KENT COUNTY COUNCIL

HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the Health and Wellbeing Board held in the Darent Room, Sessions House, County Hall, Maidstone on Wednesday, 27 January 2016.

PRESENT: Mr R W Gough (Chairman), Dr F Armstrong, Mr I Ayres, Dr B Bowes (Vice-Chairman), Ms H Carpenter, Mr P B Carter, CBE, Ms P Davies, Ms P Ford (Substitute for Ms F Cox), Mr S Inett, Mr A Ireland, Dr M Jones, Dr N Kumta, Dr E Lunt, Mr G Lymer (Substitute for Mr G K Gibbens), Mr P J Oakford, Cllr K Pugh, Mr A Scott-Clark, Dr R Stewart and Cllr L Weatherly

IN ATTENDANCE: Mr T Godfrey (Policy and Relationships Adviser (Health)), Mr M Lemon (Strategic Relationships Adviser (Health)) and Mrs A Hunter (Principal Democratic Services Officer)

UNRESTRICTED ITEMS

190. Chairman's Welcome
(Item 1)

(1) The Chairman welcomed Pennie Ford, Director of Assurance and Delivery at NHS England who was attending as substitute for Ms Cox and was also presenting agenda item 5.

(2) Mr Gough thanked Healthwatch Kent for their contribution to the development of the draft Work Programme (agenda item 8).

191. Apologies and Substitutes
(Item 2)

Apologies for absence were received from Ms Cox, Dr Cocker, Mr Gibbens, Dr Martin and Mr Perks. Ms Ford and Mr Lymer attended as substitutes for Ms Cox and Mr Gibbens respectively.

192. Declarations of Interest by Members in items on the agenda for this meeting
(Item 3)

There were no declarations of interest.

193. Minutes of the Meeting held on 18 November 2015
(Item 4)

Resolved that the minutes of the meeting held on 18 November 2015 are correctly recorded and that they be signed by the Chairman.

194. NHS preparations for and response to winter in Kent 2015/16
(Item 5)

(1) Ms Ford introduced the report which described the actions taken by the health and social care system to prepare for and respond to winter. Ms Ford said that over Christmas and New Year in 2014/15 there had been severe pressure on the health and social care system; the key vehicles for winter preparedness and response were the systems resilience groups established in 2014; and the report provided a summary of the high level assurance that was now in place.

(2) Ms Ford drew particular attention to: the System Resilience Group Assurance ahead of winter; surge management plans and exercises; the winter communication plan to reduce pressure on frontline services; and the winter resilience room that had been in operation between 17 December 2015 and 29 January 2016.

(3) Ms Ford also said that the industrial action by junior doctors planned for January had been postponed and might take place in February.

(4) Each of the CCGs provided an update on the experience over Christmas and New Year 2015/16.

North Kent

(5) In north Kent, as predicted, there was increased pressure, particularly on acute services, over the Christmas period. The Darent Valley Hospital held up last year. This had continued in many respects this year, however, there had been deterioration in the Accident & Emergency position despite a reduction in activity levels. SECamb had seen an increase of 9% in the total number of calls received and the emphasis on “see and treat” and “hear and treat” had contributed to a 1% reduction in conveyance rates to the Darent Valley Hospital. The number of ambulance conveyances had reduced from an average of 450 per week for the first 2.5 weeks of January 2015 to an average of 400 for the same period in 2016.

(6) It was considered that problems were likely to be the result of intra-hospital pressures and work was underway to understand the reasons. Efforts were also being made to understand the reasons for the increase in Delayed Transfers of Care from 1.7% in November/December 2015 to 2.74% in January 2016.

(7) Primary care and ambulance services had coped well across DGS and Swale with providers of the out of hours service being able to fill all shifts; the 111 service had also coped well particularly as 50% of calls from Yorkshire and the north of England had been re-directed to the south as part of business resilience plans in response to flooding.

(8) Ms Davies also said it was worth noting that the A&E Department at the Medway Hospital had remained “green” in the two weeks to Christmas and was one of the last hospitals nationally to declare “black” on 5 or 6 January 2016.

(9) Overall, primary care, community services and the out of hours service were robust and had performed well, while there were lessons to be learned in relation to acute services.

West Kent

(10) Admissions to hospitals in Maidstone and Tunbridge Wells had remained level with a normal seasonal increase in the number of long stay patients which put more pressure on beds. The emphasis in the A&E Departments was to find beds quickly for those who needed to be admitted. In addition to some delayed transfers of care to social services, there were issues relating to nursing and care home capacity in West Kent and the potential need for accommodation with doctor oversight particularly for those who required rehabilitation and re-ablement services but not the full services of an acute hospital.

East Kent

(11) Ms Carpenter said that East Kent's performance had to be considered in the context of on-going activity including "discharge to assess programmes" that had been in place since October 2015; the A&E recovery plan; and work continuing in primary care to reduce hospital admissions, particularly, among the over 75's. East Kent Hospitals University Foundation Trust had an 82% bed occupancy rate on Christmas Eve but the position deteriorated from New Year's Eve onwards especially at the Queen Elizabeth, Queen Mother Hospital as a result of significant staff sickness and the lack of agency staff on shifts.

(12) Footfall in primary care had been lower than predicted between Christmas and New Year but had been higher in A&E. Work was underway to understand why this was the case and to ensure people were sign posted to the correct service or capacity was provided where it was required.

(13) The System Resilience Group in East Kent was now well placed to take forward the A&E Recovery Plan and there was now a clear focus on being prepared for the half-term holiday in February.

(14) Dr Jones drew attention to work that was being done collectively to: avoid unnecessary admissions to hospital; manage the flow of patients through the hospitals; and avoid delayed transfers of care. The capacity of primary care during the day was satisfactory but there was a need to recognise capacity issues arising from seven-day working.

(15) Mr Ireland said that there was a greater collective focus on sustainable ways of supporting patients to be in their own homes, however, there were acute pressures on workforce supply in the social care market as a whole and particularly on homecare. Integrated care responses would continue to be developed.

(16) Mr Scott-Clark said that the flu rate, monitored by Public Health England was half the rate at the end of week 2 compared with the same period in 2015. However the prescribing guidance on anti-virals had been instituted in the last three weeks and this was triggered when flu rates were higher nationally. He also said that outbreaks of flu were being reported in primary schools but this could be due to increased vigilance.

(17) In response to questions, Ms Ford said that the industrial action taken by junior doctors had excluded urgent and emergency care and had affected elective activity. Trusts were now seeking to recover from this. The impact on services would be much greater if there was a full walk out and plans were being made to keep emergency care pathways open.

(18) Resolved that the report and updates be noted

195. The new planning arrangements for health and social care
(Item 6)

(1) The Chairman said that agenda items 6 and 7 (New Models of Care - Progress Report – Presentation) were closely related and would be considered together.

(2) Mark Lemon (Strategic Relationships Adviser) introduced the report on the New Planning Arrangements for Health and Social Care by giving a short presentation a copy of which is available on-line at Appendix 1 to these minutes.

(3) Mr Ayres spoke about the planning footprint from a health perspective. He said the Strategic and Transformation Plans differed from previous plans and needed to be developed by system and by place as well as demonstrating that both individual organisations and the system as a whole could balance their budgets. There had been some discussion about the options for planning footprints including footprints designed to ensure the viability of acute providers such as an "A21 Corridor" as well as the development of footprints at a Kent level, at CCG level, at joint CCG level such as "East Kent", or on a "Health Economy" level of north, east and west Kent.

(4) Ms Davies and Ms Carpenter gave presentations about the development of Strategic and Transformation Plans for the west and east Kent health economies which are available on-line as Appendices 2 and 3 of these minutes.

(5) Mr Ayres said that "Mapping the Future" project, undertaken a few years ago, had set out the vision of a sustainable future for west Kent and the foundations to build that future had been put in place over the last two years. This included:

- Re-commissioning the out of hours service into a two-year contract bringing together a range of services with a view to procuring a fully integrated care service from 2017;
- Developing Maidstone and Tunbridge Wells Hospital and the Kent Community Health Foundation Trust as a partnership of providers rather than as competitors;
- Working with GP practices and the development of two emerging federations with a view to them being at the heart of community based service provision;

- Running pilot programmes with Adult Social Care and other providers to align and integrate services with a view to procuring fully integrated services in a lead provider arrangement

(6) Mr Ireland gave a presentation about the transformation of Adult Social Care which is available on-line as Appendix 4 to these minutes

(7) There was general agreement that planning needed to be done: at the most appropriate level for the service; around natural populations rather than around acute service providers; and should focus on developing integrated primary and social care. Concerns were expressed about the difficulties presented by seeking to extend the footprint beyond Kent and Medway.

