Health Overview Panel

28 March 2018

Progress with the Locality and Wellbeing Teams

Report by the Director, Adult Services

Purpose

1. To update the Health Overview Panel on the work being undertaken by the KCC Delivery Group as supported by the Provider Principals Group. In particular to outline the new way of working being piloted and implemented across health, social care and the voluntary sector in order to achieve improved and more effective outcomes for the residents of the Royal Borough of Kingston.as jointly commissioned; and

2. The report will also set out progress on well-being teams and the new way of working that focuses on support for people within their own homes, delivered by a skilled workforce supported by providers from health, adult social care, and the voluntary sector across Kingston.

Recommendations

1. To understand and celebrate the progress in achieving collaboration and increased connectivity achieved to date and what the next steps will be in order to achieve a new way of working.the Kingston Co-ordinated Programme; and
2. To note progress on the adoption of Well-Being Teams and understand the way developments will form part of the new locality model.

Introduction

1. Kingston Coordinated Care is a whole system transformation programme to deliver better services and improved outcomes to the population of Kingston through the development of more integrated services.
2. 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

3. 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

4. The key partners in the delivery of KCC have established a joint governance structure by forming a Kingston Provider Alliance which is comprised of:

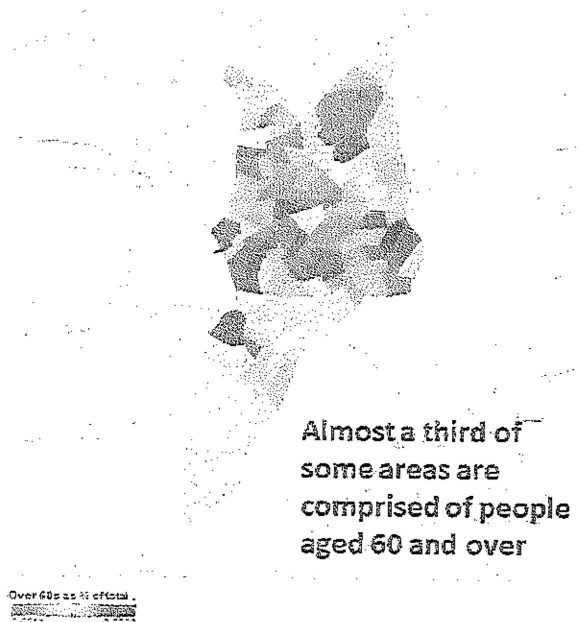
   - Kingston Hospital NHS Foundation Trust
   - Royal Borough of Kingston Council
   - Kingston GP Chambers
   - South-West London and St George's Mental Health NHS Foundation Trust
   - Staywell (representing the wider Voluntary Sector)
   - Your Healthcare

5. The partners are working together collectively to deliver the KCC vision and the Alliance is bound by a Memorandum of Understanding (MoU). A delivery group, with operational leads from each organisation has been established that report to the Provider Alliance Principals Group.

System Analysis and Population Data

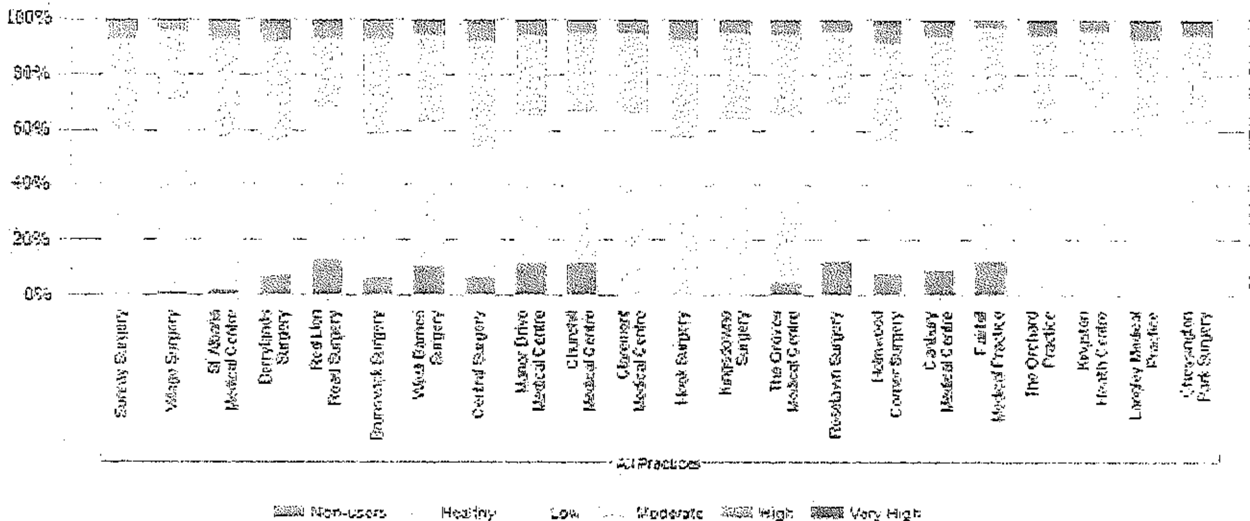
6. A population segmentation approach has been taken to ensure that the model of care is reflective of the needs of each population and that we don't deliver a one size fits all approach. The following high level data summarises the broad issues and challenges the KCC programme aims to address.

7. Looking at the whole population, Kingston has a number of unique characteristics, reflected by the diverse spread across the borough in relation to deprivation, health, income and age.



