Annex 2

Kingston Coordinated Care - Progress Report
Executive Head of Adult Care and Managing Director for Kingston and Richmond Local Delivery Unit

Purpose

To inform the Board about the Kingston Coordinated Care (KCC) Programme.

Recommendations of the Portfolio Holder for Partnerships and the Chair of the Kingston Clinical Commissioning Group

For Information

What is the Kingston Coordinated Care programme about?

Kingston Coordinated Care is all about health and social care services working together for the benefit of residents.

The Kingston Coordinated Care Programme was set up in response to what local people said they needed and wanted from local health and social care.

When asked about what they needed to stay healthy, active and independent in the face of everyday challenges, people said they wanted to be: socially connected and part of their community; mentally active with a positive attitude to life, and; physically active with practical support available if and when they needed it.

When asked about their experience of using local health and social care services and what they wanted from them, people said they wanted to: be better understood and listened to; have more choice and control over their services; have easier access to more coordinated services, and; have consistent quality across services.

Kingston Coordinated Care also responds to a number of Government policies as well as challenges facing both Local Authorities and the Health sector including:

- the Government agenda for joined up care (NHS/Local Authority/Public Health)
- NHS Sustainability and Transformation Plans (STP)
- Diminishing resources and increasing demand
- Changing demographics and people's expectations

The Kingston Coordinated Care programme objectives are:

- to ensure people stay independent, healthy and well for longer with good community support so they can enjoy their lives to the full, and;
- to ensure people have easy access to top quality, person-centred coordinated health and social care support when they need it.

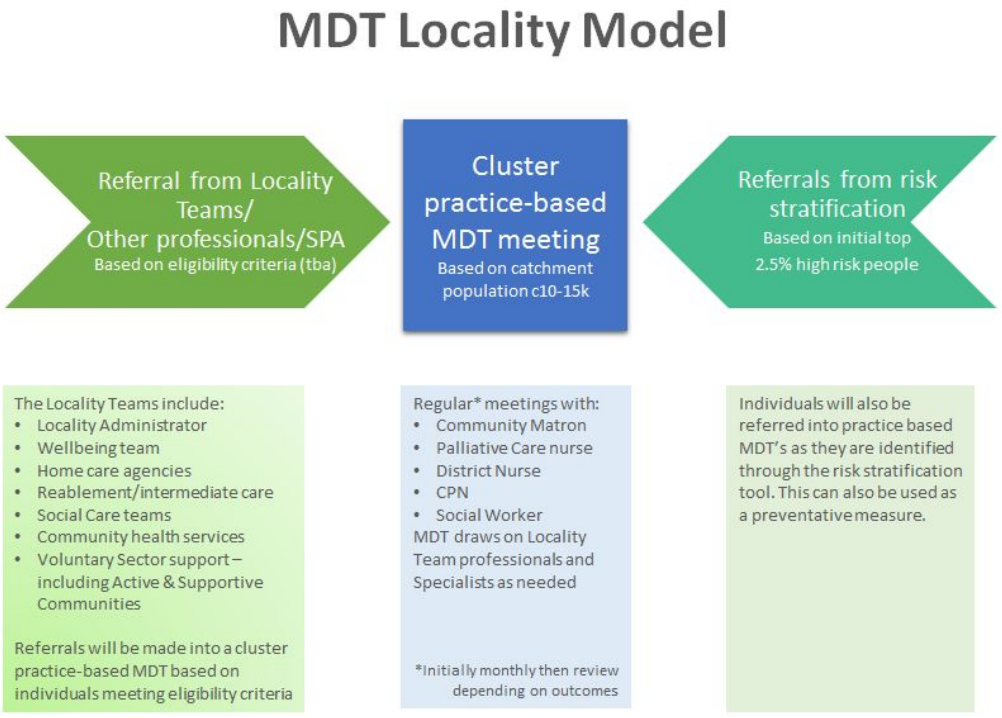
The programme comprises the following interconnected projects: Home Care

Transformation, New Model of Care, Collaborative Commissioning, Active & Supportive Communities and Kingston Care Record (KCR).

The New Model of Care project is delivering an integrated single point of access (SPA) to ensure everyone gets high quality information and advice and can be supported to access support already in the community. It will also be setting up an infrastructure that will promote self-support, enabling people to self-assess and find the information they need themselves.

The project will also create 4 locality teams across Kingston made up staff from the different providers. The four areas are New Malden, Chessington, Kingston, Surbiton. The locality teams will build on existing community based health and social care infrastructure where integrated 'locality teams' will bring together; social care, mental health, community health, secondary care, primary care, voluntary sector and home care.

These staff will work alongside GP practices forming multi-disciplinary teams (MDTs). The New Model of Care will focus on ensuring that we better understand how the well-being of a person is impacted by their medical conditions or social care needs and seek to address that, rather than focus on just treating the need / condition. This is called taking an asset based approach, building on what is working well for a person, rather than focusing on everything that is not working so well. Working this way will help a person take back control of their lives and in time support less use of GP appointments and attendance at A&E.



The first pilot of the New Model of Care will be implemented in New Malden.

The Home Care Transformation project is looking at adopt an innovative approach that will see the traditional home care function integrated as a core element of the New Model of Care. This will mean home care will be part of the locality team structure. The Council is looking to develop ‘well-being teams’. Well-being teams are small groups of semi-autonomous care workers (typically 10-12 staff) whose role is not just to provide care and support but to help people connect with the support available in the community. Teams will be clustered around the GP practices areas that will make up the MDT way of working the locality model is developing.

New ICT solutions will support people who remain in their own home including a home care ‘app’.

The Collaborative Commissioning project sees RBK and Kingston CCG working together to deliver collaborative approaches to commissioning. There is a particular focus on Mental Health, Children, Learning Disability and Kingston Coordinated Care where there is a natural alignment of aims especially around the delivery of the STP and demand management.

