

Connecting Kingston

Tulloch Kempe
Staywell and Kingston Coordinated Care Programme

What's in a name?



- Community Connectors make up the final piece of the three piece Connected Kingston jigsaw
- Navigators, social prescribers, community referrers, and now in the NHS Long Term Plan, the term social prescribing link workers is used
- In Kingston we have used the term **Community Connectors**



..... and simply put, they do what they say on the label;

through listening to and working with the person concerned, they connect them to community groups and agencies for practical and emotional support.

The Context

Social Prescribing

..... moves away from a medical model - identifying the root causes of the individual's issues, tackling them head on. It is about helping and enabling people;

- to find ways to improve their health and wellbeing by linking them up with what's going on in their local area. This could include a gardening club, food growing spaces, art classes, social activities for those who are isolated, benefits and legal advice, housing advice
- to access activities that meet their wider emotional, physical and social needs

The Context

“Social prescribing is not a new idea – good GPs have always done it - it just didn’t have a name.”

Professor Helen Stokes-Lampard, Chair, Royal College of GPs

What is new however, is the growing evidence that social prescribing can significantly improve people’s health and wellbeing (particularly those with complex health and social needs), along with the level of coordination that is required across different services, to support people

A review of evidence following referrals to social prescribing schemes, showed ;

- **average reductions in use of GP services of 28%**
- **average reductions in attendance at A&E of 24%**
- **statistically significant drops in referrals to hospital**

(Polley, MJ, Fleming, J, Anfilogoff, T, and Carpenter, A (2017) Making Sense of Social Prescribing, London University of Westminster)