(8) Dr Stewart said the Kent Integration Pioneer Steering Group had an important role, as a working group of the Kent HWB, to work with and across emerging new models of care including vanguards, integrated care organisations and federations. New community services and professional blended roles based around GP practice configurations linked to the estates and workforce strategies to support independence could be achieved by the CCGs, Social Care, Public Health and other providers coming together to design, learn and share clinical and social innovation to meet local challenges and integrate health and social care provision.

(9) Resolved:

(a) That the most appropriate planning footprints were the health economies of north, west and east Kent with recognition of the wider Kent and Medway dimension for some aspects of planning;

(b) That a range of governance models were emerging be noted; that there should be reports on the development of the Strategic and Transformation Plans to the HWB in March and May 2016 and that they should include updates on this aspect as appropriate;

(c) That the Board's workplan and forward agenda setting reflect the requirements to consider and agree the various plans to be produced over the coming months, including the evolution of the BCF in Kent, to deliver the wider integration requirement by 2020 in conjunction with the Sustainability and Transformation Plans;

(d) That the work, to be done outside the meeting, to ensure progress be recognised and that consideration be given to reframing the refreshed Health and Wellbeing Strategy, due in 2017, around plans for the integration of health and social care by 2020, although work to achieve this integration should be accelerated as much as possible;

(e) To note that, in practice the Assurance Framework covered the review and evaluation of progress towards the objectives of the plans including the nine "must-do's".

196. New Models of Care - Progress Report - Presentation
(Item 7)

This item was considered with the previous item (The New Planning Arrangements for Health and Social Care)

197. Draft Kent Health and Wellbeing Board Work Programme
(Item 8)

(1) Tristan Godfrey (Policy and Relationships Adviser) introduced the report which included: a suggested outline Forward Work Programme; a proposal to better focus the work of the Board by defining its key areas of activity; and a suggestion for improving the co-ordination of future agendas.

(2) It was suggested that the Board's primary focus should be on setting out and achieving ambitious and innovative targets and an in-depth discussion was required to define and agree this ambition.

(3) Resolved that:

(a) An annual work programme for the Board in line with the approach set out in the report be agreed;

(b) Amendments to the Forward Work Programme be suggested prior to final agreement of the programme on 16 March 2016 and its communication to the local health and wellbeing boards;

(c) The Forward Work Programme be a standing item on future agendas;

(d) A lead officer to assist in the co-ordination of future agendas be nominated where appropriate.

198. Kent Safeguarding Children's Board Annual Report
(Item 9)

(1) Mr Ireland introduced the report on behalf of Gill Rigg, Independent chair of the Kent Safeguarding Children Board (KSCB) . The report described the progress made in improving the safeguarding services provided for children and young people in Kent during 2014/15 as well as the challenges for the following year.

(2) Mr Ireland said the KSCB was waiting its Ofsted inspection which could happen at any time up to March 2017. He also drew attention to the growing understanding and commitment in relation to child sexual exploitation (CSE) and to the issue of unaccompanied asylum seeking minors (UASM). He said that currently there were 930 UASM in the care of the county with a further 500 accessing care leaving services. Discussions about a national placement scheme were continuing but there were concerns that number of UASM being cared for in Kent could increase rapidly if a scheme was not in place by April.

(3) Resolved that the progress and improvements made during 2014/15, as detailed in the annual report from the Independent Chair of Kent Safeguarding Children Board, be noted.

199. Minutes of the Children's Health and Wellbeing Board
(Item 10)

Resolved that the minutes of the meetings of the Children's Health and Wellbeing Board held on 15 September and 25 November 2015 be noted.

200. Minutes of the Local Health and Wellbeing Boards
(Item 11)

Resolved that the minutes of local health and wellbeing boards be noted as follows:

Canterbury and Coastal – 13 November 2015
Dartford, Gravesham and Swanley – 9 December 2015
Thanet 19 November - 2015
West Kent – 17 November 2015

201. Date of Next Meeting 16 March 2016
(Item 12)

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Kent Health and Wellbeing Board

27th January 2016

New planning arrangements for health and social care

Mark Lemon
Strategic Relationships Adviser

Kent County Council kent.gov.uk

Plans – Key Points

Sustainability and Transformation Plan

Agreed by Summer for 2016/2021 it must:

- **Create system stability**
- **Deliver the 5YFV and the 9 "Must Do's"**
- **Establish Footprints**

The Better Care Fund

Inflation increase in 2016/17

"New" BCF from 2017 to 2019 increases each year by –

- **£ 105 million**
- **£825 million**
- **£1.5 billion**

Integration of Health and Social Care

- **Plan by 2017 to deliver by 2020**
- **Read across to S&TP**
- **Coincides with timing on next Joint Health and Wellbeing Strategy**

Issues for the Kent Health and Wellbeing Board

- What should the footprint(s) be ?
- How do we address wider issues ?
- What must be reported, and when ?
- What should we monitor, e.g. “must do’s” ?
- How do we graduate/escape from BCF ?

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DGS CCG and Swale CCG (North Kent)

Patricia Davies

Integration and North Kent

- Two CCGs - share common demographic profile, providers and challenges
- NK (including Medway) already has in place a strategic alliance given that patient flow is predominately contained within this area non-electively;
- Developing greater alliances and a wider footprint strategy across North and West Kent
- We recognise the need for wider footprint planning and health integration;
- Most importantly we understand the value and need to integrated both commissioning and provision not only across health, but also with social care.

North Kent – integrated commissioning

- Clear governance structure in place;
  - Joint strategic commissioning board
  - Executive Programme Board
- Have aligned commissioning teams for:
  - Children's
  - LD
  - Carers
  - Aspects of mental health – dementia and integrated primary care teams
- Next steps is to move from alignment to full joint commissioning

North Kent – integrated provision

DGS

- IDT – based around DVH
- IPCTs – community
- Carers services
- Primary care mental health workers
- Dementia nurses
- ADSS

Swale

- IDT funded jointly with Medway
- IPCTs – aligned or localities and emerging Swale federation
- Paramedic practitioners
- Joint funded post with Borough council focusing on health inequalities
- Carers services
- Dementia nurses

What has worked well

- Governance structure – allows for open debate,planning and monitoring of delivery;
- Fair to say that alignment of commissioning and integration of commissioning has happened at a greater pace;
- We have more joined up provision – IPCTs, IDTs, and real inclusion of the voluntary sector;
- This has resulted in a:
  - Reduction in ambulance conveyance – 1% reduction
  - Low DTOC – Nov 1.74%
  - Success regarding 'home first' within Swale has been maintained – rolling out to DGS
  - Better patient experience

Next steps – opportunities

- Opportunity to bring together social care with through the community service tender – key plank of the bid was centred around integration of health and social care;
- Emerging federations with an opportunity of bringing together social, community health (including mental health) and primary care together;
- 90% of care takes place within the community – cornerstone and backbone of provision
- Hospitals are great for the acutely unwell and need to be an integral part of our communities, but they are not *the* community.

Key risks

- Organisational risks and bottom line
- Not more of the same but transformation requires capacity and resource
- Care markets stimulation and workforce issues
- Open governance systems will assist in mitigating such issues
- HWBB in taking receipt of plans and helping to support delivery and releasing the blocks and tensions