Working in close partnership with the voluntary and community sector, the Active and Supportive Communities project has promoted the benefits of ‘social prescribing’. This encourages health and social care practitioners to refer people to a range of local, non-clinical services often provided by the community and voluntary and sector. The project has also helped to mobilise a network of local voluntary and community sector partners who are keen to collaborate in implementing such

approaches in the borough. In addition, to support this work, the project has also specifically focused on improving the online information content provided by the Council's Adult Social Care department. This includes developing new online functionality to help residents to navigate to information about services/support relevant to them, as well as the potential costs, more quickly.

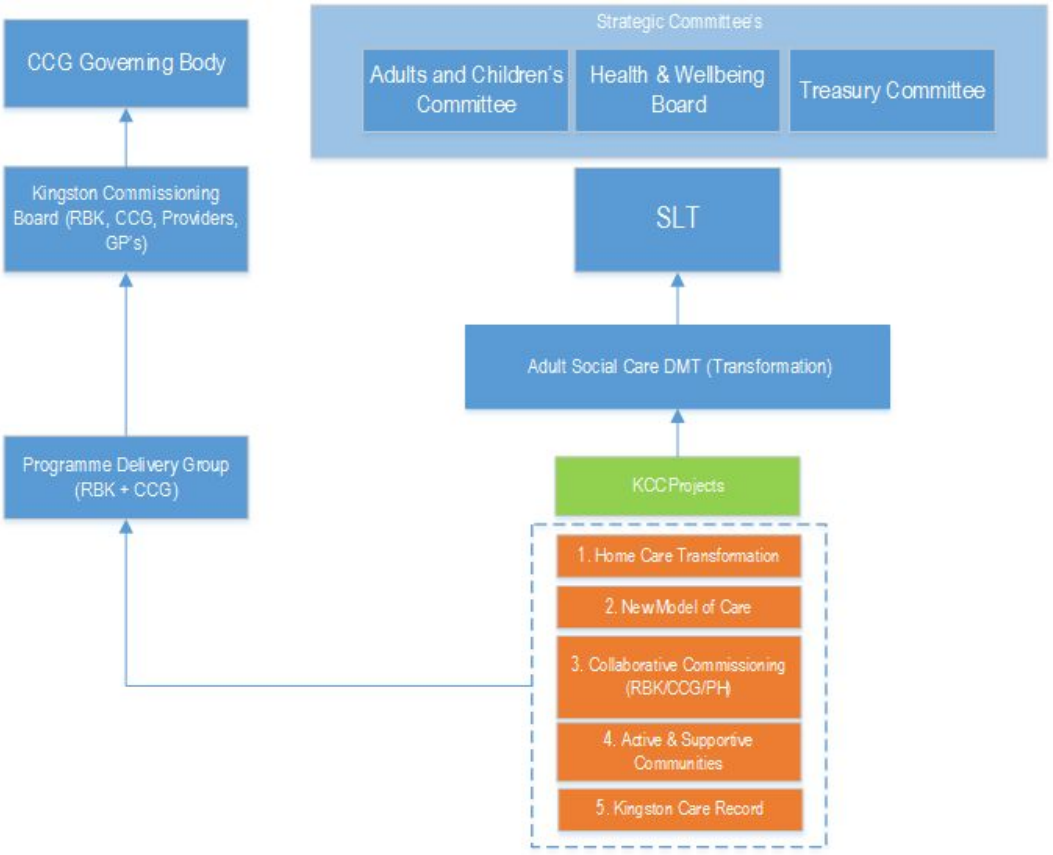
All of this is supported by the Kingston Care Record (KCR) which is a confidential electronic record containing both health and social care information. This means those delivering care can do so with up to date information and without asking people to repeat their stories numerous times.

How it relates to health partners

Kingston's health (CCG) and social care (RBK Adult Social Care) commissioners and providers are working collaboratively to develop and implement the new integrated model of health and social care for the Kingston system.

This New Model of Care enhances the capability and capacity of primary and community care services (health - physical and mental, social and voluntary) to support greater service integration and seamless care for patients as well as supporting the shift of activity out of hospital into other care settings.

Reporting lines



Improving collaborative commissioning

RBK and Kingston CCG have agreed collaborative approaches to commissioning, with a particular focus on mental health, children, learning disabilities and Kingston Coordinated Care.

There is a commitment to continue to collaborate on commissioning where there is a natural alignment of aims that contribute to the commissioning of KCC, delivery of the STP and managing demand, for example nursing and residential care, home care, supported by a stronger drive towards resource pooling and risk share agreements.

Current challenges and how they are being approached

Regarding Active and Supportive Communities the main challenge is the capacity within the voluntary and community sector to deliver the prevention and early intervention work.

Regarding Home Care the main challenge is the ability to have sufficient capacity of workers with the right skills and competencies to support people in Kingston, given most care workers live outside the Kingston area. The proposed model (well-being teams) promotes community based groups of home care workers and will give them more autonomy and control around their work, as well as improved terms and conditions.

Information sharing has improved with the implementation of the Kingston Care Record. Central to the new way of working is use of the Risk Stratification tool. This tool supports MDTs to take a different look at the people living in the area and who needs support. Currently the tool only uses health data to produce reports and social care data needs adding to give a more holistic view of the people in any given area. Kingston has agreed its approach to seeking service user consent to enable social care data to be shared. Once the necessary information governance arrangements have been signed-off this will be tested and then social care data will go-live.

The new model of care requires a significant shift in the way staff work and relate to each other. The new model will challenge traditional boundaries around which providers and roles carry out particular functions. Staff will be supported through this with a workforce development programme.

Background papers - None

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