Kingston Coordinated Care programme mandate

This mandate covers the following sections:

1. Context
2. Overall aim and structure of the Kingston Coordinated Care programme
3. Project description and deliverables
4. Programme impact
5. Governance
6. Resource requirements
7. Planned cost savings
8. Strategic fit
9. Interdependencies
10. Stakeholder identification
11. Decision point for mandate

1. **Context**

Kingston’s Health and Wellbeing Board has made clear its intention to develop a coordinated and sustainable health and care system. There is recognition that the health and care system needs to change if we are to meet the needs of our growing population. People are living longer and spending many years in poor health, suffering from multiple long-term preventable conditions with implications for both mental and physical health. The need for health and social care support is intimately entwined. There is insufficient focus on supporting people to stay healthy and well, independent and resilient and to remain part of active and supportive communities.

Commissioning and provision of services is fragmented which leads to complexity, duplication and gaps with objectives and incentives that are not aligned. And statutory sector funding is constrained or reducing.

A recent project, the voice of the customer, was jointly commissioned by health and social care commissioners. Your Healthcare, SWL and St George’s, Kingston Hospital, adult social care, primary care and the voluntary and community sector have been partners in the project which has engaged with over 80 customers in Kingston and more than 100 staff. The project provides a compelling case for change which reflects and reinforces the insights derived from previous and ongoing needs and asset analysis, engagement and consultation in Kingston. Customers state that their journey within and across the health and social care system requires significant improvement to ensure their fundamental expectations and needs are met; staff have reinforced this very clearly:
Customers frequently commented that they are not adequately listened to and their needs understood, which they believe prevents them receiving care and support which is relevant and fails to enable the outcomes they are seeking. They feel that they have insufficient control and choice in the shaping and delivery of their care and support. Furthermore, services are difficult to access and inconsistent in quality and the organisational system hard to navigate.

Staff understand that a significant gap in performance exists and have highlighted a number of factors that are likely to be driving this. Primarily, this relates to the complexity of the organisational system and the processes that run across it, the impact of non-value adding activities, the absence and conflicting nature of information and the lack of a consistent customer oriented-culture.

Commissioners recognize that salami-slicing and tinkering around the edges will be insufficient. Meeting these challenges will require the development of a truly customer-centred culture. It will require joint commissioning by health and social care, with aligned health and social care governance and budgets. Commissioners wish to facilitate a new culture that focuses on outcomes and not current professional roles and disciplines and organisational boundaries and budgets. As a system, we will all need to take on the challenge of managing within a fixed amount of resource and shifting that resource over time to prevention and proactive care.

2. **Overall aim and structure of the Kingston Coordinated Care programme**

The Kingston Coordinated Care programme is a system wide response to this context, led by the Council and the CCG and supported by statutory, voluntary and community providers of services. The aims of the programme are to:

- Support the development of active and supportive communities in which people are enabled to stay healthy and well, living independently as part of thriving and resilient communities
- Develop truly customer-centred care that supports people with complex needs to achieve the best possible quality of life and the goals that matter to them with an increased focus on prevention, proactive care and self-reliance
These aims will be achieved by the following objectives:

1. Putting in place a customer centred approach to everything we do that complements our current analysis and understanding of people's needs
2. Building resilience in Kingston's communities so that people can to remain independent and healthy for as long as possible and are able to access a variety of community support when and if needed
3. Designing and implementing a new model of integrated services that delivers what is needed by people in Kingston, is simpler, stream-lined and cost effective

The Kingston Coordinated Care programme will achieve these objectives through four component projects as set out below:

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<td>• Universal services accessible to everyone</td>
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<td>• Supporting people with existing needs to remain independent</td>
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3. **Programme deliverables**

This section describes the four projects set out above and their deliverables.

**The voice of the customer (complete)**

This project is complete and the deliverable is a **compelling case-for-change** in which customers have defined the things that most matter to them about health and social care services, their relative importance and have indicated that many of them are not being done well at present. Frontline staff have endorsed the importance of these needs and confirmed that currently they do not feel able to do meet them well.

The outcome of this project is that health and social care commissioners and providers have committed to using a customer-centred approach to designing services for people with complex needs in Kingston. The expected benefit is that this will result in services that meet the needs of the people using them, are of the highest quality, and with reduced duplication, fragmentation, inefficiency and waste.
Active and supportive communities
The Active and Supportive communities project will have 4 workstreams that will focus on:

1. Customers and communities having a voice and being able to influence and engage with decision making
2. Appropriate access to universal services and provision in the voluntary and community sector for all, particularly socially excluded and more disadvantaged groups and people at risk of ill health
3. Supporting people with existing health and social care needs to maintain as much independence in their lives as possible
4. Creating a more co-ordinated and extensive information and advice provision that supports resilience

In Kingston there is a very comprehensive evidence base emerging through a variety of in-depth consultations, participatory needs assessments and the Joint Strategic Needs Assessment augmented through ‘Community Voice’ work. Further mapping and gapping work across all areas will be undertaken to identify existing good practice in promoting resilience and early intervention work. The diagnostics and analysis will provide the basis for how we expand provisions that enable people to access appropriate information and advice, support and services as seamlessly as possible, reducing delays in the system that can result in escalation of need or crisis for individuals. The intended overall impact is improved health, well-being and independence for adults in Kingston and reduced/delayed demand for high intensity (and long term) health and social care interventions e.g. hospital in-patient admissions, Accident and Emergency attendances, outpatient appointments and long term social care support.