Risk Stratification

8. The Kingston Risk Stratification system aligns practice and hospital data and assigns a risk score to each patient. Below is the Resource Utilisation/ risk Band (RUB) for Kingston CCG, and is also shown by practice.

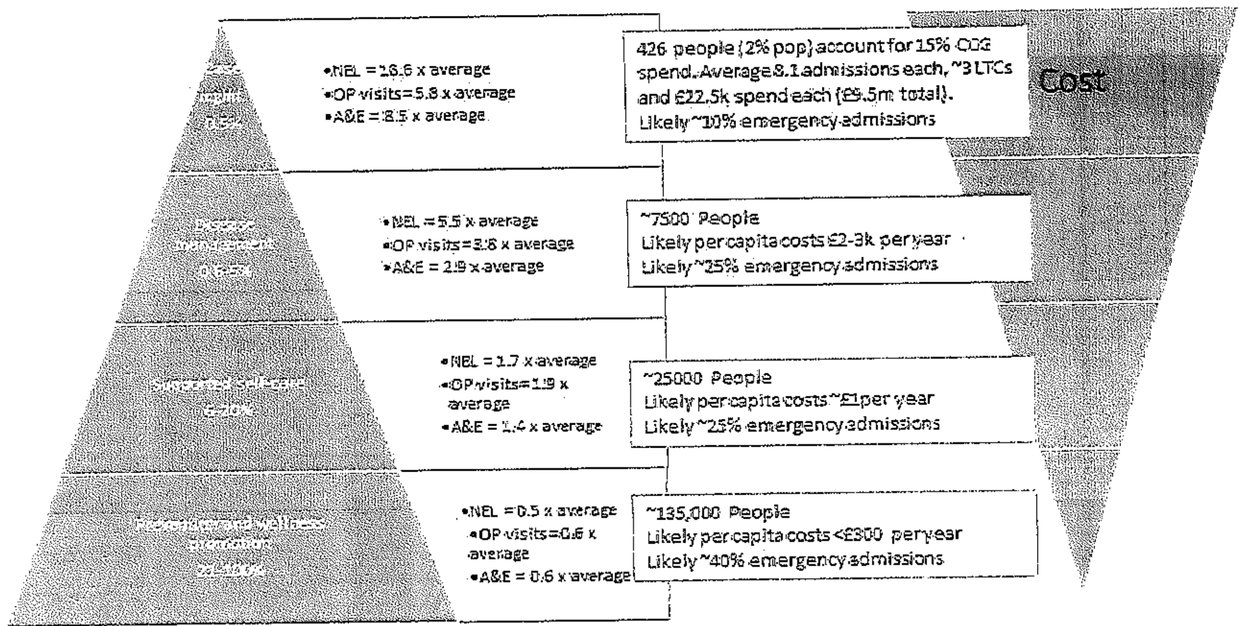


9. Early work in the pilot areas has focused on looking at people at the top of the risk stratification list. Learning from this approach will mean the wider implementation will look at people further down the risk stratification list, where it is believed a greater impact can be made on the way people use health and social care resources.

10. All the modelling around the use of health and social care resources shows that the smallest number of people who have the most complex needs, use most of the resources. You would expect this, however, not all of that use of resources is appropriate. The challenge for KCC is to address two aspects of the system.

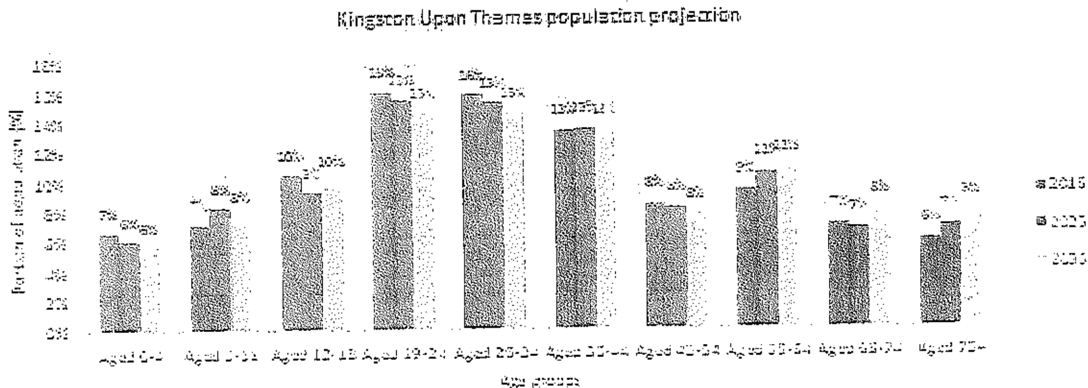
    - ensure we have resources and support in the community so that people only use resources in the right place at the right time, but also

- to change the way people behave and staff interact with people to manage their expectations of what support they need



Frailty

11. The over 75 population of Kingston is set to increase by 4,400 over the next twenty years, the fastest growing portion of the populace.



12. In Kingston, there are 2699 people recorded as having a electronic frailty index of mild, moderate or severe (epilepsy excluded).

13. 9.8% of people in Kingston aged 65 and over have a frailty flag in their primary care record. This rises to 24% of the 85 to 89-year-old population and 1 in 3 of the over 90s.

14. Looking at over 65s split into frail and non-frail populations, we see a three-fold increase in the probability of an emergency hospitalisation , increased probability of an extended hospitalisation and the probability of high total costs compared to the non-frail population.