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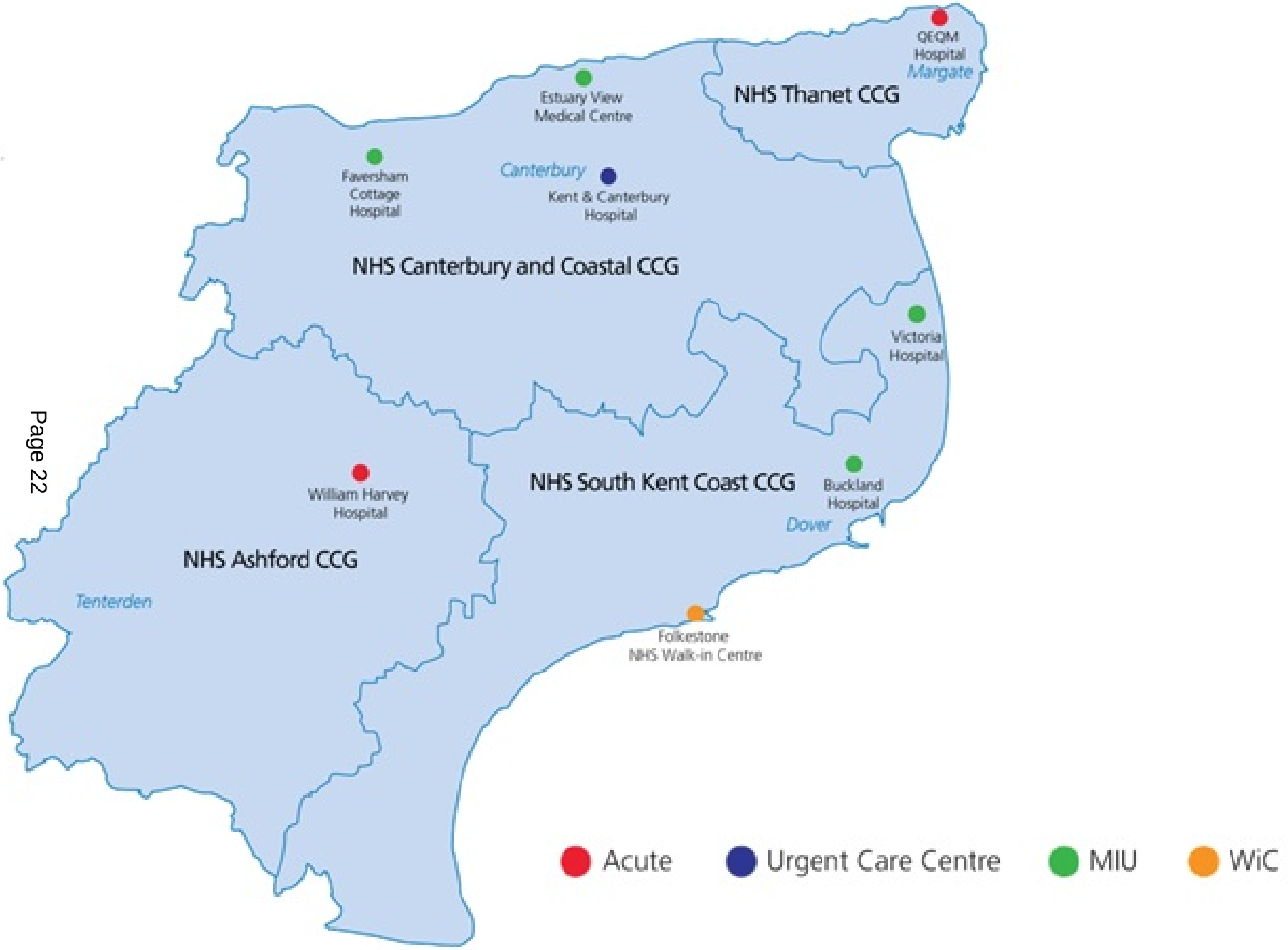
Appendix 3

East Kent Sustainability and Transformation Plan


QEQM
Hospital
Margate
Estuary View
Medical Centre
NHS Thanet CCG
Faversham
Cottage
Hospital
Canterbury
Kent & Canterbury
Hospital
NHS Canterbury and Coastal CCG
Victoria
Hospital
William Harvey
Hospital
NHS South Kent Coast CCG
Buckland
Hospital
Dover
NHS Ashford CCG
Tenterden
Folkestone
NHS Walk-in Centre
Acute
Urgent Care Centre
MIU
WiC

East Kent Health Economy Approach

- All 4 Clinical Commissioning Groups
  - *Canterbury & Coastal, South Kent Coast, Thanet and Ashford*

- Our Service Providers
  - *East Kent Hospitals University NHS Foundation Trust*
  - *Kent Community Health NHS Foundation Trust*
  - *Kent & Medway NHS and Social Care Partnership Trust*
  - *Kent County Council*
  - *Other Partners*
    - *Independent Sector, Health & Wellbeing Board, Local Authorities etc.*

- NHS England
  - *Specialist Commissioning*
  - *Primary Care*

Our approach

"What care will you receive?"

Clear service models and pathway specifications

"Who will provide your care?"

Provider/organisational models

- New shape of integrated, local out of hospital providers (ICOs/MCPs/Vanguards)
- Acute physical provision
- Acute mental health provision

"Who will commission your local services?"

Commissioning models

- Local Health and Wellbeing Boards
- CCG development within and alongside the above
- Aligning primary and specialist commissioning to seek devolution within the new models of care

Whole System Clinical Strategy – Overview

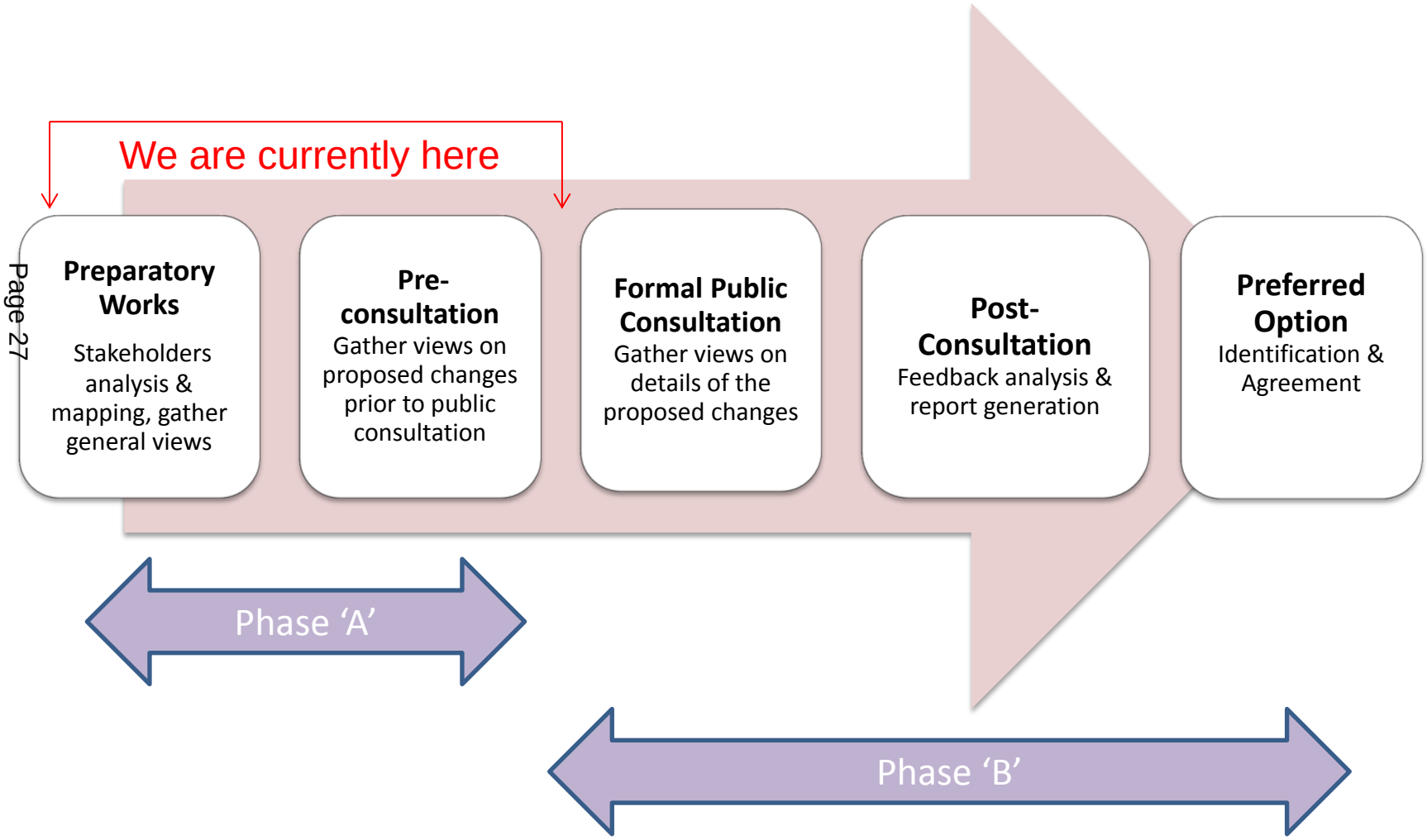
- Simplify services and remove unnecessary complexity.
- Use these services to build multidisciplinary care teams for patients with complex needs.
- Wrap multidisciplinary teams around groups of practices, including mental health, social care, specialist nursing and community resources.
- Support these teams with new models of specialist input.
- Develop teams and services to provide support to patients as an alternative to admission or hospital stay.
- Build the information infrastructure, workforce, and ways of working and commissioning that are required to support this.
- Reach out into the wider community to improve prevention, provide support for isolated people, and create healthy communities

End State

Comprehensive, integrated local care and health services

- Tailored to communities
- List based, grounded in primary care
- Maximum scope for the team around the patient GP
- Social Services, Voluntary Sector and NHS working together
- Out of hospital provision through Multispecialty Community Providers (MCP)
- Supported by a chain of high quality, smaller, acute hospitals with access to safer specialist services

