

Care Navigation and Social Prescribing

18 June 2018

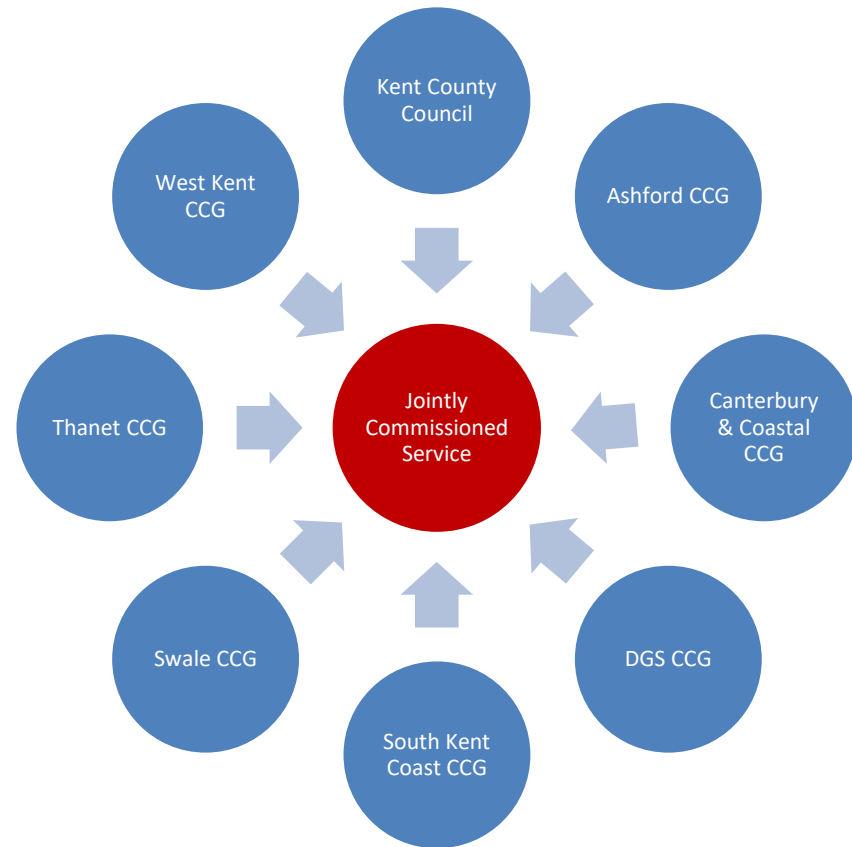
Agenda

- Outline of Future Commissioning Plans for Care Navigation and Social Prescribing
(Presentation by KCC Commissioning)
- Discussion topics looking at how Care Navigation and Social Prescribing currently work in practice
(Group Work)
- Feedback and Questions

Commissioning for the Future

Kent County Council and the 7 CCGs in Kent all currently commission a variety of roles to deliver care navigation and social prescribing services.