15. The KCC root cause analysis for the frail population shows multiple complex reasons for acute admissions, with responsibility falling to (and between) many

agencies, from primary care, social care to housing. Services are fragmented and so not person centred, resulting in duplication of effort and contact and an overall lack of coordination. The KCC programme is a direct response to this to ensure that services are more co-ordinated and that we can identify and intervene earlier to prevent loss of independence amongst this group of people.

Mental Health

16. 1,613 people in Kingston have bipolar or schizophrenia as defined in their primary care record, less than 1% of the population. 5,700 people in Kingston have personality disorder

17. A further 23k people have mention of depression in their primary care record, 12% of the population.

    - Mental health conditions play a significant role in wider health system use:
    - 22% of SWL emergency admissions are in contact with specialist mental health
    - 14% of SWL A&E attendances are in contact with specialist mental health
    - 7% of SWL day case admissions are in contact with specialist mental health
    - 7% of SWL day out-patient attendances are in contact with specialist mental health

18. The presence of a mental health condition often inhibits how an individual manages their own health and accesses services.

    - 30% of people with a long-term condition have a mental health problem
    - 46% of people with a mental health problem have a long-term condition

19. The underlying mental health condition can make accessing appropriate care difficult – this is exacerbated by relatively low awareness of mental health conditions amongst some staff groups.

    - Those with more visible mental health conditions may have their physical needs overlooked
    - Those with less visible mental health needs may have their mental health needs overlooked
    - Well managed mental and physical health are key to maintaining the daily wellbeing of this group.

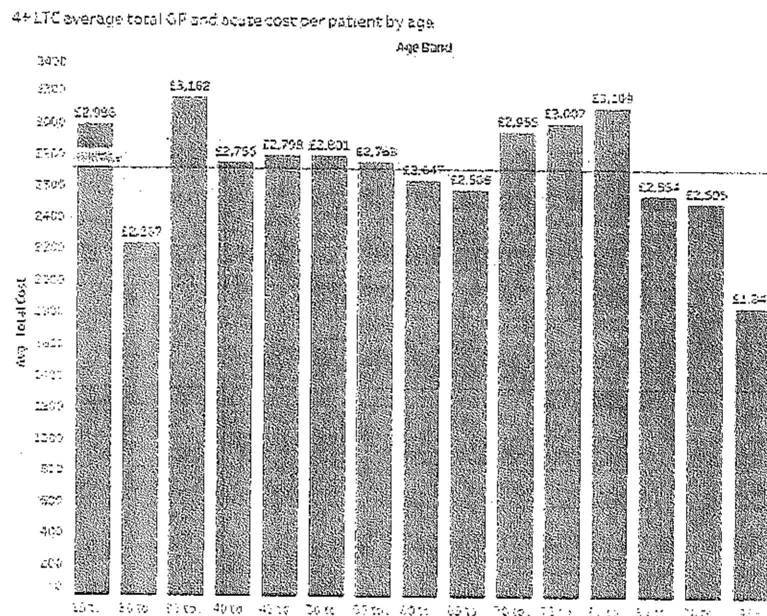
20. Countering these root causes to reduce costs to the system are not straightforward for this population – however increased awareness amongst clinicians of the needs of this cohort will help them manage their own care better.

Long Term Conditions

21. Using the Sollis risk stratification data set of primary and acute patient level data for Kingston, we see 13,392 people who fall into this Long term condition segment; around 7% of the Sollis population data. The median age group is 70-74, with 50% of this segment being aged over 70 and 22% aged over 80.

22. The average total cost of GP and acute services per person in this segment is fairly flat across adult age groups, meaning that a 45 year old costs the same (on average) as a 75 year old.

    - People in this segment have, on average, 4.8 LTCs. The average for the whole population is just under 1.
    - They have 9.6 GP appointments a year, five times the number of the healthy population.
    - Their A&E visits are reasonably low at 0.6 per person, per year – in line with other healthier segments.
    - Elective activity is high, but non-elective activity is lower than expected at 0.3 interventions per person per year.



The Kingston Coordinated Care Programme

23. The KCC programme will be delivered by the following key building blocks:

    - **Social and Community Care** – build community and voluntary sector capacity and infrastructure to support self-support through information and advice and social prescribers
    - **Single Point of Access** – multi-disciplinary triage and screening team from health, social care, mental health and voluntary sector to make the right decision first time. This includes support for discharge to assess in hospitals.

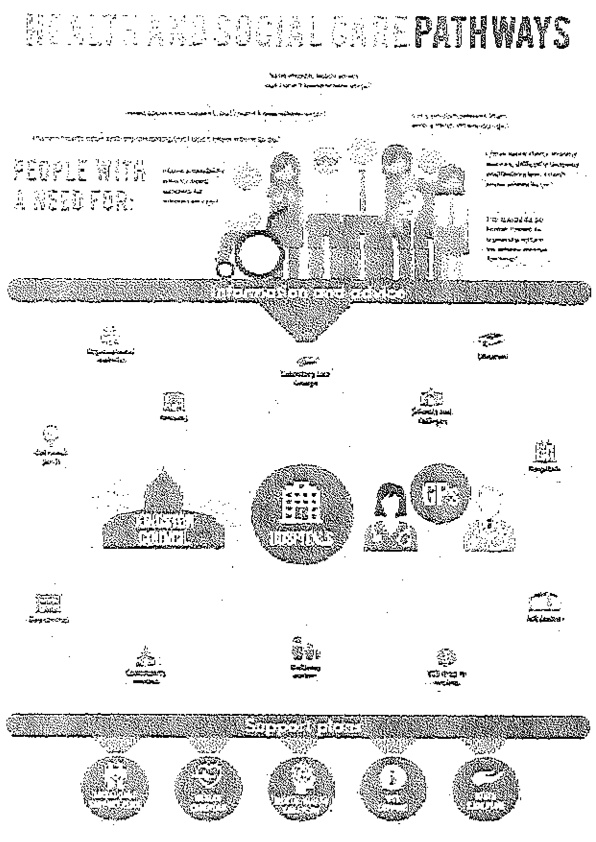
- **Multi-Disciplinary Locality Teams** – based on GP practices, with health, social care and a new type of home care worker all working together
- **Enablers** - co-location of teams and a single view of the person through joined up ICT via a Kingston Care Record

