Integrating Health & Social Care in Kent

Saga Pavilion
19 June 2013
Welcome

Tim Pethick
Dr Mark Jackson
Director of Strategy, Saga
Opportunities for Kent: A personal perspective

Paul Carter
Leader of Kent County Council
Integration: Holy Grail for patient care, or service & financial necessity?

Mark Lobban
KCC Director of Strategic Commissioning

Ian Ayres
West Kent CCG
Integration: Holy Grail for patient care or service and financial necessity?
Holy grail for patient care

“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.”
Service and financial necessity

Council cuts will bring local government 'to its knees'
The Guardian 26 March

Social Care Funding Outlook 'Getting Bleaker'
Sky News 8th May

Exclusive: Ministers want CCG topslice to fund health and social care integration
HSJ 2nd May

NHS 'ring fence' threatened by plan to help social care
The Independent 26th April

Nicholson: Transferring health funds to social care spells 'radical changes' to hospitals
LGC 7th June

Dozens of local councils close to collapse, says MPs' committee
The Guardian 7th June

Elderly bear brunt of A&E crisis: Number of over-90s rushed to hospital by ambulance soars by 66% after £1.7bn cut to social care
Daily Mail 11th June
Sustainability of health & social care in Kent

**Risk**

- CCGs £1750m
- KCC – ASC 34% £8000m

**Opportunity**

- Health and Adult Social Care – ASC 16% £2085m

No real term growth

Demographic & Price Pressures

- £20m
- ... In 2 years time

ASC £285m

- £200m deficit 14/16
- Transport
  - Highways £68m
  - Waste £68m
- Libraries £14m
- £40m
- £68m
- £50m

It’s not what you do with £20m more, but what you do with £70m less!

We **must** consider Health and Social Care as a whole

... but only if we work together!
thank you

Mark Lobban
Director of Strategic Commissioning

Ian Ayres
Accountable Officer West Kent CCG
Innovation: Ideas into Action

Proactive Care:
Dr Tuan Nguyen, South Kent Coast CCG

Crossroads Care:
Irene Jeffrey, CEO Crossroads Care West Kent
Elizabeth Champion, MTW NHS Trust

Maureen’s Journey:
Dr Mark Jones, Canterbury & Coastal CCG
INTEGRATION OF HEALTH AND SOCIAL CARE

Irene Jeffrey
Crossroads Care West Kent

Elizabeth Champion
Lead Nurse Dementia Care
OUR IDEAS INTO ACTION

Two innovative, person centred projects supporting our Health colleagues:

1. Dementia Crisis and Emergency Response started April 2010
2. Hospital Admission Avoidance/Early Discharge started February 2013
DEMENTIA CRISIS AND EMERGENCY RESPONSE

- Aims to prevent breakdown of a caring situation through support in crisis situations
- Only open to those with known or suspected dementia
- Joint commissioning between NHS West Kent and Kent County Council
- Contract awarded through a competitive tendering process
THE SERVICE

- 24/7 service with a 2 hour response
- Staff attend client’s home, assess situation, provide support as needed
- Involve family where possible
- Refer to other services as needed
- Liaise with Social Services, Health and Mental Health teams
FACTS AND FIGURES

- Over 500 referrals to date
- 151 referrals over last 12 months
- Referral routes were 52% Health; 40% Social Services and 8% other routes
- KCC estimate savings of £800,000 on a £100,000 investment for the year
Mr and Mrs J, very private couple in their 90s
While shopping, Mr J fell and cut his head
Mrs J was being looked after by a neighbour who could not stay
We responded immediately
Took over responsibility of Mrs J’s care
Mr J was able to come home from hospital that night because we were there
HOSPITAL ADMISSION AVOIDANCE

- Aims to prevent inappropriate hospital admissions for those with dementia also relieve pressure on hospital beds
- One year pilot at Pembury Hospital
- Successful Dementia Challenge application
- Pilot working alongside Dementia Crisis service
THE SERVICE

