Integrated Care and Social Care

SBRI Healthcare NHS England and NHS Improvement competition for development contracts

June 2019

The AHSN Network

Summary

A new national Small Business Research Initiative (SBRI) Healthcare competition is being launched by NHS England and NHS Improvement in partnership with the Academic Health Science Networks (AHSNs) to find innovative new products and services. The projects will be selected primarily on their potential value to the health service and social care system and on the improved outcomes delivered for those in receipt of care.

The competition is open to single companies or organisations from the private, public and third sectors, including charities. The competition runs in two phases (subject to availability of budget in 2020):

- Phase 1 is intended to show the technical feasibility of the proposed concept. The development contracts placed will be for a maximum of 6 months and up to £100,000 **(inc. VAT)** per project
- Phase 2 contracts are intended to develop and evaluate prototypes or demonstration units from the more promising technologies in Phase 1. Only those projects that have completed Phase 1 successfully will be eligible for Phase 2 (12 months and up to £1m per project).

Developments will be 100% funded and suppliers for each project will be selected by an open competition process and retain the intellectual property rights (IPR) generated from the project, with certain rights of use retained by the NHS.

The competition opens on **Monday 24th June 2019**. The deadline for applications is **12:00 (noon) on Wednesday 14th August 2019**.

Introduction & Background

There is currently a drive to transform the NHS and social care system to address the growing, and increasingly unsustainable, pressures faced by the system. This drive includes initiatives to transform the health and care workforce, to integrate health and care to better meet the needs of the population and to expand and improve access to health and social care[1].

Integration of care across primary, secondary (hospital), tertiary (specialist centres), social and community care, that is increasingly person-centred, is an aspiration described in the NHS Long Term Plan[2] (LTP). The NHS has been piloting 'New Models of Care[3]' with the Vanguards projects that came out of the Five Year Forward View[4] and is now planning to have Integrated Care Systems (ICSs)[5] across England by April 2021.

The ICSs represent a major part of the response to the unsustainable increase in demand on the healthcare system from an ageing population. More joined up care has demonstrated the ability to keep people living at home for longer, cared for at home rather than being admitted to hospital and being discharged from hospital sooner, but this now needs to be widely spread across the country.

[1] Understanding and supporting the integration of health and social care at a neighbourhood level in the City of Manchester
[2] NHS Long Term Plan
[3] NHS New Models of Care
[4] NHS Five Year Forward View
[5] NHS Integrated Care

The Industrial Strategy Challenge Fund has a Healthy Ageing Framework[6] aimed at addressing the 19.4% increase in over 65s from 10.4M to 12.4M from 2017 to 2025 and the 25% increase in those living with disability from 2.25M to 2.81M.

The total cost of Adult Social care in England in 2017/18 was £17.9 billion, a real terms rise on the previous year with the largest increase being in long term support, costing £14 billion despite a decrease in over-65's receiving long term care[7].

An analysis by NHS England and NHS Improvement of the cost of care by frailty categories for over 65's (fit, mild, moderate, severe) indicates that:

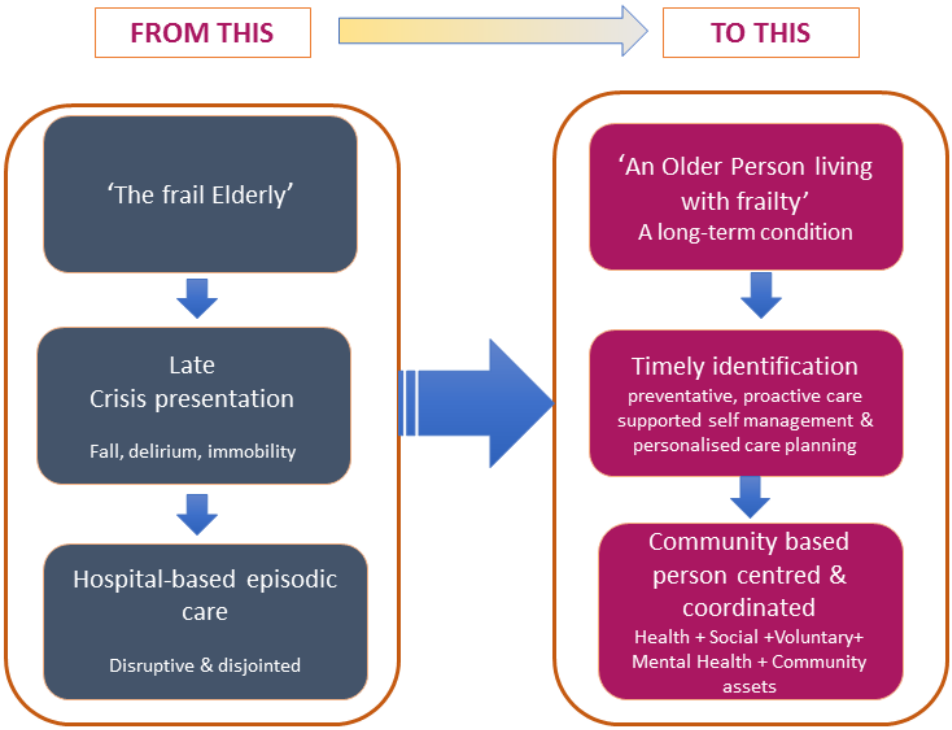
- The estimated annual care cost for people aged ≥ 65 with severe frailty in England is £2.0 billion
- The estimated annual care cost for all people ≥ 65 in England is £15.3 billion
- If only 10% of people in each category were one category lower the savings would be £605.3 million

