

- Kent Joint Health and Wellbeing Strategy

- Better Care Fund and Integration Pioneer documents as presented to the Health and Wellbeing Board.