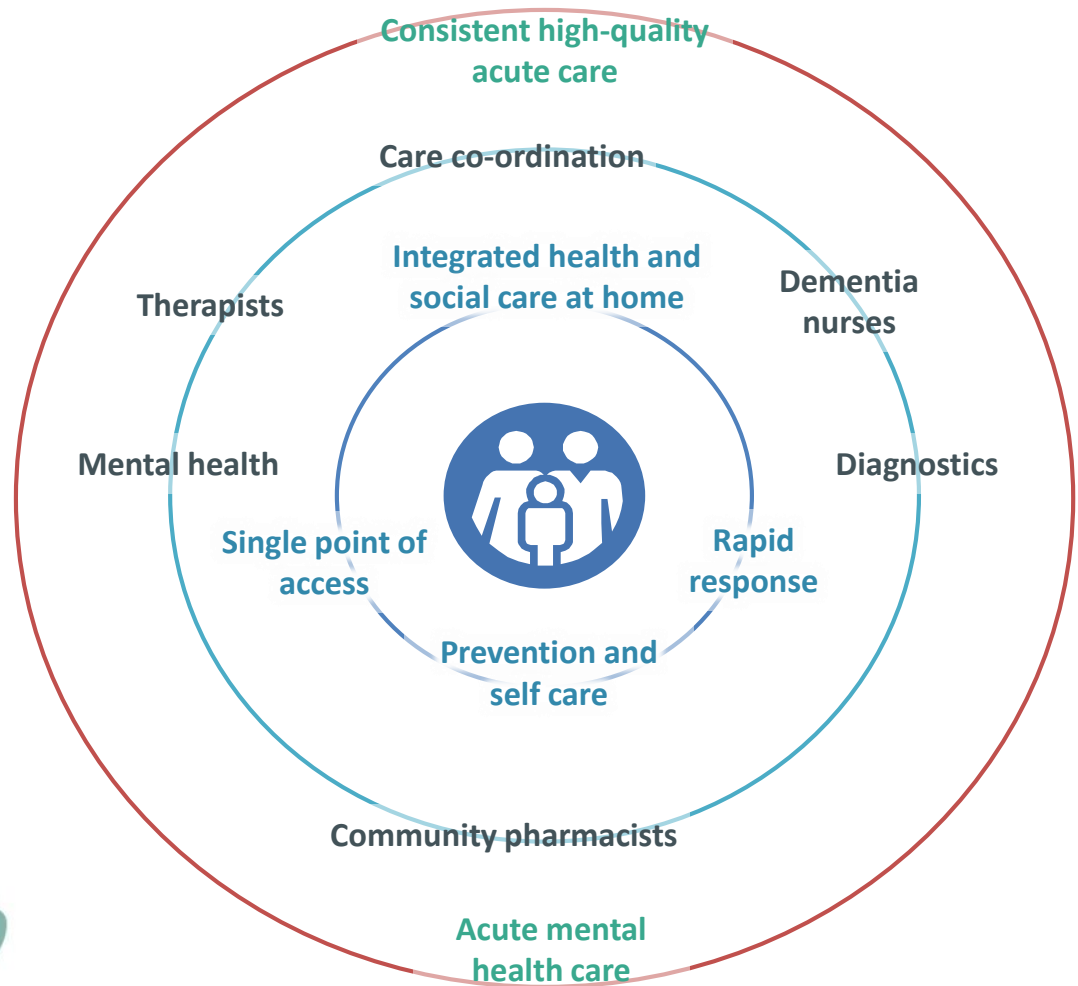
In the future we want to simplify this and are looking to jointly commission the services so that there is equitable delivery across the county.



Kent and Medway's future local care model

We aim to:

- prevent ill health
- intervene earlier
- support wellbeing and independence
- deliver integrated care closer to home.



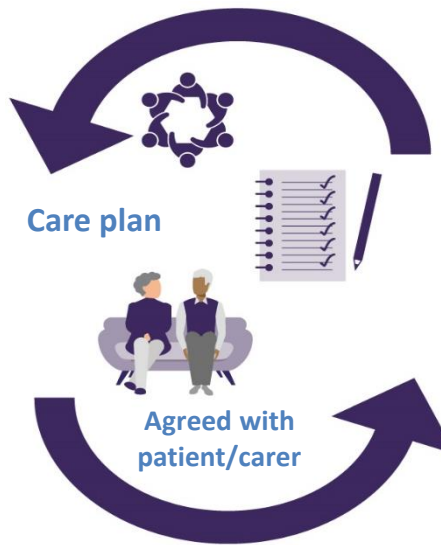
All skills in **one** team



Multi-Disciplinary Team (MDT)

A core MDT team includes:

Our Integrated Case Management (ICM) Approach



Shared IT is essential to communicate effectively

Health and social care coordinator



Pharmacist



GP



Community nurse / LTC Nurse



Geriatrician



Allied Health Professional



Social Care representative / social worker



Mental Health worker



Social Prescribing



Nurse Specialist



Administrator

Additional members which vary locally:



Integrated Discharge Team



Police



Fire and rescue

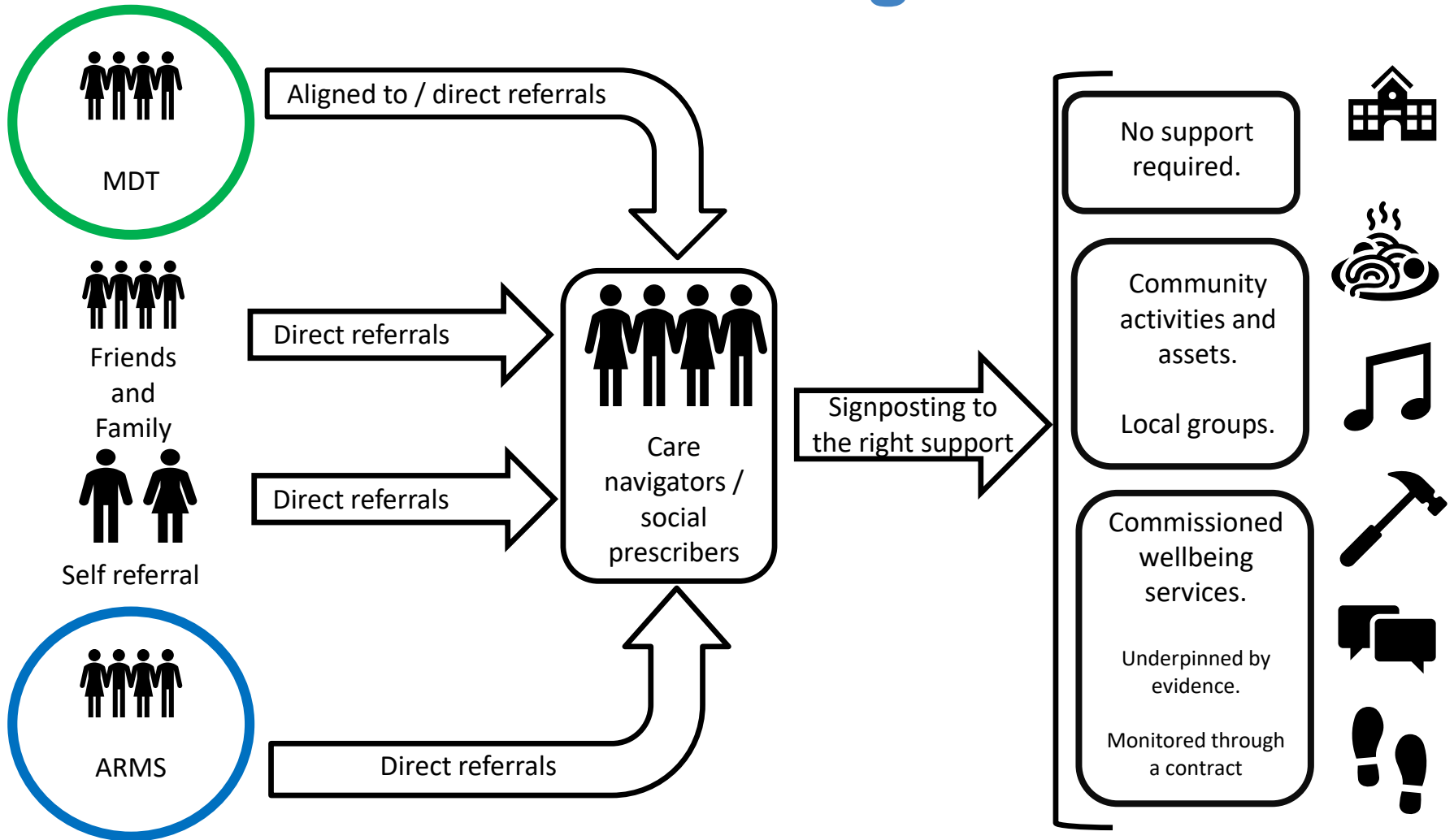


Acute specialists



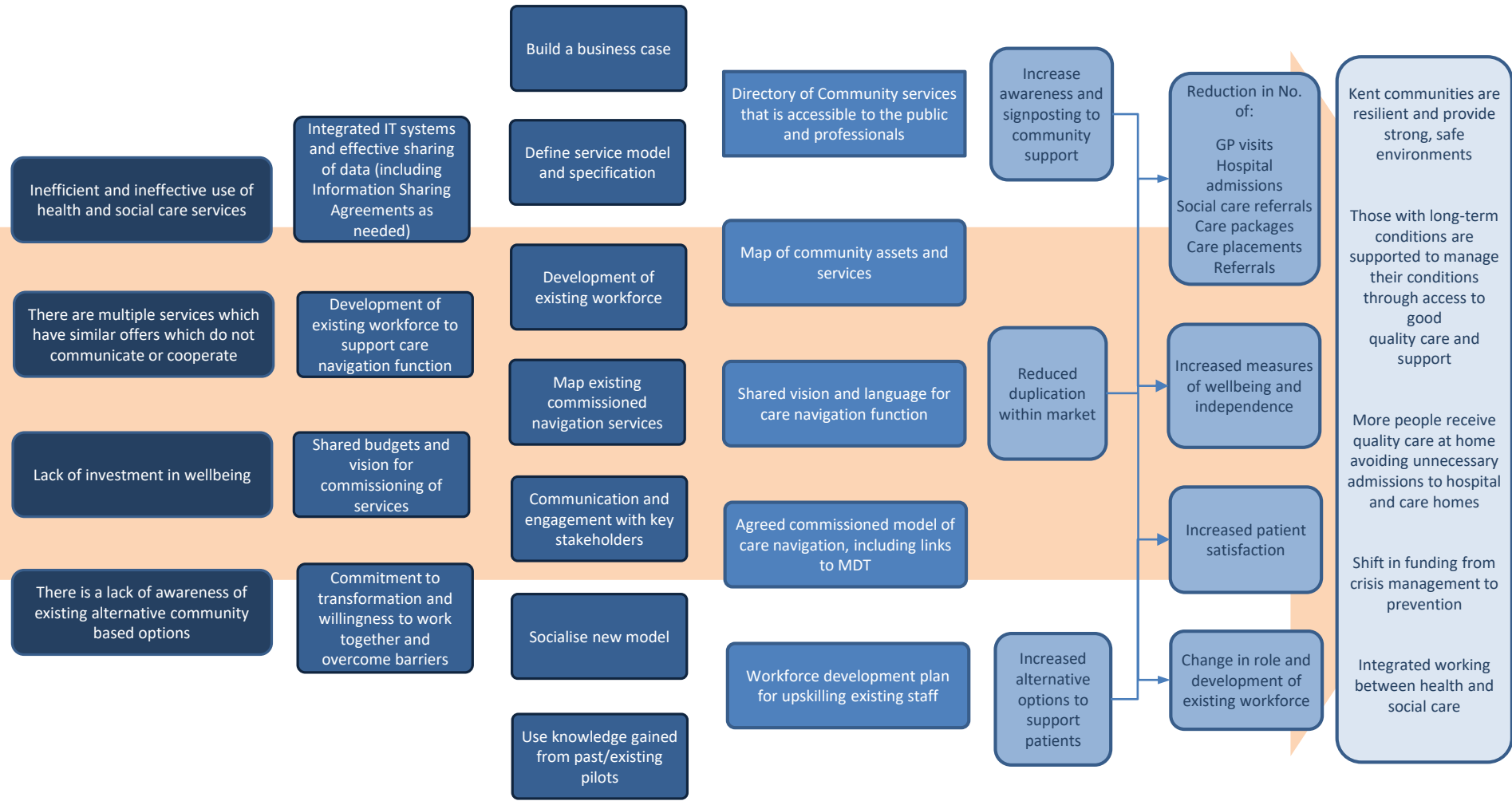
Local Government
i.e. housing

Future Wellbeing Model



Care Navigator - Logic Model

This project aims to design a model of care navigation and social prescribing that can be jointly commissioned between KCC and Kent CCG's. The new contract will provide support services for people (client group to be defined in next workshop) to help them navigate the health and social care systems, connect them to support and resources in their communities and thereby reduce demand on health and social care services.



ISSUE

INPUT

ACTIVITY

OUTPUT

OUTCOME

IMPACT



What do we mean by Care Navigation and Social Prescribing?

- Care navigation:
 - The Care Navigator role provides a proactive link between different parts of the system; being both a first point of contact for individuals, carers and health and social care professionals, as well as guiding and co-ordinating the individual's journey through the care system.
- Social Prescribing:
 - Social prescribing is a way of linking people to sources of support within the community. It provides health and social care professionals with non-medical / non-service focused options that can operate alongside existing treatments or care packages to improve health and well-being.

Our Thinking...