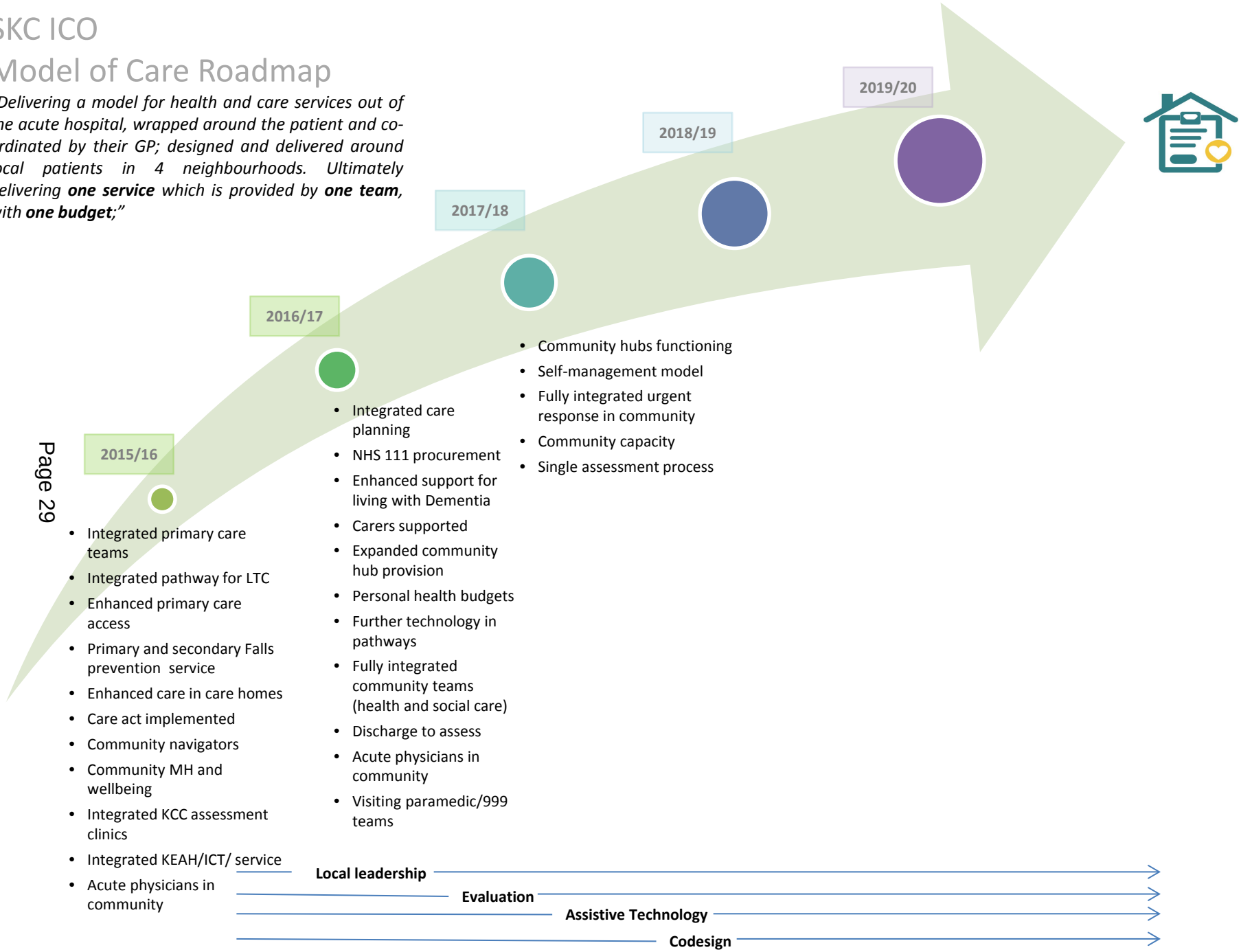
Engagement Process: Overview



South Kent Coast

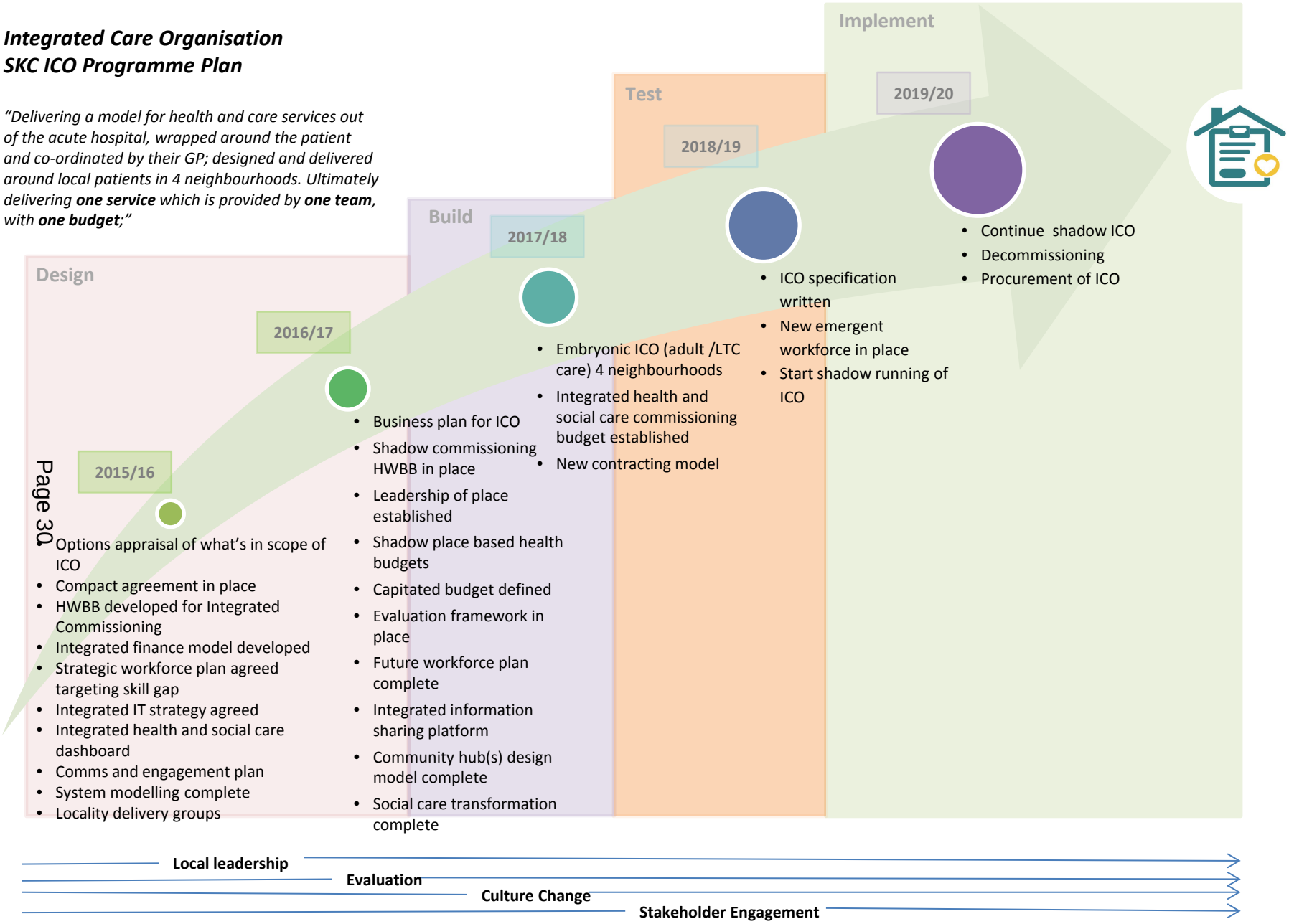
SKC ICO
Model of Care Roadmap

*"Delivering a model for health and care services out of the acute hospital, wrapped around the patient and co-ordinated by their GP; designed and delivered around local patients in 4 neighbourhoods. Ultimately delivering **one service** which is provided by **one team**, with **one budget**;"*