Most frail GP patients are much older than average, although there are many frail younger people as well.

Frail people are more likely to live in deprived areas and do not always get the optimum care on discharge from hospital, which is inconsistent across the country.

National Audit data (NAIC 2017[8]) suggests that intermediate care capacity needs to increase and be more responsive. The average age of service users in bed-based intermediate care is 83 years (25% of these >90), in home based services, 80, and reablement services, 79.

The LTP aspires to a significant change in the management of frail patients:



Specifically, the commitments include:

- the use of community multidisciplinary teams (MDTs) to assess 1.2m people with moderate frailty

[6] ISCF Healthy Ageing Framework
[7] Adult Social Care Activity and Finance Report, England – 2017-18
[8] National Audit of Intermediate Care

- guaranteed offer of enhanced health in care homes (upgraded NHS support in care homes for those who would benefit and whole country roll-out over 10 years)
- urgent community response delivered by 2023/24
    - crisis response delivered in 2 hours
    - reablement delivered in 2 days

According to the National Clinical Director for Older people, systems should aim to build the following into their 5 year plans[9]:

- Benchmarking of Ageing Well services
- Supporting complete and quality data submission to the Community Services Dataset (CSDS)
- Planning for appropriate activity changes
- Workforce growth and development plans, including working with local voluntary sector
- Development of local Ageing Well service specifications
- Planning to achieve required metric reporting
- Cross sector and organisation information/data sharing agreements
- A cross sector engagement strategy
- Plan to identify and address issues which prevent cross-organisational and integrated team working

For the frail young as well as the elderly and other chronically ill, the overlap of mental and physical health is now well-established[10] but effective integration is not available broadly or consistently.

In addition, it is now increasingly appreciated that patients that are supported to manage their own health (patient activation) have better outcomes[11], although the levels of patient activation remain low at only 1 in 6. The NHS has a Patient Activation Measure[12] that is designed to support the concept of personalised care that was set out in the Five Year Forward View and developed further in the LTP.

Successful innovations will deliver[5]:

- Social impact – achieving better outcomes for individuals, families and communities
- Economic impact – development of new products, services and markets
- Fiscal impact – reducing the rise in cost of public services

by stimulating the development of products, services, system innovations and alternative business models that can generate impact at scale, are inclusive and affordable to ensure health inequalities are addressed and can reach people with limited incomes.

It will be essential for innovators to develop proposed technologies and services in partnerships with people with lived experience and key collaborators, tackling problem definition, co-design and co-production throughout the innovation process. It will be important to understand the impact of any changes across the system to avoid simply moving costs around the system.

[9] Ageing Well presentation by Martin Vernon
[10] Academy of Medical Sciences Forum 2016, Sir Simon Wessely
[11] Supporting people to manage their health – An introduction to patient activation – Health Foundation
[12] Patient Activation Measure quick guide

The Categories

Under the overall theme of 'Integrated Care and Social Care', two categories have been identified via consultation with clinicians and other stakeholders working in provision of care across the spectrum of care. These are outlined in detail below.

Applicants are expected to respond to one of the two categories, whilst being mindful of the broader system.