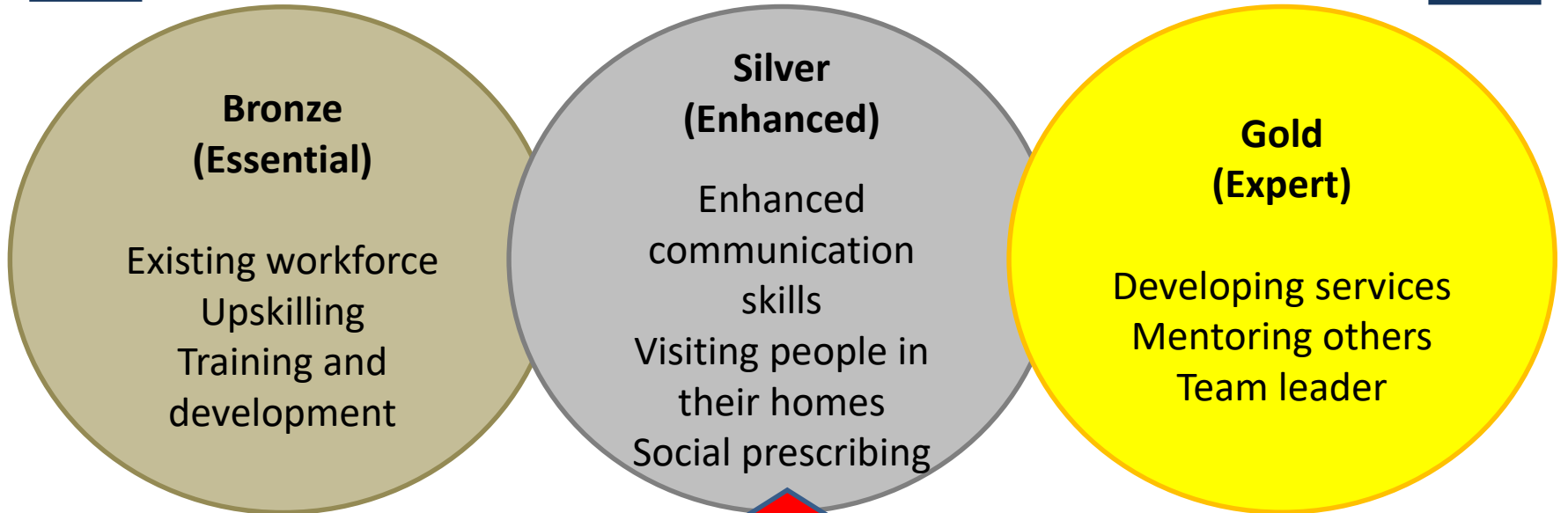
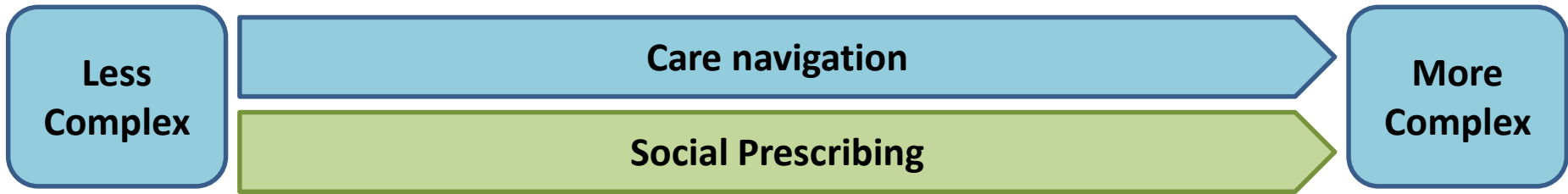
We should think of care navigation and social prescribing as functions rather than two distinct roles

Social prescribing and care navigation are everybody's business



Topic for discussion

Do providers agree with the above?



What we think the role will look like



Scope of the Role

The role will initially focus on supporting the following groups:

- Older people (over 55 years)
- People with complex issues / frailty (under 55 years)

The minimum age for those without a complex/long term condition could be lowered during the lifetime of the contract.