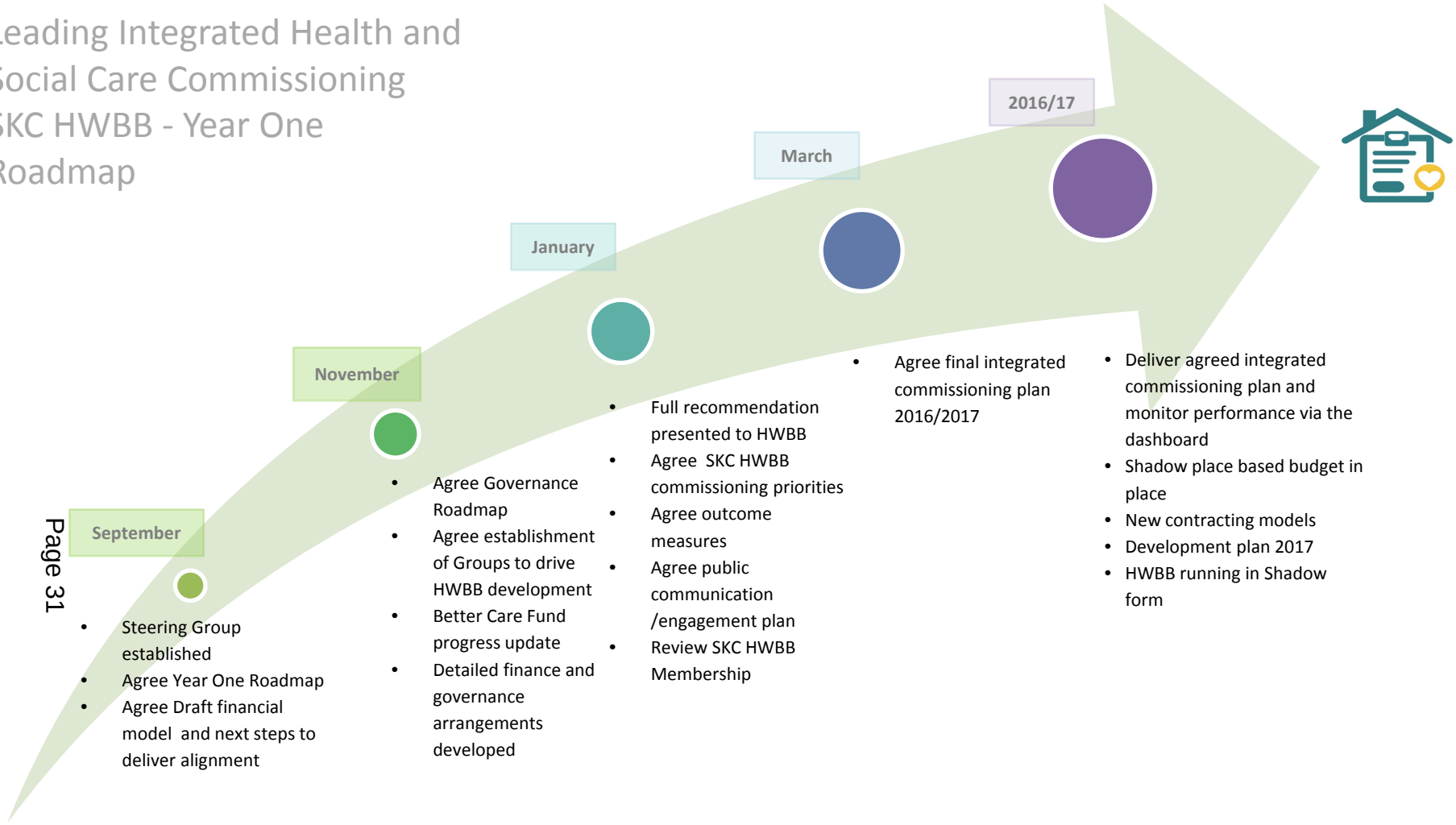


Integrated Care Organisation
SKC ICO Programme Plan

*"Delivering a model for health and care services out of the acute hospital, wrapped around the patient and co-ordinated by their GP; designed and delivered around local patients in 4 neighbourhoods. Ultimately delivering **one service** which is provided by **one team**, with **one budget**;"*



Leading Integrated Health and Social Care Commissioning SKC HWBB - Year One Roadmap



DRAFT Nov 15

Accountable Care Organisation (ACO)

SKC HWBB commission integrated OUTCOMES & PRIORITIES

SKC Integrated Commissioning Plan

Locality Commissioning Priorities

There are 4 Localities within SKC ACO

Key Components

- **Dover**– population 57.7k (64.7k*)
- **Folkestone**– population 87.1k (94.6k*)
- **Romney Marsh**– population 21.1k (26.9k*)
- **Deal**– population 34.5k (38.0k*)

*Weighted

That will become a provider of integrated out of hospital care

Key Components

- Access to specialist clinics in the community
- Pathways to prevent admission and to facilitate earlier discharge from hospital
- Rehabilitation
- Prevention
- Supporting independence
- Primary mental health
- Provider risk share agreement across localities

They will have an Integrated (capitated) commissioning budget

Key Components

- Accountability for budget spend
- Accountable for purchasing local services to deliver model of care
- Lead provider commissioning model
- Financial risk management

And become a locality Commissioner

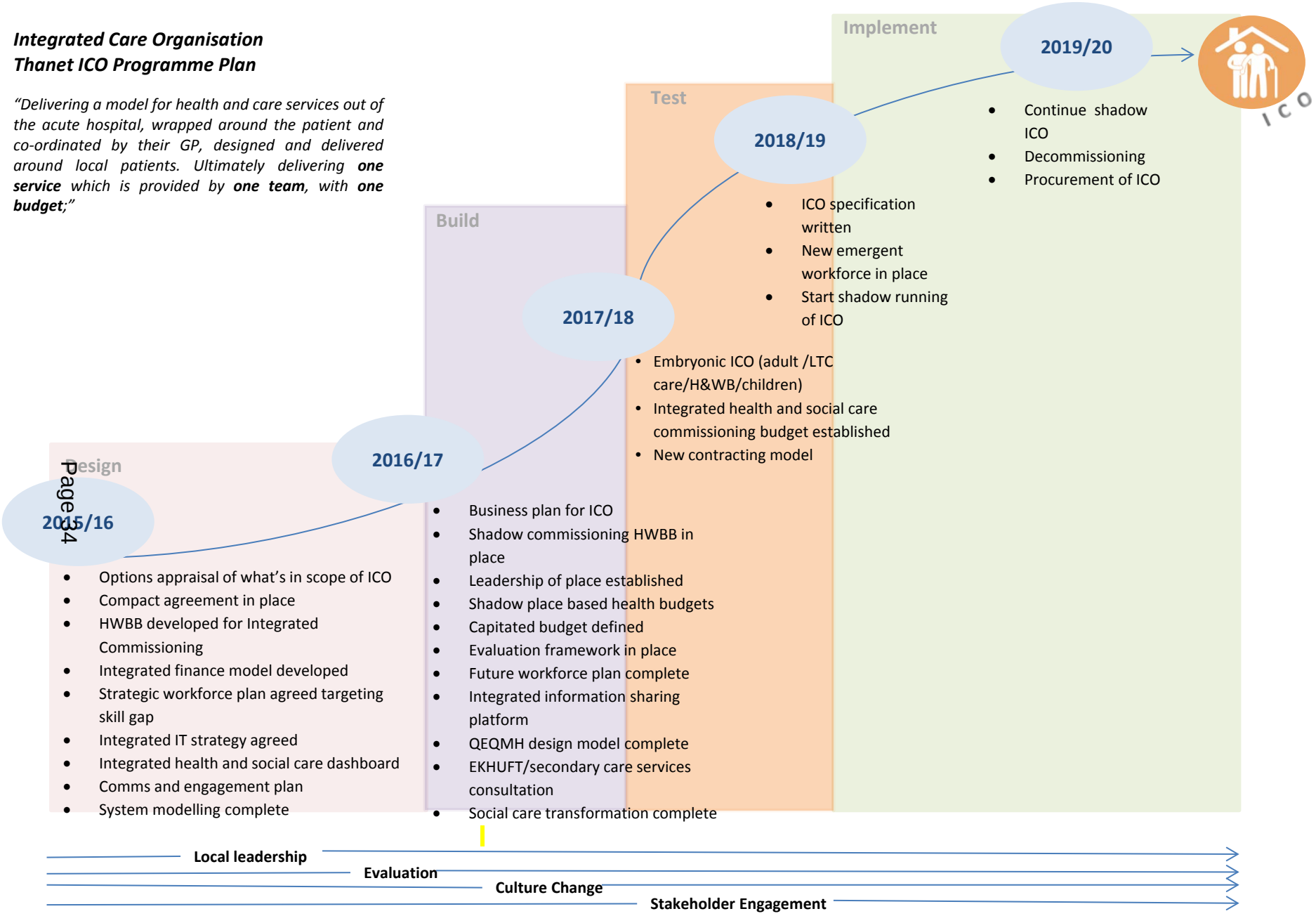
Key Components

- Integrated locality capitated commissioning budget
- Accountability to develop local commissioning plan
- Risk share agreement across 4 localities
- Commissioning for quality and outcomes
- Commission to meet locality health needs and priorities
- Integrated commissioner

Thanet Future
Accountable Care Organisation

Integrated Care Organisation
Thanet ICO Programme Plan

*"Delivering a model for health and care services out of the acute hospital, wrapped around the patient and co-ordinated by their GP, designed and delivered around local patients. Ultimately delivering **one service** which is provided by **one team**, with **one budget**;"*



Thanet ICO
Model of Care Roadmap

*"Delivering a model for health and care services out of the acute hospital, wrapped around the patient and co-ordinated by their GP, designed and delivered around local patients. Ultimately delivering **one service** which is provided by **one team**, with **one budget**;"*