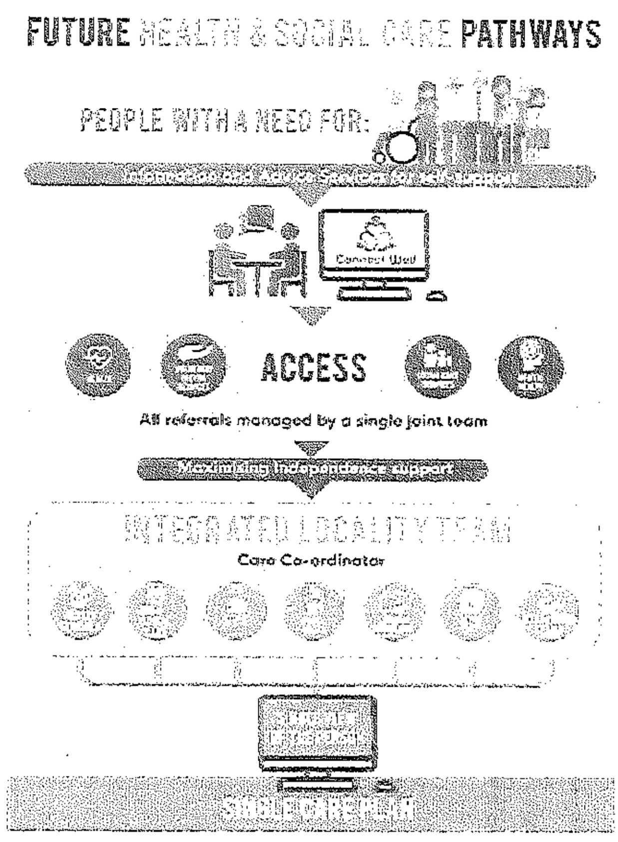
24. The current model of provision is complex and very hard to navigate. The borough, not unlike many areas has a number of invaluable services, but they are not connected with each other. This leads to duplication and inefficient use of resources for both the person needing support and the professionals involved.

As an example, a gentleman, who cares for his wife, at a workshop took out a piece of paper to explain to the group that he had to write down a list of over 20 names of the different people he had to contact if something changed around the support to his wife

25. The first diagram below illustrate the current complex care pathways people in and out of the system need to navigate and way the it does not produce a joined view of the support a person needs.

26. The second shows how the pathways will be simplified through joined up information and advice, a single point of access to all services and single view of the person.





Social and Community Care

27. The KCC programme promotes self-support and enabling the use of community resources to improve and sustain people's independence. Part of the workforce culture change required is around the way people interact with people to better understanding them so that support can be identified that will promote a person's sense of well-being, or their quality of life and the role that they can play in this themselves.

28. There is a building evidence base demonstrating that if you can improve a person's sense of well-being and quality of life, they will significantly use health and social care resources less.

29. The KCC programme is tackling this from two directions. Firstly by improving the ability for people to support themselves and improve their quality of life themselves. Secondly by targeting people though the locality model and discuss discuss with them how their well-being could be improved.

30. The **Connect Well** project is building the right infrastructure for enabling people to support themselves. One of the central issues people have is accessing information and advice, or simply knowing what resources there are in the community.

31. Connect Well focuses on the whole population, and supports the change in culture change through social prescribing that promotes self-care and management and helps build both personal and community resilience.

32. **Social Prescribing is** a process to help people make positive changes in their lives and within their communities by linking people to volunteers, activities, voluntary and community groups and public services that help them to:
    - feel more involved in their community
    - meet new people
    - make some changes to improve your health and wellbeing