- Crossroads Co-ordinators based within A&E
- Supported by team of community based staff including night staff
- Referrals are not 24/7 but service is
- Identifying barriers to discharge with Health professionals
- Working together to find solutions
- Own Bed is Best
CLINICAL PERSEPECTIVE

- Early, significant impact especially within wards
- Crossroads has provided professional, respected, point of contact for hospital staff
- Enhanced staff education around community services
- Joint home visits between OT staff, patient and Crossroads
CASE STUDY

- Lady, aged 81 with Vascular Dementia
- Admitted with fractured femur
- Crossroads Team liaised with Hospital
- Joint home assessment conducted with OT
- During home visit, agreed that lady could remain at home with support from Crossroads Challenge Team and not return to hospital for discharge date
THE FINAL SAY GOES TO SERVICE USERS...

DEMENTIA CRISIS SERVICE

- “So valuable, I didn’t know where to go or who to turn to”
- “Without your help, my husband would have had to go into care”
- “Wonderful service, such a relief to know help was on its way”
THE FINAL SAY....

HOSPITAL AVOIDANCE

- “enabled me to go back into my own home and gain confidence. Also gave re-assurance to my daughter when she was at work and I was on my own”

- “enabled mother to live independently following 9 days in hospital and complete confusion and anxiety”
System model of integrated UC and LTC

“LTC care in the community that prevents patients going into crisis”

“24x7 urgent care that deals with crisis in appropriate setting and swiftly route patients back into community”

Legend

Services
Enablers
Single Points of Access
Maureen's Journey

Maureen is known to the GP practice and has been treated by a district nurse team.

82 year old with multiple, complex LTCs
- COPD
- Neuropathy
- Possible cancer

She is on the palliative care register.

Falls and Shortness of Breath

She deteriorates with falls and shortness of breath.

Out of Hours

Her daughter calls 111, who are fully aware of advanced care plan and palliative care register.

999

111 assessment identifies two options:
- Either a community response or that Maureen needs assessment at hospital.

Community response

Admitted to Integrated Urgent Care Centre (IUCC)

Advanced care plan

Out of Hours refers to 999

Does not need admission

Assessed and transferred within 4 hours

Admitted for symptom control

Transferred to NCT

NCT providing care in the community

Discharged home

The neighbourhood care team (NCT) is mobilised.

7 day stay in hospital

The neighbourhood care team (NCT) is working with hospital around estimated discharge date.

Discharged home

The neighbourhood care team may access hospice team for additional care.

She is treated in the community and dies in her preferred place of death.

Dies in preferred place of death

Maureen dies 1 day later in the hospice.
Thank you
Delivery: Enablement in Practice

Saga, Hertfordshire, CACI

John Cahill, Regional Managing Director - South

Vanessa Readhead, Director
Partnering to drive innovation and outcomes for mutual benefit
Agenda

- Enablement
- Hertfordshire County Council- The Commissioner
- Principles of partner working
- Roadmap – service design through to stable state services
- Results to date
- Critical Success factors
Enablement

Objectives of service

• To maximise users long term independence, choice and quality of life
• To appropriately minimise on-going support required and thereby minimise the whole life cost of care

Definition of service

• Helping people ‘to do’ rather than ‘being done to’
• Outcome focused with defined maximum durations
• Continual assessment over a defined period to assist in maximising independence and reducing the cost of on going care
• Enabling similar or same levels of competence
Context for Hertfordshire

**HCC in context**
- £1.2M population and rising
- Demographics around National Averages
- £200M council budget reductions by 2015 plus
- 45% of that budget in Adult Social Care
- Majority of services outsourced

**HCC commissioning intent**
- Bold commissioning recognising the need for new services to develop over time
- Outcomes agreed allowing an iterative process to test concepts
- Guidance set through evidence based practice
## Partner Working

### Partner Selection

1. Shared Values and culture
2. Capability and capacity
3. Risk sensitive
4. Senior level commitment to innovate
5. R&D pipeline
6. Expertise
7. Network
8. Experience

### Characteristics

- Transparent decision making
- Co-exploration
- Single road map of progress
- Regular contact
- Co location of teams
- Shared risk and reward
- Open book
- Payment by results
- Prioritised investment plans
Roadmap