2015/16

- Integrated health and social care teams
- Integrated pathway for diabetes, COPD, HF
- Elective pathway re design
- Extended access to PCMH
- Falls and frailty pathway
- Enhanced care in care homes
- Discharge to assess
- Ambulatory care
- Community equipment
- Care act
- Dementia diagnosis
- Community navigators

2016/17

- Integrated care planning
- NHS 111 procurement
- Community ownership model (Newington)
- Exemplary end of life care
- Primary care hub in QEQMH
- Enhanced support for living with Dementia
- Patient transport
- MH crisis teams and psychiatric liason
- Carers supported
- Expanded community provision
- Personal health budgets

2017/18

- QEQMH functioning as community hub
- Self-management model
- Fully integrated urgent response in community
- Visiting paramedic/999 teams

2018/19

2019/20

Local leadership

Evaluation

Assistive Technology

Codesign

DRAFT Nov 15

Accountable Care Organisation (ACO)

Thanet HWBB commission integrated OUTCOMES & PRIORITIES

Thanet Integrated Commissioning Plan

Locality Commissioning Priorities

There are
4 Localities within Thanet ACO

Key Components

- **Quex** – population 30k
- **Ramsgate** – population 51k
- **Margate** – population 42k
- **Broadstairs** – population 20k

That will become a provider of integrated out of hospital care

Key Components

- Access to specialist clinics in the community
- Pathways to prevent admission and to facilitate earlier discharge from hospital
- Rehabilitation
- Prevention
- Supporting independence
- Primary mental health
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And become a locality Commissioner

Key Components

- Integrated locality capitated commissioning budget
- Accountability to develop local commissioning plan
- Risk share agreement across 4 localities
- Commissioning for quality and outcomes
- Commission to meet locality health needs and priorities
- Integrated commissioner

Ashford and Canterbury

Multispecialty Community Providers

Towards Integrated Provision

In Place

- Community Networks
- Canterbury, Whitstable and Faversham MCP *Commenced*

2016/17

- East Kent Clinical Strategy
- Canterbury, Whitstable and Faversham MCP - *Phase 2*
- Herne Bay Integrated Care - *Phase 1*
- Develop business case for Ashford MCP

2017/18

- East Kent Clinical Strategy – *Phase 1*
- Canterbury, Whitstable and Faversham MCP - *Phase 3*
- HB Integrated Care - *Phase 2*
- Ashford MCP – Phase 1 & 2

2018/19

- East Kent Clinical Strategy – *Phase 2*
- Canterbury, Whitstable and Faversham MCP - *Phase 4*
- HB Integrated Care - *Phase 3*
- Ashford MCP – Phase 3

2019/20

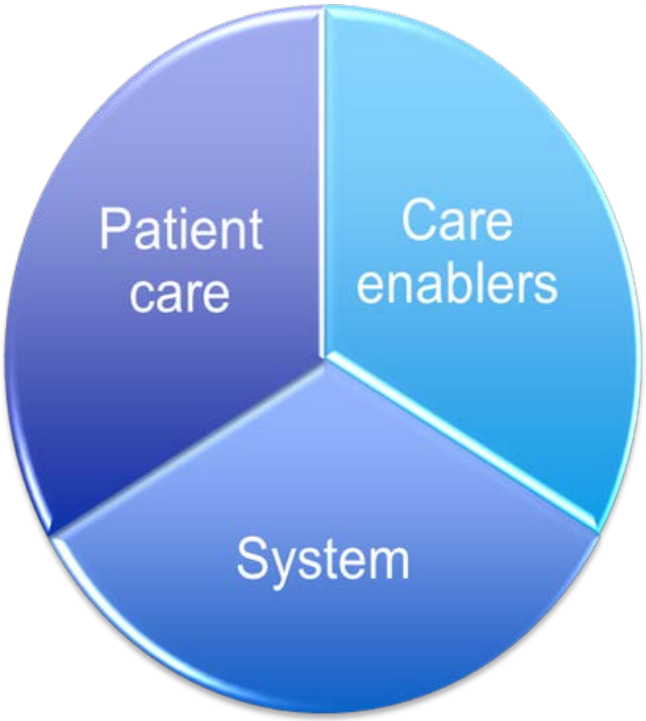
- Smaller, safer, more specialist secondary care services
- Secondary care (physical and mental health) support to primary care out of hospital
- Out of hospital provision through Multispecialty Community Providers (MCP)
- Access conducive to decrease health inequalities

encompass
Working together for better health and care

Encompass: Components

Patient care perspective

- Primary care at scale with extended / enhanced range of offers
- Person-centred care: supporting independence and well being
- Focus on prevention and self-care
- Whole population model with specific targeted pathways (e.g. extensivist for over 65 with comorbidities)
- Community asset based approaches and social prescribing
- Assistive technologies (mobile apps, telehealth, telecare, telemedicine)



Care enablers perspective

- Single points of access for patients and staff
- Integrated community multidisciplinary teams with new roles, e.g. navigators
- Single shared assessments and joint approaches to clinical governance and management of clinical risk
- Information hubs integrated shared digital care records and interoperable systems
- Risk stratified care planning and case management – with dedicated support to those at higher risk of admission
- Care hubs and new health and wellbeing centres
- In-reach and out-reach from secondary care

System perspective

- Primary care provider development
- Integration of health and social care funding and commissioning
- Outcome based evaluation, payment and performance
- Multi-agency partnership working; systems leadership and shared governance models
- Horizontal integration of existing 'out of hospital' provision
- Care funded through fully delegated capitated budget; with risk and gain share
- Care model operating on neighbourhood footprint
- Provider responsible for whole population health – based on registered GP lists

Encompass - Community Hub Operating Centres (CHOCs)

- Located in Whitstable, Canterbury, Faversham and Sandwich
- Include as core
  - Integrated nursing and social care services
  - Health prevention and health promotion services
  - Access to voluntary and community services via social prescribing
- Each hub will incorporate:
  - General Practice
  - Integrated nursing and social care (including domiciliary care)
  - Functional therapy services
  - Access to voluntary and community service via social prescribing
  - Health promotion and prevention services
  - Integrated mental health services

Towards “Full Integration” of Commissioning

- What is the decision making process?
- Where does accountability and responsibility sit?
  - Department of Health/NHS England
  - Department for Communities and Local Government
  - Local Councillors
- How does this fit with existing Joint Commissioning Group and the Better Care Fund?
- What is the link with Five Year Forward View and “Place Based Systems of Care”?
- Do we need to develop local HWBB as a commissioning entity?
- How will local HWBB address issues which affect East Kent?