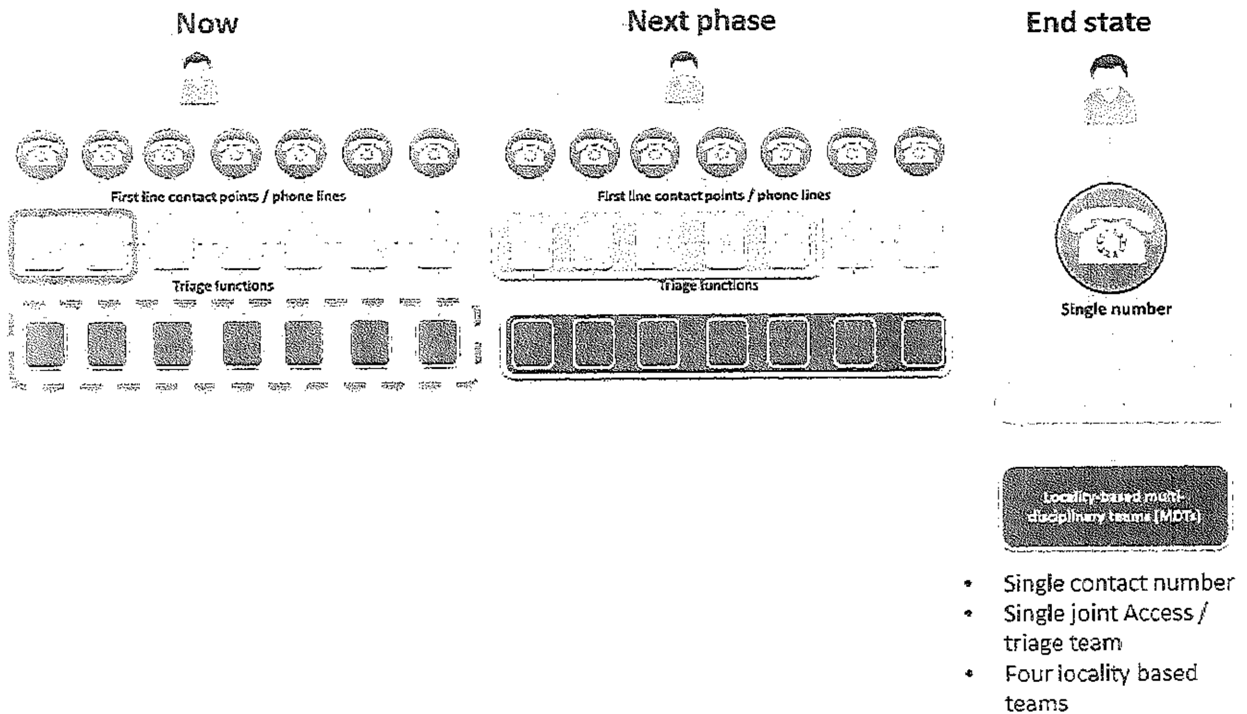
33. Experience from the pilot MDT meetings in New Malden has supported the national evidence and has demonstrated how by addressing a persons well-being (or sense of isolation, depression, loneliness) you can reduce their use of health and social care resources.

An elderly gentleman was contacting the GP and attending hospital on a regular basis regarding his health conditions. There was not much more that could be done about his health conditions, as these were being well managed albeit the gentleman was still very anxious. However, discussions at an MDT meeting led to a discussion with the gentleman's son, and the person acquiring a dog. The result has been the gentleman is now getting out of the house more, has a structured exercise regime, and is much

happier. He is also not contacting the GP or going to hospital regarding his health conditions.

Single Point of Access

34. The programme will establish a single point of access in the Borough with a first phase of work focusing on integrated triage functions across physical and mental health and social care. An initial pilot has been running co-locating the social care and Your Healthcare access and triage teams. The next stage is to add Mental Health, Learning Disability and the Voluntary Sector.



35. The current model works if you know all the different options in the community. Quite often staff are unaware of resources or services already available in the community. This results in GPs and people ringing multiple different providers, hoping that they will get a response from at least one of them.

36. For the providers, commissioned and set up to support people within specific criteria, this leads to handling inappropriate referrals and passing people between each other to help manage the finite resources they have.

37. None of this results in the right support at the right time, which means providers then have to deal with more resource intensive crisis situations, that sometimes could have been avoided.

38. By bringing staff from different background together, the intentions is to create a single location and team who can appropriately triage and ensure the right person responds. The team can ensure either voluntary sector is deployed or if health and social care teams need to become involved.

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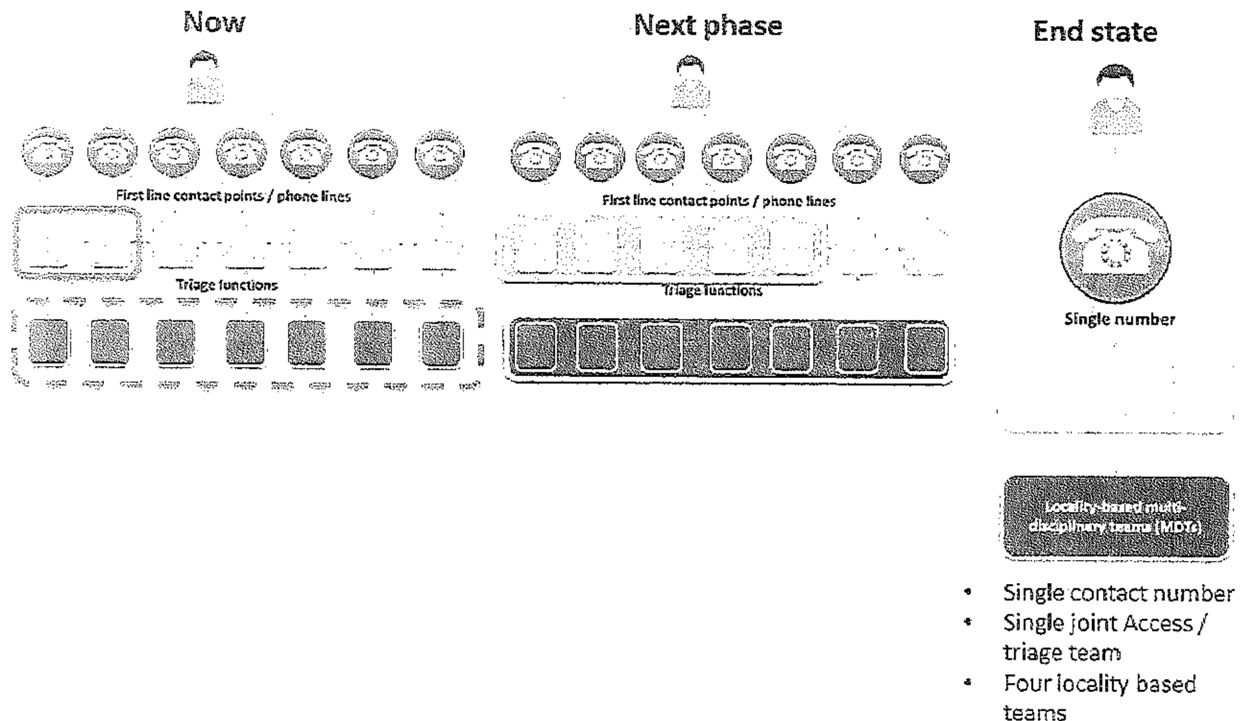