The information and advice strand joins the Council up with Kingston Information and Advice Alliance (KIAA) and the CCG to ensure the coherence of the overall “offer”. There will be further work on Kingston’s ‘One Click’ information and advice web-site, which will be linked to ‘Care Place’, the new health and social care service providers’ web-site that is being purchased and adapted across London Boroughs. This work stream will also test the ability of KIAA to act as a conduit to enable access to voluntary and community sector information, advice and provision and offer a single point of referral for health, social care and voluntary and community sector workers enabling statutory information and advice providers e.g. Adult Social Care and Housing Contact Centres to focus resources on residents with higher levels of need. The outcomes will also inform joint commissioning intentions for integrated information and advice provision for 2016/17.

The Active and Supportive Communities project will test a joint commissioning approach for the voluntary and community sector with the appropriate governance, lines of accountability and risk strategy.

Care for people with complex needs
Implementing ‘quick wins’ during 15/16
The deliverable of this workstream is to make pragmatic changes to services during 2015/16 that incrementally improve the integration of services for people with complex needs, reducing the number of people who have unnecessary hospital stays or who’s return home from hospital is delayed. This will be achieved by

- expanding the operating hours and capacity of the Your Healthcare rapid response team
- developing a single point of access by aligning social care managers from the short-term team with the Your Healthcare integrated health and care teams
- developing better connections between social care professionals and general practice
- providing guidance and educational support to enable providers to make best use of risk stratification, care planning, care coordination and multi-disciplinary teamworking

**Designing a new model of care and operating model**
This workstream will build on the voice of the customer work to design a model of care that is centred on the needs of customers in Kingston and the issues they and staff have articulated about the current ways of working. The model will be co-developed with staff and customers, resulting in a design which is based on user experience and informed review, challenge and engagement. The model will be tested in two phases. First, using past cases, to confirm that it delivers the target benefits and then by deploying the new model for use within a limited but representative scope to confirm that it is effective in practice. The phases and deliverables of the workstream are set out below:

**Designing the conceptual model**

![Diagram of the conceptual model process]

- **15 weeks**
  - Programme Scoping and Launch
    - Setting objectives
    - Agreeing scope
    - Getting commitment
  - Mobilising the Care Design Team
    - Confirming fit
    - Inducting to the role and the programme
  - Designing the Conceptual Model
    - Building the conceptual model
    - Using review and challenge to evolve the best design
    - Creating a customer centred mindset
    - Builds in a review process to confirm integrity of design

**Proof of Concept**

![Diagram of the proof of concept process]

- **10 weeks**
  - Proof of Concept, paper-based
    - Simulating testing the model with past cases to confirm the benefits
  - Proof of Concept, live cases
    - Testing the model in a live environment to confirm it is effective in practice
  - Decision event – agreeing which elements of the model will be implemented

**Delivers:**
- A validated future model – tested by customers for customers
- A robust foundation for delivering sustainable change, with confidence
- Increased internal change capability

The first, programme scoping step will include

- describing how the programme will align with and/or incorporate current initiatives eg risk stratification and MDT working, customer journey, breaking the cycle, care coordination by primary care and plans to progress the integration of social care and community health services.
- defining the population in scope, recognising that the programme will ultimately provide care and support for the whole population in Kingston. This will be done in a phased way, recognising that some segments of the population are already better served by integrated care eg children and young people, people with learning difficulties. It is likely that the initial scope will be people over 65 years old.

**Commissioning and contracting for the new operating model**
Once the model of care and operating model have been designed and tested, changes will be made to commissioning intentions and contracts, in order to implement it at
scale. This will include defining the budgets in scope; how health and care budgets will be aligned/joined; the approach to contracting with providers; and the implications for recommissioning community health services, including defining and recommissioning any services that are not in scope for Kingston Coordinated Care.

The deliverable for this workstream will be changes to commissioning intentions and contracts for 2015/6 that enable implementation of the new model of care and operating model.

**Joint commissioning of health and social care**
Commissioning capacity and resource in both the Council and the CCG is stretched. Both sets of commissioners commission from the same providers, often requiring multiple conversations with the same provider and resulting in the risk that objectives and incentives are not aligned.

The Active and Supportive Communities project will test a joint commissioning approach with the voluntary and community sector. And as part of the Care for people with complex needs project, a joint commissioning and contracting approach will be developed in order to implement the new model of care and operating model.