Thank You

Appendix 4

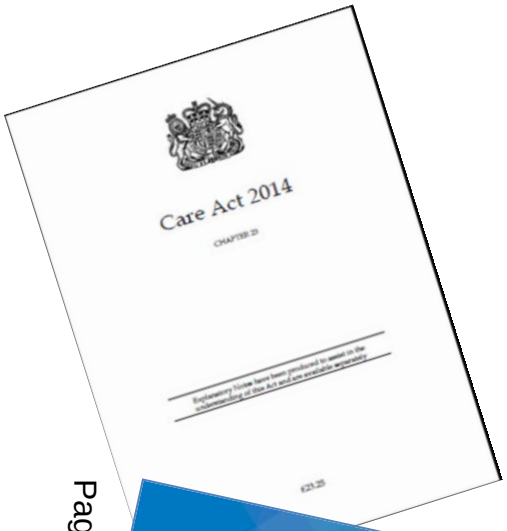
ASC Transformation

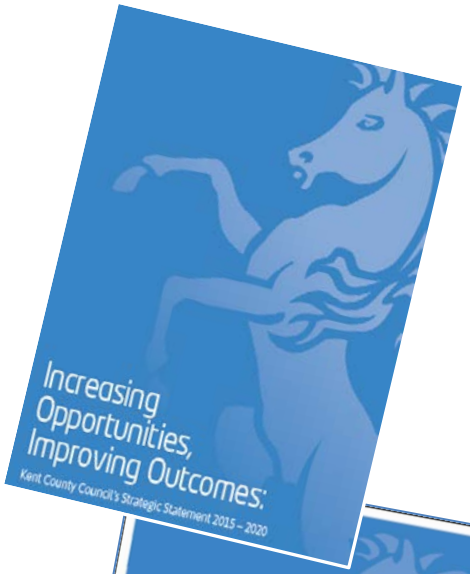
Health and Wellbeing Board

Andrew Ireland
Corporate Director
27 January 2016

Kent County Council
kent.gov.uk

Strategic Approach





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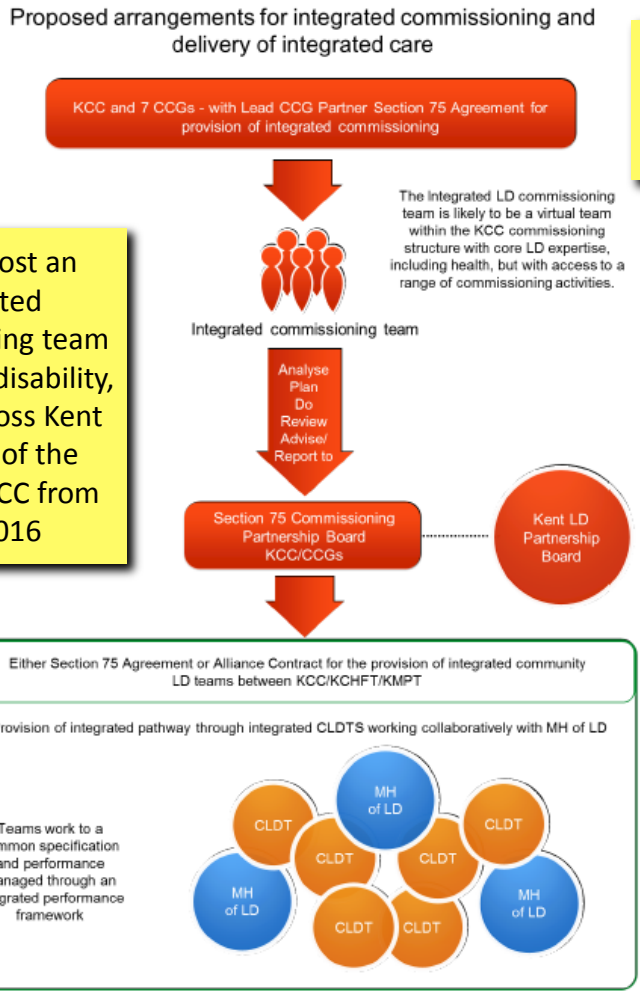
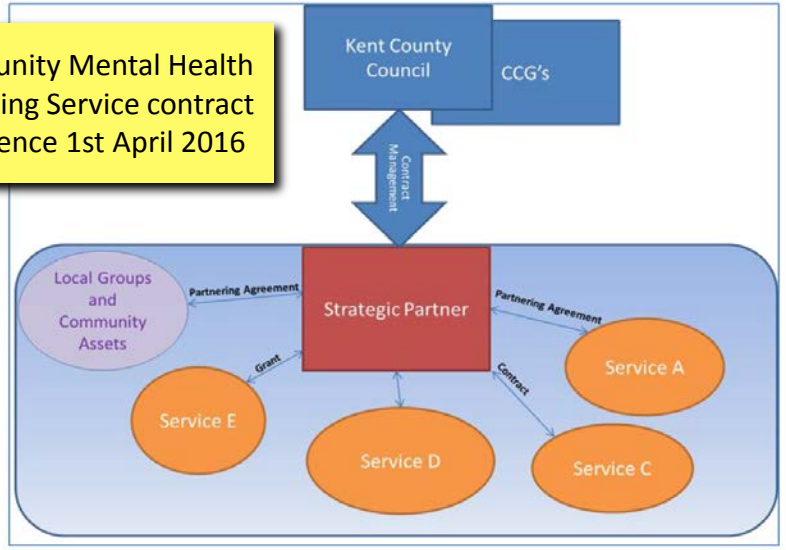
Mental Health, Learning Disability and Children Services

KCC will host an integrated commissioning team for learning disability, to work across Kent on behalf of the CCGs and KCC from April 2016



The Community Mental Health and Wellbeing Service contract will commence 1st April 2016



Mental Health is the next priority area for the Accommodation Strategy

Joint Commissioning of Children Services with North Kent CCGs since April 2015

Phased Strategic Transformation

A 'layered' approach across whole County

Savings & outcomes

- Enablement
- Acute Demand
- H/C Rationalisation
- Care Pathways
- Optimisation

Prioritised by value

Best use of existing resources

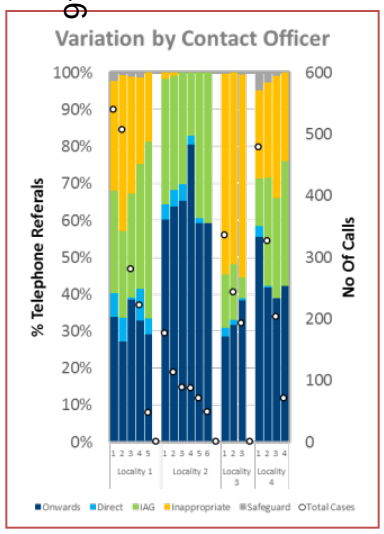
Pace & scale

Phased strategic transformation

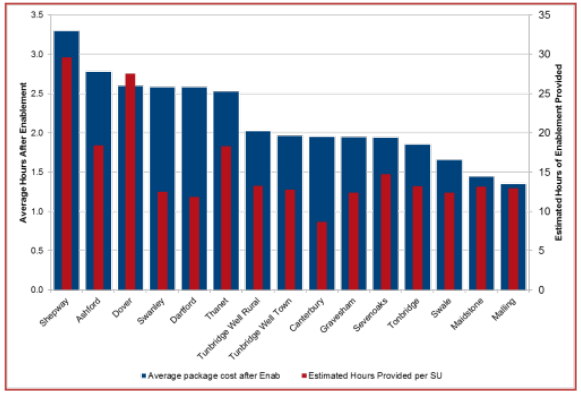
OPPD boundary realignment

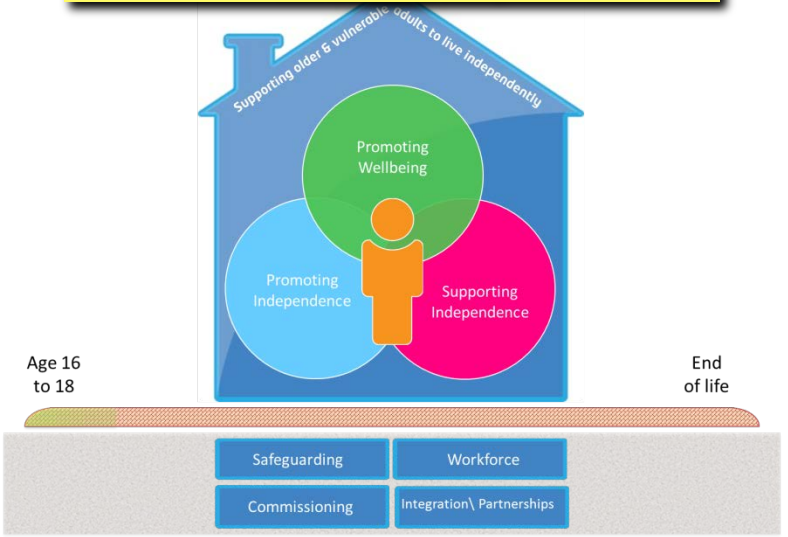
We can work differently with CCGs but this must be part of, and not separate to, our transformation programme

We are now ready to consider alternative models which can be **fully** integrated with NHS

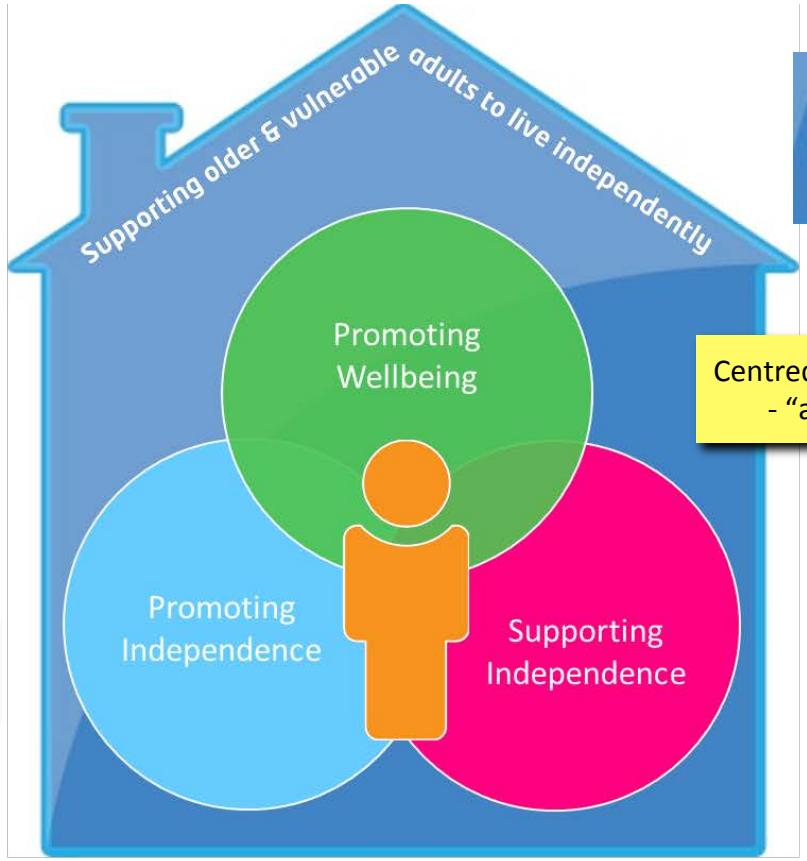


Consistency is central to the transformation approach

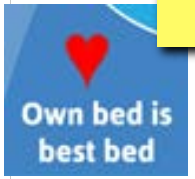




Our Vision – Adult Social Care



Where people live



Centred around the individual - “a life not a service”