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43. The MDT meetings started in New Malden in July 2017 and have been testing the approach ahead of roll-out to the other three localities from April 2018. This includes:

- Testing use of the risk stratification tool in identifying people appropriate for an MDT approach
- Testing ways of working and documentation to support an integrated approach
- Action learning to inform the approach and future roll-out to the other three localities.

44. Implementing MDTs will do a number of things to help improve the way people are supported.

- Staff will take on a generic role around care coordination, to ensure every person has a single person to contact who is responsible for their care and support
- All staff will be responsible for taking a more holistic approach, working across current commissioning and provider boundaries
- Staff will be co-located to improve communication and feedback about working with people and planning who needs to be involved to be more responsive

45. Although MDTs will meet with GPs each month to discuss complex or challenging cases, the intention is that teams will be working more collaboratively and proactively on a day to day basis. The intention would be not to have to discuss people at an MDT meeting if it can be avoided.

46. GP contracts will have a new Complex Needs Service as part of the new KMS contracts all GP will sign from April 2018. This will require them to work with the MDTs and to agree a support plan for everyone who is at risk of hospital admission, or where they have needs that require a MDT approach to address any vulnerability.

One of the patients for Holmwood is a 80 year old lady with advanced Parkinson's, living with a live-in carer in her own own home. Although she has a mild cognitive impairment she still has capacity.She spends most of her time In bed but can move to a chair with assistance.Recognising issues were building the GP went to speak to her about what she wanted from her support. She expressed a wish to avoid hospital admission if possible, though wanted to be treated if she became unwell.

The GP was called out to see her recently. She was extremely unwell due to pneumonia, monosyllabic and hardly drinking at all. The GP spoke to the carer who was exhausted, and the family who were concerned.

A decision was made to keep her at home. GP called the Single Point of Access at 4pm, spoke to RRT nurse. She arranged IV team to support her and start IV antibiotics. As this lady may have died overnight arrangements were made to have drugs and a syringe

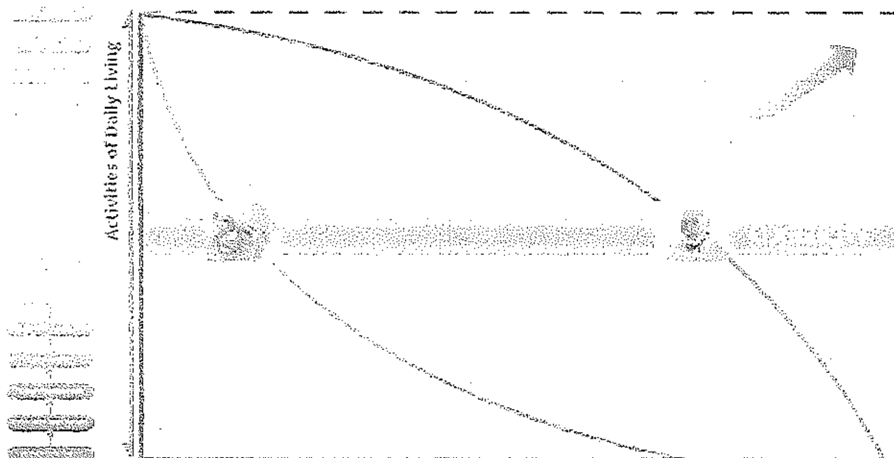
driver available. The RRT prescribed all these meds and wrote the drug chart. She also spoke to Marie Curie to get a night sitter in to give the live-in carer some respite, though this could not start until the next day (the carer accepted this). She also sent a SALT referral and asked the IV team to give the lady fluids.

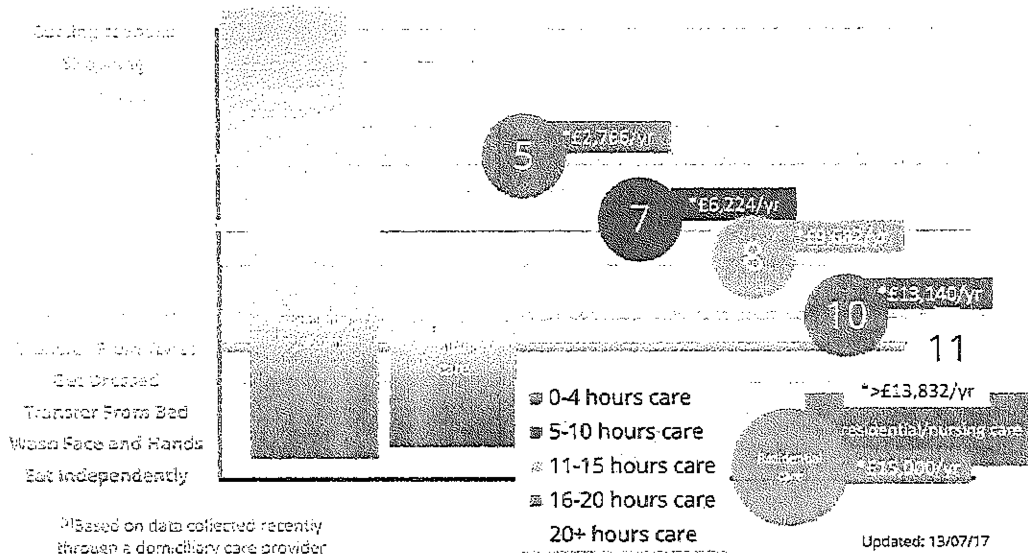
The GP saw the lady twice over the next 5 days and she gradually got better. The family were happy that she had been kept at home as was the lady. She is now back to her baseline starting position. Outcome was better for the lady, and avoided her being admitted to Hospital.

