**Appendix 7:**



**Home Care and Wellbeing Teams Update**

Question and Answer Session with Andrew Osborn (RBK)

Monday 18th September 2017

***Background***

*Kingston Coordinated Care commissioning have signed off and have handed over to the providers to go and deliver the health and social care integrated model.*

*To do this the providers have set up a ‘Principals’ group to provide top level governance. This group consists of: -*

*Shane Brennan – Voluntary Sector Representative (currently the acting chair)*

*Siohban Clarke – Managing Director of Frontline Services at YourHealthcare*

*Steve Taylor – Director of Adult Services*

*Ann Radmore – Chief Executive Kingston Hospital NHS Trust*

*Dr Nick Merrifield- GP Representative*

*David Bradley – Chief Executive SWL & St Georges Mental Health Trust*

This group is accountable to the Commissioners to deliver this model.

1.    Can you provide us with an understanding of the process undertaken to date and planned for moving forwards?

The borough has been divided into 4 localities: New Malden, Surbiton, Kingston and Chessington, roughly 50,000 people in each

The approach has been piloted in New Malden since end of July 2017. So far a locality model has been applied and: -

* Set up multi-disciplinary teams (MDTs) centred around GP practices made up of professionals from across nursing, therapy, GPs, social care, mental health and voluntary sector organisations
* Aligned staff from all the organisation to work with New Malden people
* These MDTs will start to work together to see how best to support people
* Staff work collaboratively to avoid referring/signposting posting between each other
* Using Kingston Care Record (a confidential electronic record of health and social care information stored on a secure computer system) which is now live - it currently stores GP, hospital, YourHealthcare, and mental health data - social care data is due to go on anytime from now.

The feedback so far has been positive but there is a long way to go before they can focus on the real issues that are going to help. The MDT meetings are a great place for people to get together and share ideas and looking at the different options for supporting people and focusing on health and social care needs.

The wellbeing team element is seen as a core part of the locality model working alongside social workers, OT’s, district nurses and therapist. The role will draw on the notion of an ‘advanced homeworkers role’ which the design team suggested could be developed. There will be a focus on quality, dignity and respect when providing homecare.

It has been estimated that 300 to 400 staff will be needed to cover the whole of Kingston (this will take about 2 years to grow) but initially 30 – 40 people will be recruited for the New Malden area. This will help ascertain if staff can be recruited and to see if the role and pathways have been designed correctly.

RBK is looking at setting up a limited trading company to administer this service which is why it’s taking longer to get things up and running.

2. Could Healthwatch potentially meet with and/or talk to some of these customers directly

Once the above has been done there will be a need for consultation with the users of this service and this is where HWK may be able to play a part in helping to collect this data as a neutral body. Potentially the earliest this will happen is April 2018 however the logistics of this need would need to be looked at and discussed in further detail.

3. Are you anticipating we would pay homecare workers, PAs and skilled-up workers at the same pay rate?

Pa’s will always be paid a different rate because it is up the service user how much they want to pay them and so there will always be a separate rate. The rate for the new ‘advanced’ role will pay a higher rate than home care workers receive and will take into account the additional tasks and responsibilities to be taken on, we expect this will be above the rate that agencies are currently paying. The exact amount has not been finalised but the figure will probably be at least £11 an hour. It will be a proper salaried job (not a zero hours’ contract) and will include a pension contribution, paid travel time. Around 75% of this role will be delivering direct care while the rest will be reserved for mentoring, coaching, training and attending MDT meetings. We anticipate it will also involve them taking part in assessments and creating service users support plans. They will also play a pivotal part helping users in identifying their social needs and look at ways to improve wellbeing and encouraging more social contact and finding activities for individuals. Ideally this role will be given a proper career structure so it will attract more home grown candidates who will have a better knowledge of local opportunities.

4. Are the social and medical models of disability taught to ensure it fits the person’s agenda, together with personalisation agenda?

I think this is a question of language. The Well-Being team philosophy is grounded on core personalisation principles and we will be changing the assessment and support plan documentation to reflect this, rather than continue with the needs based assessments that are only there to create a financial figure.

Well-Being teams will discuss how a person wants to be supported, understand the things they want to do and are important to them and support them to find ways to achieve that. The Council will still only be able to fund the elements that address eligible needs. If people are not able to access the community due to a disability or social reason their role is to look at how this can be addressed.

The people discussed so far in MDT meetings have had complex medical conditions or disabilities, but the main element not being addressed was their social needs or general well-being.

Previous questions asked

5. Has a decision been taken not to proceed with a re-commissioning of home care services/agencies as such? If so, please can you explain when and why this decision was taken, and how daily home care provision will be delivered to Kingston residents going forward?

Following the soft market testing we ran it became clear that we could re-commission home care, but that we would only be recommissioning with the same problems that all councils have at the moment around lack of capacity, rising costs and concerns around quality. We therefore wanted to look at alternative approaches.

Linked to this was all the work from the KCC programme, which had identified the need for much closer involvement of home care workers and up-skilling home care workers to do more tasks for people to avoid multiple people having to visit to do different support tasks.  The design team called this an advanced care worker role.

Supreme the main block providers have had their contract cancelled and people are currently being transferred to other providers, this sort of emphasises the position we want to avoid being in again in the future and why we want to try a different model.