Topic for discussion

Further consideration needs to be given as to whether carers, dementia outreach services and hospital should come into scope

Scope of the Role

Whilst the service will not be rigidly time limited, the role should not hold caseloads indefinitely

- Proposal: a 12 week intervention limit and guidance around importance of working at person centred level (recognising that both shorter or longer time frames are needed). This will enable some ability to evidence levels of performance

Topic for discussion

Should a time limit be put on how long community navigators work with individuals?

Social Prescribing Database

- A database of community based activities and resources will be essential in supporting this role
- Organisations could have ownership of their profiles - inputting and updating their own entries which would simply need to be verified by a moderator before going live on the database
- Public facing resource

Topic for discussion

How would this work given the number of existing databases?

What might a contract look like?

We are considering a block contract / framework contract

- This will be assessed through an options appraisal

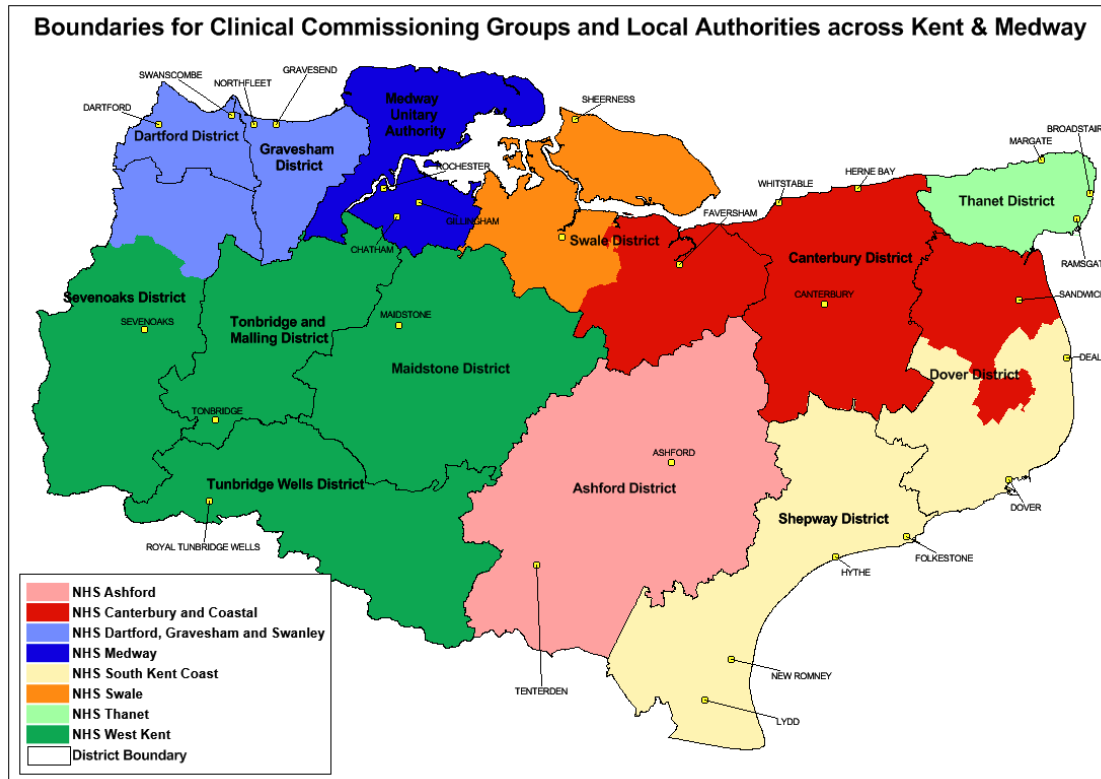
A number of different lotting strategies are currently being considered, including:

-The database and community navigation role could be commissioned as two different lots within the same contract OR as separate contracts

- This will be assessed through an options appraisal

What might a contract look like?

The contract will likely have lots by geographical area (DGS, East Kent, West Kent)



This, and the overall value of the contract, will depend on the commissioning intentions of the individual CCGs.

For Discussion

- How does the service that you deliver fit with the community navigation role?
- Should we think of care navigation and social prescribing as functions rather than two distinct roles?
- Is there anything that we have missed that you feel is integral to the role?
- Should carers and dementia services should come into scope for this contract?
- Does your organisation currently limit how long staff work with individuals? Should a time limit be imposed in the future?
- Do we need to commission a social prescribing database?
- Should the database and the community navigator role be commissioned as separate contracts?