47. Each MDT will be responsible for drawing up a long list of people who are at risk. This will come from the risk stratification system, data in GP systems around frailty and also local knowledge from staff in MDTs about the people they know.

48. From that long list a short list will be drawn up of people who they think they can proactively get involved with. The MDT will systematically work through these people over the course of the next year. New people who become known to the MDT could still be added, so the people MDTs work with will not be fixed.

As an example, evidence shows that people can become less independent as they become unable to perform a number of activities of daily living. The order in which people lose the ability to do these generally happens in a predictable way. If MDTs can identify or spot people as they start to show signs of losing their independence, they can intervene to redress that decline. For the most frail, this could be through some direct support or reablement, for those less frail it could community equipment or information and advice to support them to access public health resources. This could help reduce the high costs of long term care for older people.





Well Being Teams and care in the home

49. Previous reports provided an update around the commissioning intentions for Home Care. The Council and the Provider Alliance are currently working on developing the well-being team approach.

50. Well-Being teams will be just one of the ways locality teams can respond to people and as such will be an integral part of the teams. A key part of their role will be around working with people who are at risk of losing their independence.

51. Well-being is different for each person, so the support a person needs to address their well-being has to be different. Current commissioned home care services do not promote this approach as Providers are often only capable of working in one way and contracts are based on working in that way.

52. The current pilot phase in New Malden for MDTs has highlighted the number of people with complex health and social care needs not receiving appropriate support because their well-being has not been addressed.

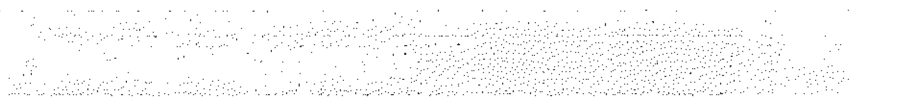
53. Recommissioning of home care has to ensure that there is sufficient capacity in the carers workforce. To recruit sufficient capacity you need to be able to raise the profile and attractiveness of the Care Worker role. Care workers are traditionally paid low wages and often employed on zero hours contracts. Existing Providers recruit from abroad and bring care workers in from outside the borough to ensure there is sufficient capacity. Providers typically can experience high turnover in their workforce which leads to significant costs around induction and training.

54. The Well-Being team approach is to organise staff into smaller semi-autonomous teams to address quality of care, staff retention and job satisfaction. The approach gives staff more autonomy in their role and greater flexibility in what they can do for a person. Employing care workers on conditions that suit them and gives them more autonomy around how they support the people they work

with improves recruitment and retention rates. This helps reduce the level of overheads organisations need to carry, which keeps cost lower.

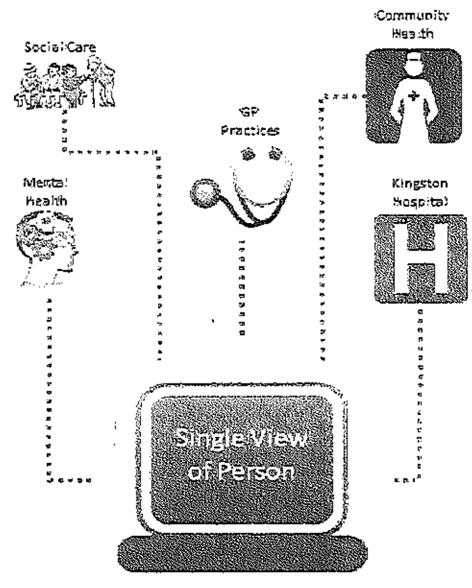
55. Currently a single well-being, of 8 people, has been recruited. They were recruited following a values based recruitment approach to establish if they had the right culture and capability to work as required. The purpose of the pilot team is to test what functions and support roles they can take on and how they will work alongside other health and social care staff.

56. Embedding well-being teams in the new locality model enables a blending of roles and responsibilities that enables the new care pathway to work more smoothly. Well-Being staff offer a range of prevention and self-support options for people as well as support currently delivered through intermediate care, reablement and traditional home care services.



Enablers

57. A major improvement resulting from the KCC programme is the ability to share information between different organisations. This has the benefit of reducing the level of duplication in the way information is collected by staff, meaning people won't have to repeat their stories to different professionals. The other key benefit will be the ability for staff to see all the important information about people in a single place, which will improve the timeliness of decision making.



58. Kingston has developed a shared care record in the form of Kingston Care Record (KCR).

KCR currently includes data from general practice, mental health services and community health services. The Council is currently undertaking a process to include social care data as part of this record which will be integrated into the record later this year.