Building on existing joint commissioning, including for mental health, children’s services and of Your Healthcare, and on the learning from the above projects, joint commissioning will be strengthened to enable the delivery of shared outcomes and priorities across health and care. This will streamline processes, reduce duplication, make better use of resources and enable an efficient and effective operating model that achieve joint working, where appropriate, at all stage in the commissioning cycle. Priorities for joint commissioning will be Kingston’s bed-base, including residential and care homes, and continuing health care.

The section 75 agreement will be a key enabler for the development of joint commissioning, building on the s75 in place for 2015/16.

4. **Programme impact**

The planned impact of the programme is as follows:

**Improved outcomes for customers as informed by the customer voice work**

- customers feel understood as a person and can understand the system and what is being offered to them
- customers feel in control and have choices, are a partner in their care and are supported to stay independent of services for as long as possible
- care is coordinated around the needs of the customer, recognizing their mental, physical and social care needs
- care is of a consistently high quality
- customers have a better quality of life

**Improved staff experience and effectiveness**

- staff are able to provide the care they know customers want, in a way that makes good use of their skills and time
- staff roles are designed to support this
- staff have a greater range of development and career opportunities
- staff recruitment and retention is improved

**A more effective and efficient health and care system**

- the system is focused on keeping people healthy and well, on personal self-reliance, on community resilience
- care is proactive
- care is provided in the most appropriate and safe setting with fewer inappropriate admissions to hospital and care homes
- timely and coordinated transitions out of hospital
- reduced duplication, fragmentation, complexity and waste in service delivery
- a viable and sustainable health and care system

5. **Governance**

The proposed governance for the Kingston Coordinated Care programme is as follows:

6. **Resource requirements**

In order to deliver the benefits described above, the Kingston Coordinated Care programme will require adequate resourcing. Significant resource has already been found to support the programme within the existing capacity of the Council and the CCG. This will need to be supplemented, and a proposal is currently being developed.
7. **Planned cost-savings**

The scale of cost-savings is difficult to assess at this stage of the programme. The following estimates will be developed further as the scope and plans for the programme progress.

**Active and supportive communities**: the target for savings for the Council is £187k for the period 2015-19.

**Care for people with complex needs**: a case study from Plymouth, in which a similar process was followed of care model design and operationalisation has resulted in a forecast 4 year cost saving of £9.3m for social care, hospital and community health care services with a combined budget of £56m for the same period (extrapolated from £14m pa).

**Joint commissioning**: it is expected that there will be a greater capacity to transform services and achieve savings once joint commissioning is strengthened. Because commissioning capacity is currently stretched, strengthening commissioning itself may require additional resources and is not expected to result in savings.

8. **Strategic fit**

The Kingston Coordinated Care programme is a response to key local and national strategic priorities and drivers

- One Kingston, particularly the Resilient communities theme
- Kingston’s Health and Wellbeing strategy, particularly the themes focused on older people and people with long term conditions and on people who are disadvantaged or vulnerable
- The Care Act
- The NHS Five Year Forward View
- The financial context for local government and the NHS

The Kingston Coordinated Care programme will bring together multiple current initiatives in a coherent programme that will achieve greater momentum and pace. These initiatives include:

- Active and supportive communities programme
- Adult social care customer journey
- Better Care Programme projects (information and advice; supporting self-care; expanding Kingston at Home; risk stratification and MDT working, shared care planning; seven-day working)
- Initiatives to reduce delays in transfers of care from hospital to other settings of care (discharge to assess and breaking the cycle)

9. **Interdependencies**

The Kingston Coordinated Care programme will align with other programmes, particularly

- the Mental Health programme, including the dementia strategy
- the Adult Social Care Transformation Programme
- primary care development
- provision of continuing health care

10. **Stakeholder identification**

**Service users**
- The programme director will meet regularly with Kingston Voluntary Action and Healthwatch service user leads
- The voice of people in Kingston is the foundation for the programme
- The design of the new model of care will involve service users

**Councillors** – represented on the Health and Wellbeing Board and the Residents, Health and Care Services Committee and Children, Youth and Leisure Committee.

**Health and social care commissioning leaders** – represented on the Health and Wellbeing Board, Kingston Coordinated Care Programme Board, Kingston Coordinated Care Design Authority and in project and work streams

**Health and social care providers** - represented on the Health and Wellbeing Board, Kingston Coordinated Care Programme Board and in project and work streams. Invited to Kingston Coordinated Care Design Authority as appropriate.

**Frontline provider staff** – will be part of core design team for new model of care and operating model

**Staff from commissioning and provider organisations** – a communications plan will be developed.

11. **Decision point for Mandate**

The priority for the next month is to secure the mandate for the Kingston Coordinated Care programme and to establish the programme. All approvals are subject to corresponding approval by other boards.

- 22 April – review and comment by CLT (complete)
- 27 April – mandate approval by Commissioning Support Board (complete)
- 5 May – mandate approval by CCG Governing Body (this meeting)
- 6 May – mandate approval by Council and CCG leaders
- 4 June – mandate sign-off by Health and Wellbeing Board
- 17 June – Residents, Health and Care Services Committee