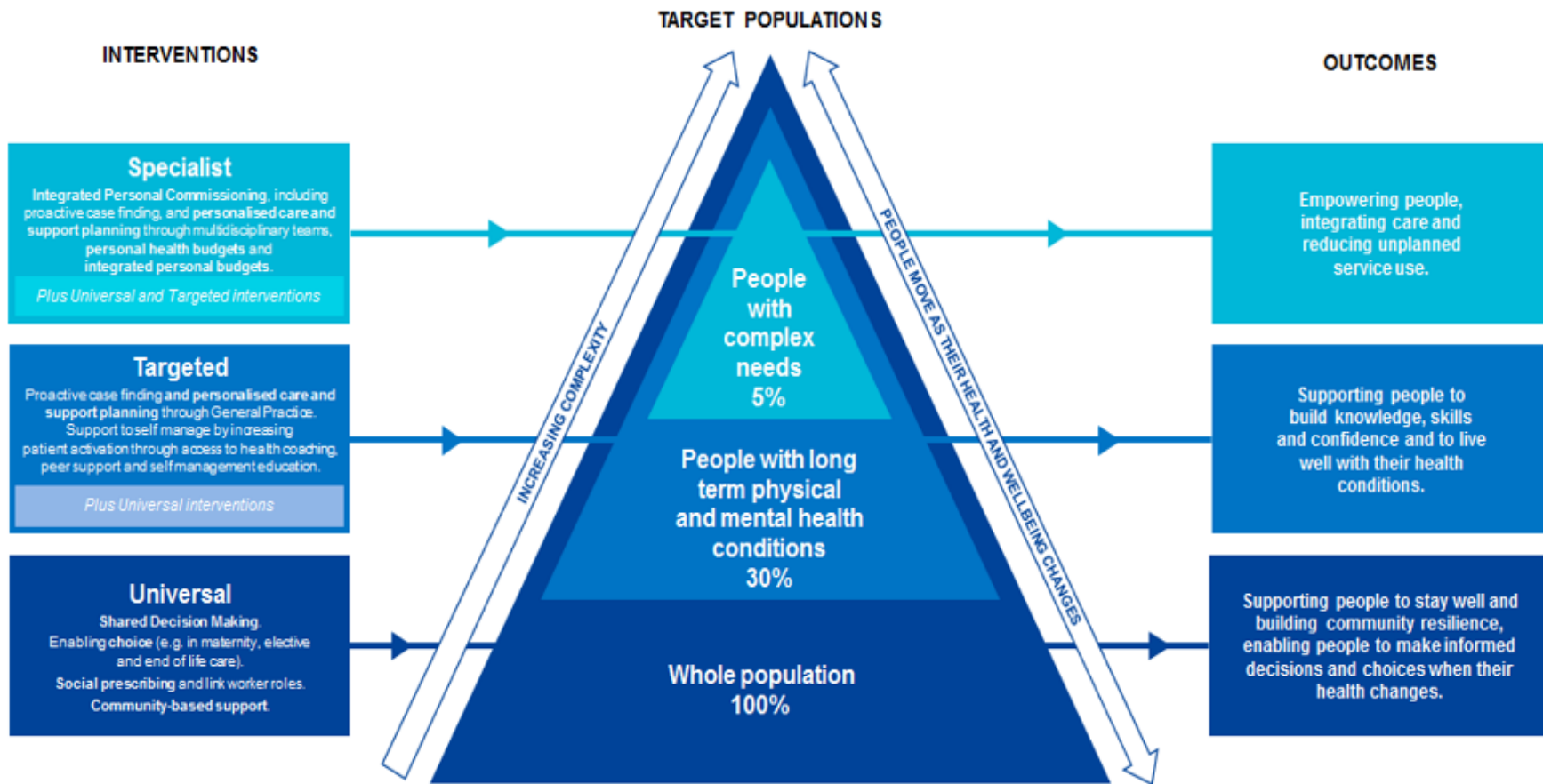
How does the Service work

- The service has been sponsored as a pilot by the CCG through the Kingston Coordinated Care Programme, which Staywell has been part of and central to since its genesis over five years ago
- It commenced in October 2018, building up the team to the current six Community Connectors based at Staywell and working closely with Staywell's long established Community Team who also work with GP practices across the borough
- Each Community Connector is assigned to a number of GP surgeries, altogether attending **21** GP-based MDT meetings a month.

Here patients with complex and challenging needs, or who are high users of health and social care services and/or may not be engaging with services, but who may benefit from social prescribing are discussed, and where appropriate referred into the Community Connector service

Comprehensive Model for Personalised Care

All age, whole population approach to Personalised Care



How does the Service work

Accessing the service is easy

Referrals come from GPs, Health Professionals, Adult Social Care, voluntary and community agencies, the CK Digital tool, family, friends or by self referral.

Community Connectors;

- Provide **Time** to listen to a person during their initial home visit
- **Focus** on what matters to the person by helping them to think about and identify concerns regarding their general health and wellbeing and how these might be addressed through shared decision making and support planning
- **With** the individual, develop an action plan, addressing non-medical issues such as loneliness, isolation, loss of confidence, stress and low level anxiety
- **With** the individual, focus on their interests and strengths, and ways for them to help themselves and sustain their independence

How does the Service work

Community Connectors;

- **Support** and **facilitate** access to services offered by local partners and community groups e.g. LEAH, KCN, Alzheimer's Society, OVP service, KAG, Icope, Milaap, KVA, libraries and education, Thinking Works etc
- Are **on hand** to support the individual to work on their personal plan for up to 6 weeks
- **Collaborate** with local partners and community groups. Staywell holds the contract for a number of voluntary and community agencies in the borough, as well as chairing the Active and Supportive Community Services Network which brings additional VCS agencies under one roof
- Can draw on Staywell's extensive range of services

Meet the team



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“Hi, my name is Rachel. I have 3 years’ experience as a trained Speech and Language Therapist, and 7 years as an administrator for a church followed by volunteering work with the Befriending service at Staywell.

As a Kingston resident of 22 years I bring a good local knowledge of the available groups and services in the borough. I am passionate about meeting vulnerable and isolated people and I am enjoying working with this client group - giving them information and the support and confidence to connect with suitable groups within the community.”

“My name is Debbie, and I have lived in Kingston for over 30 years. I am a trained counsellor and oversee a number of volunteer Community Connectors training as counsellors. My past has involved careers guidance, coaching, training and assessing. I have also worked as an information and advise officer following a period of volunteering with Staywell’s Community Team. Volunteers bring a wide range of benefits to the Community Connector service, increasing its capacity and reach.”