Lessons from the New Malden Pilot

59. The New Malden GP practices have been running MDT meetings since August 2017. As a result of these meetings the following changes and improvements were captured

- Appointment of a locality co-ordinator to provide support to each MDT meeting through ensuring that the details of people to be discussed are circulated in advance, and to capture outcomes for people discussed.
- Appointment of a Community referrer to ensure the voluntary sector is represented at each MDT meeting to provide advice and support around resources in the community.
- Evidence to support the new Complex Needs Service to replace the risk stratification KPI for GP contracts, which will ensure the focus of resources is on the people where most impact can be made.
- The development of a common holistic assessment tool to ensure that all staff can discuss wider well-being issues with a person and not just focus on their immediate presenting needs
- Development of a common support plan to enable staff to see a single view of what support a person is receiving
- Informing workforce development around a number of key areas that impacts on the way staff work with each other in the community
    1. Advanced Care Planning / End of Life Planning
    2. Risk, and the level of risk professionals believe people can live independently at home with
    3. Care Co-ordination to support staff understand the new autonomy they will have in the new model.

On-Going Developments and Links to other Areas

60. The KCC programme is a system wide change programme. Whilst the current focus has been on implementing locality teams and the supporting infrastructure the programme will over the next year also look at other areas. These will include;

- Enhance the collaboration between primary care (GPs) and acute hospitals. A pilot around community GPs in-reaching into the hospital to aid getting people back into the community quicker
- Improving performance around discharge to assess protocols. A "perfect week" is being piloted to see what the blockages and barriers currently prevent discharges.
- The Kingston Thrive Mental Health strategy will be implemented and has a number of aspects in common with the KCC programme. These

include the single point of contact, prevention, information and advice options.

- Developing more options in the community such as Community Pharmacy support around dispensing of medication

Integrated Care Partnerships

61. The direction of travel is towards looking at options around Integrated Care Partnerships. The intention is that different organisations from the health and care system work together to improve the health of their local population by integrating services and tackling the causes of ill health.

62. It marks a shift away from policies that have encouraged competition towards an approach that relies on collaboration between the different organisations delivering care – such as hospitals, GPs, community services, mental health services and social care – and the organisations paying for it – including clinical commissioning groups (CCGs) and local authorities. It should also engage the capacity and capabilities of the voluntary sector.

63. The emphasis is on places, populations and systems rather than organisations. If successful,it will accelerate the implementation of new care models designed to integrate care and promote population health. It will also enable local leaders to take more control of funding and performance in their areas with much less involvement by national bodies and regulators.

64. Kingston is very well placed with the work it has done to implement KCC to adopt this approach.

Outcome Measures

65. Commissioners and Providers have developed a range of whole system performance measures. These will be collated from existing data collection sources plus a new customer experience survey that people who have been supported by MDTs will be asked to complete.

Domain	Outcome	Time line to see statistical significant shift
Population Health	People are healthy	Long Term
	Reduction in Premature Deaths	Long Term
	Reduction in Health and Social Inequalities	Long Term
Quality of Life	Being Independent and staying at home	Medium Term
	Good Experience of Care when its needed	Short Term

	Delaying or reducing care needs	Medium Term
System	Reduced demand on acute services - A&E attendance - Non-elective admissions - GP appointments	Medium Term
	Reduced demand on residential care	Medium Term
Quality and outcome of care	Care delivers best outcomes to optimise sustainable health and independence - People reporting better quality of life	Short Term

On-Going Challenges

66. With any transformation programme of this scale maintaining momentum and embedding new ways of working takes continued commitment from both alliance leaders, and managers and time from community team staff.

67. There is a need to demonstrate the impact the changes are having as both health and social care commissioners need to see an impact in order to keep health and social care budgets sustainable.

68. Implementing changes requires releasing capacity and resources to do things differently. Some additional resources to support implementing the model has been provided, but will still lead to challenges for all providers to demonstrate the impacts everyone is looking for.

69. One of the main issues will be identifying people early enough to be able to intervene before a crisis or emergency occurs. Local knowledge of the people in each MDT cluster will be as important as the risk stratification and frailty information that teams will have access to, to identify the right people to work with.

70. South West London intend to implement a new ICT system in Kingston. The plan is that this would be in place by October 2018. KCC has invested in the Kingston Care Record as key enabling tool, which will be replaced by this new system. While timescales for implement are yet to be finalised, it makes committing to further development of KCR difficult.

Resource Implications

71. The KCC programme is part of the plans for how efficiencies for the Service Transformation Plans will be achieved. The CCG has invested in the implementation plans for the Provider Alliance in order to achieve reductions on non-elective admissions and A&E attendance.

72. Each Provider has been required to commit resources for programme management support and staff time around developing elements of the programme.

Legal Implications

73. The main challenge currently is around information governance arrangements. These are required to enable providers to share information between each other through the Kingston Care Record.

74. Information Governance and Data Protection is also a consideration for population segmentation analysis. The data protection legislation is due to be updated in April 2018 and will need to be reviewed to ensure continued compliance.

Conclusions

75. Kingston Provider Alliance continues to make good progress on implementing the new model of care. The governance arrangements around the Principals Group has meant there has been regular dialogue and commitment from leaders towards implementing the model.

76. The model directly addresses the issues that were not working for people receiving support in Kingston.

77. The programme is on track to adopt the MDT approach across the whole of Kingston during 2018/19 and will be closely tracking the impact on the system wider performance measures it has identified.

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