Through transition on an all age pathway

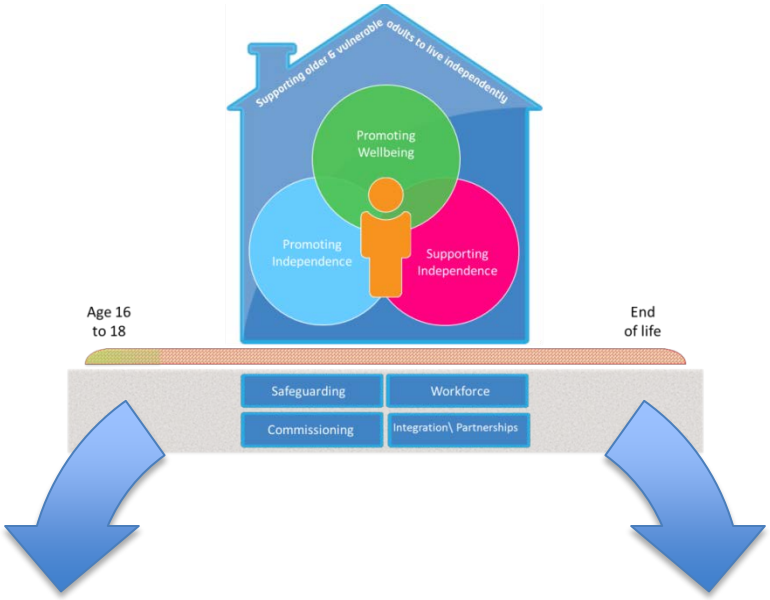
Age 16 to 18

End of life

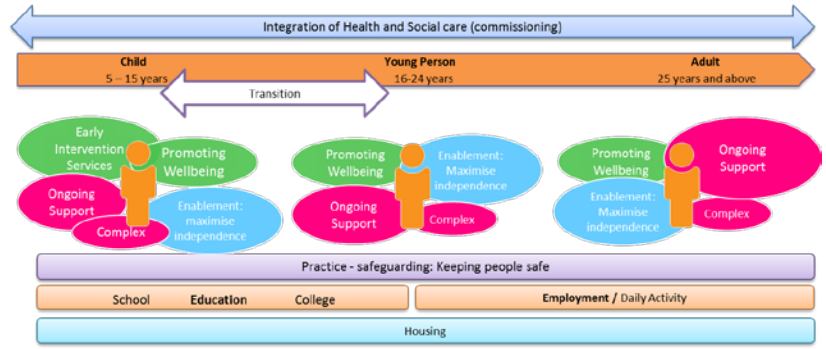
Supported by building blocks

- Safeguarding
- Workforce
- Commissioning
- Integration\ Partnerships

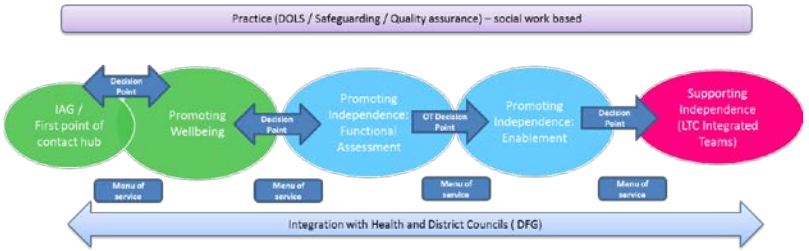
Pathways for Individuals



LDMH



OPPD



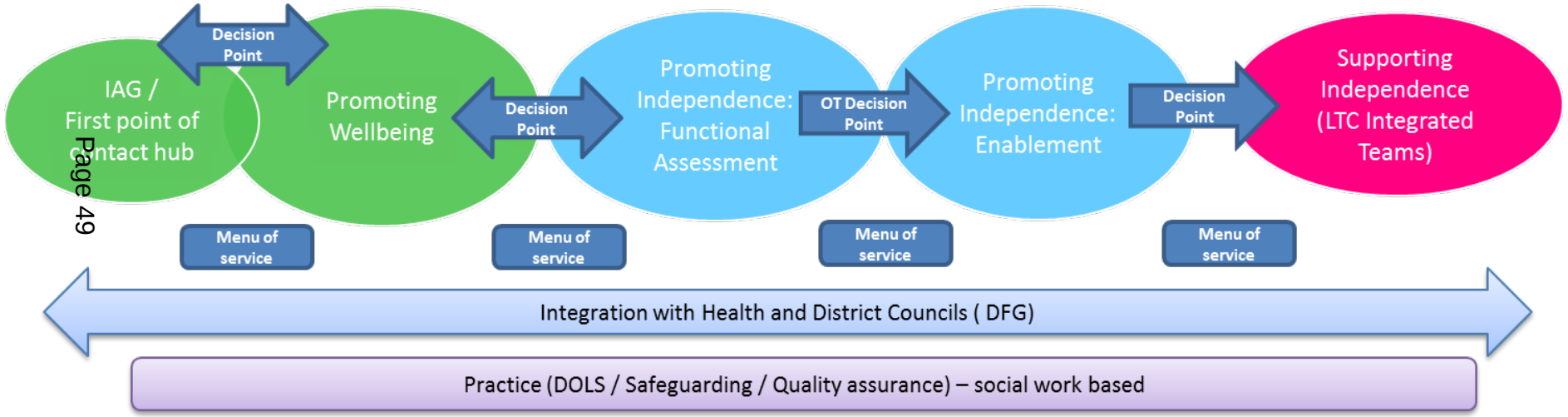
Individual Pathway / Journey (primarily for Older People)

Care navigators / Community agents signposting and building community capacity

Integrated OT service accessing equipment and assistive technologies

OT led rapidly responding integrated reablement linked to paramedic service

Nurse led outcome focussed homecare (new joint roles created)



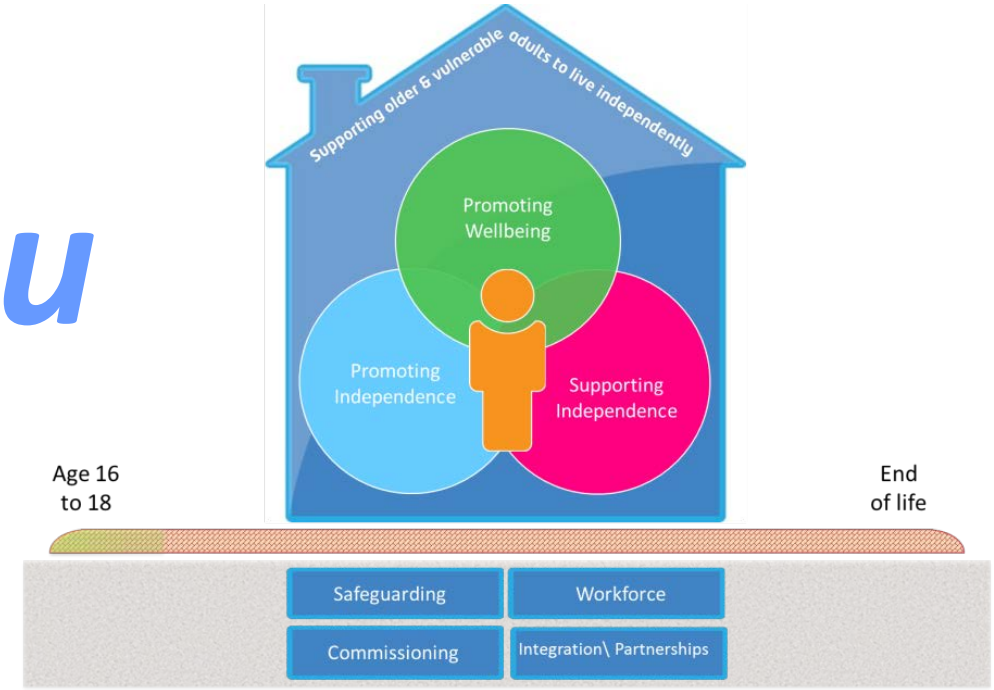
Integrated career pathway

Single patient record

'one' team around the GP

Support to care homes

thank you



"a life not a service"

Andrew Ireland
Corporate Director
27 January 2016

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