Those submitting applications are also asked to consider:

- How will the proposed solution impact on the care pathway and how will the care pathway need to be changed in order to deliver system-wide benefits?
- How will you ensure that the technology will be acceptable to patients (and their families and wider support network) and to health and social care workers? How could these groups be involved in the development of the innovation?
- How will you ensure that the technology is affordable to the NHS and wider system such as ICSs both immediately and throughout the life of the product? What health economics evidence will the NHS and wider system require before the technology can be adopted?

Category 1: Improve effective data sharing systems across the care network

Background

The ideal solution of everyone having access to the information they need at the point of care and to manage remote MDT assessments in a secure and compliant way across patients, family, primary, secondary, tertiary, social and community care, is the ultimate goal but there are several key steps along the way to achieve an efficient integrated care.

Improving health and social care will involve integrating services around people, in particular those who need an integrated service offer. The direction of travel in integrated care is the focus on enabling patients and citizens to gain greater control over the design of their own care- including Personalised Care Budgets.

It is well-evidenced that patients recover or do better if they are 'activated'[13]. In other words they are encouraged and enabled to take a more active and positive role in their own care planning and delivery. In many studies, activation level was found to have significant effects on patient adherence to treatment and eventual outcomes as well as costs of care[9].

Physical activity can help in maintaining cognitive function. However, there is currently a significant number of people living with dementia who are yet to receive a diagnosis. As of January 2019, around 68% of over 65s estimated to have dementia had been diagnosed. Even after diagnosis, people continue to live at home for a number of years, often with support from family carers. Maintaining functional ability during these years is critical in extending the period of time before people require intensive care and support.

[13] What the evidence shows about patient activation, Hibbard & Green, Health Affairs 2013, Vol 32 No. 2

The new models of care should be based on what people need, not on what services have traditionally provided, with joined-up processes for how patients access services, how they are triaged and assessed and how their care needs are planned[14].

Challenges

Potential solutions to this challenge should be able to work across both metropolitan and rural settings, be scalable and favour integrated neighbourhood teams to consider the health and care needs of the local population, deliver seamless care for individuals across health and social care services and reduce referrals through the system and the number of different professionals one individual may see.

In addition, recognising the key demographic factors and growing inequalities in health life expectancy, potential solutions to these challenges also include system innovations that focus on prevention and delay of the factors leading to poor health, maintain functional ability and that are inclusive, affordable and delivered where and when needed. Understanding the challenge from both a health and social care perspective, which may be different and prevent early diagnoses in different ways.

Potential solutions to this challenge include strategies that help:

1. Redesign of outpatient services and referrals using digital platforms or devices- linking GPs, hospitals services and social care providers providing clinical information to work collaboratively as an MDT, enabling remote working for efficiency improvements and enhance patient flow into and out of acute care providers, while at the same time remaining sensitive to existing systems and work already in progress.

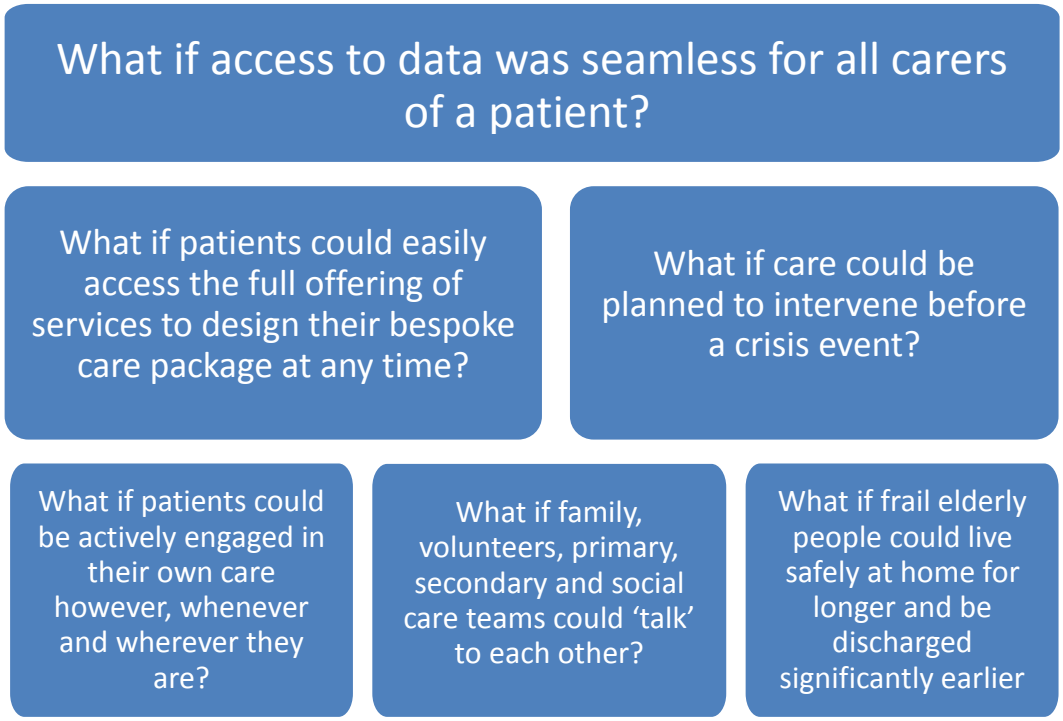
2. Develop efficient communications systems between secondary care, care homes and citizens' homes to facilitate the tracking and sharing of data across social and health systems and to enable improved communication with integrated neighbourhood teams.