Meet the team

“ Hello, my name is Elizabeth. I trained as a Social Worker and have experience of working with Children and Families and then as a support worker with adults with learning disabilities for 15 years, and also working in a mental health rehabilitation home. As a Community Connector, I have supported elderly clients as well as younger adults to access and to engage in community services and activities in order to improve their health and wellbeing.”

“Hi, I’m Ruth. I have a nutrition, fitness and behaviour change support background, specialising in exercise referral for older adults, cardiac rehabilitation, obesity and diabetes. I have enjoyed facilitating community weight management programmes for families and older adults and running healthy eating, cooking , parenting and confidence building courses in schools and children’s centres.

I enjoy supporting and empowering people to find their own solutions to improve their wellbeing.”

Meet the team

“I’m Lene, and over the past three years, I have supported the borough in obtaining ‘Dementia friendly community’ status, which Kingston achieved for the first time in September 2017, and so I bring a ‘dementia specialism’ to the role.

To date I have delivered 126 ‘Dementia Friends’ information sessions, reaching 1,895 people who now know more about dementia, and most importantly what services are available to support people living with dementia and/or their carers and families in Kingston.

I also run Kingston Dementia Action Alliance, with a membership of over 40 Kingston businesses who have committed to transforming the lives of people living with dementia. Schools, churches, charities, care homes and 250 local organisations have been invited to become Dementia friendly, something I am passionate about continuing.”

Meet the team

“Hi, I’m Anna. With an Occupational Therapy background, I have worked at South West London and St George’s Mental Health NHS Trust since 2014 and continue to do so on a part time basis. This has involved working with individuals with mental health conditions - schizophrenia, schizoaffective disorder, bipolar disorder, personality disorder, EUPD, OCD, depression, anxiety, ADHD, autism, anxiety and drug induced psychosis as well as with individuals who have experienced physical and mental abuse, homelessness, MS, and drug and alcohol issues.

Previously I have worked as a Therapeutic Art Group Leader and in care homes.

I have also recently set up a voluntary group for older adults who suffer from loneliness and social isolation, which I have called the ‘Surbiton Elderberries’.

I enjoy working collaboratively with individuals, devising personalised plans that will help them regain their independence and motivation to move forward.”

The story so far – a snap shot

Community Connectors;

- Have received **158** referrals to date;
88 women, and 70 men. 93 people lived alone.
 - 9 people were below the age of 50
 - 41 were between the ages of 50 - 70
 - 108 were between the ages of 70 - 100
- Are currently working on 54 open cases
- Have attended 78 Multi Disciplinary Meetings to date, with 86 MDT referrals
- Have all completed Connected Kingston Champion and MECC training
- Have attended a number of Connected Kingston and Kingston Coordinated Care MDT Workshops
- Have attended Kingston Hospital's Frailty Journey Conference

The story so far – a snap shot

The reasons for referrals;

Confidence building	8
Mobility support	1
Mental health	20
Home adaptations	2
Home help needed	2
A personal crisis	11
Social support	90
Social support - Befriending	21
Transport options	3

..... and what it's really all about

Story one:

Story two:

..... and of the future opportunities?

For the first time, with the recent publication of the NHS Long Term Plan, there is a national framework for social prescribing now in place, underpinned by Primary Care Networks (PCNs) – formalised clusters of GP practices working with populations of typically between 30,000 – 50,000 people.

This recognises the role social prescribing can play in reducing pressure on emergency services and primary care, and in supporting the model of integrated and personalised self care.

There is an established National Social Prescribing Network in place.

Evidence of the impact of social prescribing is being collected across the country.

..... and, as of this year, an International Social Prescribing Day - **March 14th!**

..... and of the future opportunities?

With the core elements of Connected Kingston now established - the Digital Tool, Champions and Community Connectors, albeit continuing to evolve and improve, Kingston is in a great place to move forward with social prescribing.

Local partners are being brought together to develop a shared local plan for social prescribing to be in place by June, with Primary Care Networks needing to be in place by July 2019.

Partners will be looking at how they can build on existing local social prescribing schemes, along with a commitment to support the VCSE sector and community groups to receive future social prescribing referrals.

With the development of Primary Care Networks, they will now be looking to employ Social Prescribing Link Workers or in Kingston, **Community Connectors** for the benefit of all of Kingston residents.