The current block contracts were extended and will run out in September next year. We therefore still need to have a solution in place up until then. Commissioning have agreed a single flat rate for all spot commissioned home care support

The well-being team concept builds on a set of principles that is similar to the way Your Healthcare would say they have built their own organisation.

As such Your Healthcare have been very positive about the proposed model; The Provider Principals group discussed the approach to well-being teams and concluded that RBK would be best placed to lead on developing this service at the current time

Setting up well-being teams will mean that home care staff make up the core aspect of those teams, and will probably be people who know those people the best. As such they will have much greater input to assessment, support planning and review activity, probably leading on those activities in some cases.

6. Were any other approaches were considered or discussed apart from Wellbeing Teams?

There were not that many other options for commissioning home care. Bringing the service back in-house was considered, but would be an expensive way of providing the service and is why Councils commission external agencies to provide these services.

Promoting greater use of direct payments remains a core part of the offer in Kingston, so we will continue to work with KCIL around supporting people take up direct payments to employ PAs or use an agency of their choice.

The route we are developing is also about trying to change the way home care is delivered and use the commissioning influence the Council has to change the way the market operates. We want a person managing their own care to have quality support that addresses their well-being as much as someone who the Council is funding.

7. Which body or bodies will be responsible for taking decisions on the introduction of wellbeing teams, and how will elected members be involved in this decision-making

A Board of directors will be appointed but Councillors are unlikely to be involved at this level. Once the governance and business plan has been agreed we expect to go back to committee for final approval.

8. Exactly how many Wellbeing teams are actually up and running across the country, and how many clients do they actually support – both self-funders, and Council funded?

There have been a number of areas across the Country that have been trying this model, mainly with self-funders, and producing really positive results around customer feedback. Devon have a self-funder company called Love2Care, Suffolk are looking at a wider application of the model for all Health and Social Care, Doncaster have examples as do some Scottish areas.

9. If, as has been implied, wellbeing teams are the solution for the delivery of domiciliary home care in the future, has a business case looking at the **cost implications** of their introduction been prepared and discussed by the Provider Alliance? If so, please can Healthwatch have a copy of this business plan? Home care provision comes at a substantial cost to the borough, so we are keen to see that the money is being used to the best possible effect.

A report will be going to the 21st September Adults and Children’s committee to ask for in principal agreement to setting up a limited company to deliver well-being teams, that report is publicly available and sets out a lot of the rationale for well-being teams, the options we looked at and why doing it via a local authority trading company.

The intention is that well-being teams will support self-funders, but this will depend on the success of recruiting sufficient capacity. Given the profile of self-funders in Kingston and the way we imagine Locality teams to work, they will need to be able to support self-funders in time.

There is a financial business plan that we are currently working on. It shows how over a two-year period we would look to build up capacity to take on the current work currently commissioned. I can share the final version of that with you, but at the moment we are still working on some core assumptions, like the rate of pay for well-being workers. This will be part of the future report to committee and if part of the public papers will share with Healthwatch.

10. Does this mean that in a team of say 10-12 wellbeing staff workers (is this number correct?), the majority of staff will be delivering the day to day home care tasks i.e. personnel care, food prep, medication etc?

The well-being team model is still in the design phas, but yes, they will be responsible for the delivery of the personal care aspects, but with a greater emphasis on community resources and well-being.

Well-Being teams will give greater levels of accountability and autonomy to care workers, gives them time and space for professional development and meeting as a team, all things that don’t happen working for an agency.

The other difference is the focus teams have on supporting people around well-being and accessing the community, this is another key area agency staff would never prioritise as it’s not how they make their money.

Once working, well-being teams will need to build strong working relationships with KCN, KCIL, Staywell, GPs and YH as they will be part of the MDT locality teams. Well-Being team’s role is as much about supporting people in the community as it is in their own home, so a large number of Staywell and KCN referrals are likely to come from well-being teams.

11. What public engagement and/or consultation will be undertaken - if and when it is proposed to establish well-being teams?

As the model for well-being teams is largely built around KCC model, it is wholly consistent with the voice of the customer work and the engagement from the earlier KCC work. We will want to do more consultation as we test out the model, primarily by talking to the people supported through well-being teams to see if the experience and support was better.

We did run a short session with the advisory group before the summer around the thinking behind well-being teams and they were very positive about the rationale and approach behind well-being teams.

The process for setting up well-being teams has got a bit delayed as we need to address a number of governance issues around the setting up of a limited company. So it may be early next year before the teams are able to start to be operational.

It would be very helpful to run some workshops with home care users to explore with them their thoughts on our proposals, rather than send out a further survey that will not explain the subtleties of the model. If we can do ths jointly with Healthwatch in October, that would be very positive and help inform the EQIA.

12. What would be the best way to standardise the language used across commissioning and delivery of Community Care?

Well we can start to keep the language nice and simple for starters, but there are a number of catchphrases around currently, but essentially they are all talking about the same thing. So social prescribing, asset based community development, strength based models are essentially all about ensuring that we have proper conversations with people and build on what is important to them and look to work more with communities to create new opportunities for community support. Not everyone sees their future as going to the Day Centre.