3. Develop digital systems of engagement for providers of care to assist delivery of support from the voluntary sector and accessing social prescribing services which 'talk' to other systems for ease of communication.

4. Enhance and support older people living with frailty (75+) and patients with chronic and/or multiple conditions, in particular those with dementia, to keep them out of hospital and prevent late and poor diagnosis where possible

The following "what if's" are some examples of scenarios that have the potential to help meet unmet needs in this "Improve acute & community data sharing systems" challenge. The statements are intended as examples only.

[14] Manchester City Council Health Scrutiny Committee- 5 September 2017 "New Models of care"



Category 2: Reduce social care workforce pressure

Background

Across the UK, more people work in social care than in the NHS, with social care representing 6% of total UK employment[15].

Adult social care spending in the UK has fallen by 9.9% between 2009/10 and 2016/17. An ageing population and younger adults with disabilities living longer are pushing up the cost of caring for older and disabled people, placing the social care system under huge strain. Based on current spending, a UK funding gap of £18 billion will open up by 2030/31.

There was a 6.6% vacancy rate for the adult social care sector in 2016/17 and particularly high turnover rates for care workers. Informal carers, including charities, volunteers, friends and family, continue to adsorb the bulk of the pressure. 75% said they had not received any support or service which allowed them to take a break from caring of between one and 24 hours in the last 12 months.

Moreover, cuts in local authority social care spending have led to increased use of A&E services by people aged 65 and over[16]. Co-designing personal care packages that are delivered at home creates additional pressures related to logistics and time for carers, which can be exacerbated by geography (e.g. long distances in rural locations).

Challenges

Potential solutions to these challenges include system innovations that help in relieving pressure on a stretched social care workforce while at the same time:

[15] ICF Consulting Limited (2018). The economic value of the Adult social care sector- UK
[16] What the problem with social care and why do we need to do better

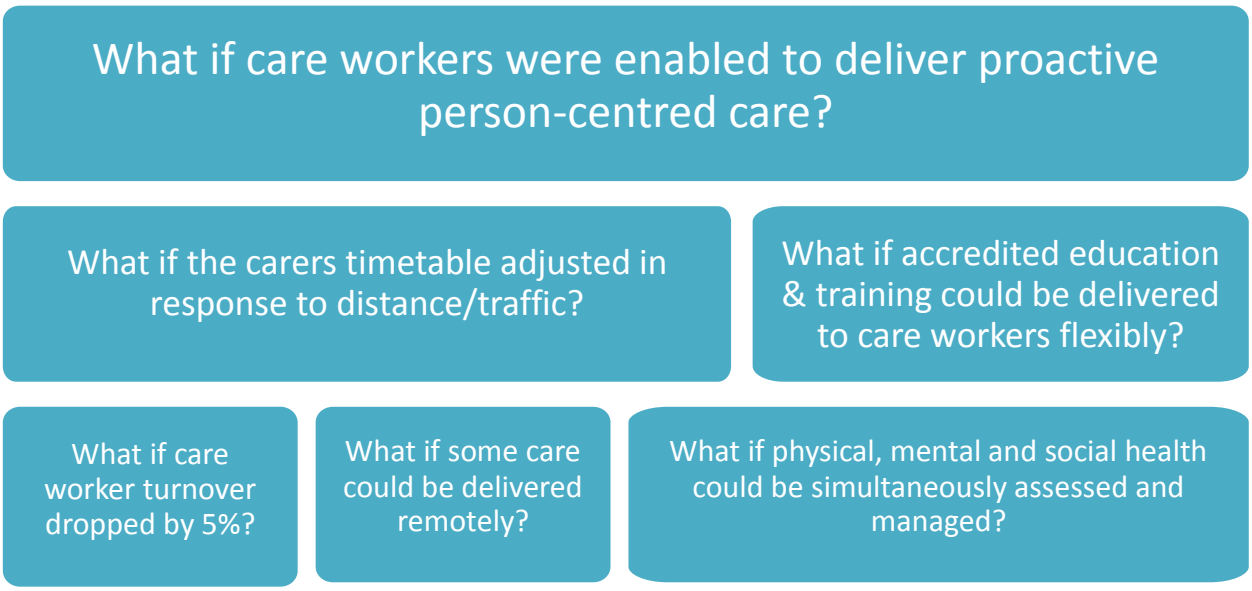
1. Enhancing the quality of life in care settings, delivering more personalised care to end users