Apr 2010
- Partnership work with HCC and CSED on specification development

Aug 10-April 11
- Commissioned as part of HCC mainstream contract
- Staff mix based on HCC referral projections
- Referrals source: Hospital and Community

Nov 11- Apr 12
- HCC’s Social Work teams under consultation from Nov 11 to Apr 12 when they were outsourced to Serco
Roadmap

Feb 11
- Change in referrals to include scheduled and unscheduled reviews, LD, MH and EOL

Nov 11
- Introduction of ACSIS / Universal Assessment tool, which led to changes in referral management and flexing in back office arrangements
  - Introduction to CACI

Nov 12
- Introduction of partnership and quality
Investment decisions

CACI
- Carer smart-phone deployed
- Real-time rosters
- Discreet authentication
- Notes on Service User
- Capture of outcomes
- Lone worker safety
Outcomes Monitoring

- Fed from point-of-care
- Planned vs actual
- Quantitative & Qualitative
Future progress and innovation

- Deliver Herts Commissioning real-time data and existing systems integration
- Explore providing key data through internet to Friends & Family
- Horizon scan and test assistive technologies
- Profiling cases (health x crisis x support x AT= average cost to serve)
Results to date
Immediate Financial Results

- £3.5M saved annually on staffing
- £3M+ saved through enablement
- Cost to serve was reduced over first 12 months by 15%
HCC and Customer benefit

Referrals In 2012/13 - Percentage GHC/ Non-GHC p/m

Month 2012/2013

% of Tot. Referrals, 12/13

Referrals in % (GHC)

Referrals in % (Non-GHC)
HCC and Customer Benefit
Customer and HCC benefit

Service User Outcomes

Percentage of Planned Exits

- No Service: 50% (2010/2011), 63% (2011/12)
- Reduced Service: 10% (2010/2011), 15% (2011/12)
- Same Service: 30% (2010/2011), 21% (2011/12)
- Increased Service: 1% (2010/2011), 1% (2011/12)

Ongoing Homecare Service: commissioned hours at exit compared to hours at entry

Goldsborough
Hertfordshire
CACI
The Enablement Service Made a positive Difference to me

- Reporting period 1
- Reporting Period 2

- target
- total satisfied
Critical Success Factors

- Open dialogue and co-production
- Comprehensive change management
- Multiple partnering
- Using technology and information well
- Views of service users and carers
- Shared ownership of outcomes
- Shared understanding of HCC commissioning goals/targets
Public Health: The Changing Landscape

Professor Chris Bentley
Integrating Health and Social Care in Kent

Public Health: The changing landscape

Professor Chris Bentley
HINST Associates
Partnership, Vision and Strategy, Leadership and Engagement

Population Level Interventions

Systematic and scaled interventions through services

Systematic community engagement

Intervention Through Services

Service engagement with the community

Intervention Through Communities

Producing Percentage Change at Population Level
a) Coronary Heart Disease (Harison et al. 2006)

![Diagram showing the stages of coronary heart disease]

b) Generic ‘Decay’ model (not to scale)

Have the problem | Aware of problem | Eligible for intervention | Optimal input | Active use of systems
---|---|---|---|---
Have LTC | 2.6m | 2.3m | 1.3m | 1m
Aware of LTC | 5.7m |
A. Defining and reaching out to the vulnerable
   creating a ‘list-of-lists’ virtual register of most at risk

B. Screening for risk and the ability to benefit
   systematic checklist of eligibility for 9 interventions

C. Quality service inputs
   what good looks like for 8 of the interventions

D. Supporting good self management
   the 9th intervention – maximising personal assets
## Assessment of vulnerable elderly against 9 interventions

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<th>Falls assessment</th>
<th>Vaccinations</th>
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- **Assessed/No problem**: No issues found.
- **Referred/In process**: Undergoing assessment.
- **At risk**: Requires further attention.
Benefit from evidence based interventions across populations
(not to scale)
Discussion:
What’s stopping integration in Kent?
Summary & Next Steps

Dr Mark Jackson

Dr Robert Stewart