2. Addressing social isolation amongst the most vulnerable adult population and enable people to sustain and broaden their social connections and relationships; it is indeed recognised that lonely or isolated people are also likely to face a range of other health and social problems[5]

3. Delivering flexible working and education and training programmes, leading to improved delivery through increasing skill sets, satisfaction of the workforce and increased retention of staff.

4. Enabling remote delivery of care and improved recording of care delivered, as well as assisting with transport planning (both metropolitan/urban and rural) and the logistics of the delivery of care that take account of the specific problems in both rural and metropolitan areas.

The following "what if's" are some examples of scenarios that have the potential to help meet unmet needs in this "Reduce social care workforce pressure" challenge. The statements are intended as examples only.



Technologies excluded from this competition

There are a number of technologies or types of solution which are already available, sometimes from multiple suppliers; these are listed below. Any technologies that negatively impact GP workloads will also be excluded.

- 'Manage my condition' apps (e.g. glucose monitoring apps)
- Bed capacity monitoring systems
- Social networking, messaging or imaging apps
- Patient tracking systems
- Task lists
- Wearables that are not part of innovative business models of delivering integrated care
- Anything only to do with diabetes prevention and management

Additional Considerations

Given the rural nature of many places with the largest need, an over-reliance on being online is to be discouraged (wifi and phone signals in rural locations may be weak or unreliable)

For any digital intervention, the NICE Digital Health Technology Framework should be consulted and your application should evidence your plan to meet the appropriate evidence guidelines. This comprises both clinical effectiveness and economic evaluation.

Application process

This competition is part of the Small Business Research Initiative (SBRI) programme which aims to bring novel solutions to Government departments' issues by engaging with innovative companies that would not be reached in other ways:

- It enables Government departments and public sector agencies to procure new technologies faster and with managed risk;
- It provides vital funding for a critical stage of technology development through demonstration and trial – especially for early-stage companies.

The SBRI scheme is particularly suited to small and medium-sized businesses, as the contracts are of relatively small value and operate on short timescales for Government departments.

It is an opportunity for new companies to engage a public sector customer pre-procurement. The intellectual property rights are retained by the company, with certain rights of use retained by the NHS and Department of Health.

The competition is designed to show the technical feasibility of the proposed concept, and the development contracts placed will be for a maximum of 6 months and up to £100,000 (incl. VAT) per project.

The application process is managed on behalf of NHS England and NHS Improvement by LGC Group. All applications should be made using the application portal which can be accessed through the SBRI Healthcare Website

Briefing events for businesses interested in finding out more about these competitions will be held on 1st July in London and on 10th July in Manchester. Please check the SBRI Healthcare Website for confirmation of dates and venues, information on how to register and details of the challenges that will be presented at each event.

Please complete your application using the online portal and submit all relevant forms by **12:00 (noon) on Wednesday 14th August 2019**.

Key dates

Competition launch	24 June 2019
Briefing events	1 July, London
	10 July, Manchester
Deadline for applications	14 August 2019 (12:00)
Assessment	August/September 2019
Interview Panels	10 October 2019
Contracts awarded	November 2019

More information

For more information on this competition, visit: www.sbrihealthcare.co.uk

For any enquiries e-mail: sbri@LGCGroup.com

For more information about the SBRI programme, visit: https://www.gov.uk/government/collections/sbri-the-small-business-research-initiative

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