AGENDA

KENT AND MEDWAY JOINT HEALTH AND WELLBEING BOARD

Tuesday, 20th July, 2021, at 2.00 pm Ask for: **Ann Hunter**

Council Chamber, Sessions House, County Hall, Maidstone Telephone **03000 416287**

Membership

Mrs C Bell (Chairman), Cllr A Jarrett, Dr J Allingham, Ms L Ashley, Mr P Bentley, Dr B Bowes, Cllr David Brake (Vice-Chairman), Ms J Brown, Sir Paul Carter, CBE, Mrs S Chandler, Cllr H Doe, Dr A Duggal, Mr M Dunkley CBE, Dr L Farach, Dr J Findlay, Mr R W Gough, P Graham, Mr P Gulvin, Cllr Mrs A Harrison, Cllr Mrs J Hollingsbee, Ms R Jones, Dr N Kumta, Cllr M Potter, Mr R Riley, Mr Rivers, Mr M Scott, Mr M Scott, Ms C Selkirk, Mr R Smith, Mr J Williams and Mr W Williams

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

1. Election of Chairman

To elect a chairman for the current municipal year.

2. Election of Vice- Chairman

To elect a vice-chairman for the current municipal year.

3. Apologies and Substitutes

4. Declarations of Interest by Members in items on the agenda for this meeting

To receive any declarations of interest by Members in items on the agenda for the meeting

5. Minutes of the meeting held on 10 March 2021 (Pages 1 - 6)

6. Chairman's announcements

7. COVID-19 Local Outbreak Control Plan (Pages 7 - 14)

8. Feedback from the Health Inequalities Workshop held on 10 June 2021 and Next Steps (Pages 15 - 20)

9. Update on the establishment of a Kent and Medway Integrated Care System (Pages 21 - 64)

10. The appointment of a representative to attend meetings of the Kent and Medway Primary Care Commissioning Group (Pages 65 - 96)

11. Re-Appointment of Dr Bob Bowes (Pages 97 - 98)

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Monday, 12 July 2021

Medway Council

Virtual Meeting of Kent and Medway Joint Health and Wellbeing Board

Wednesday, 10 March 2021

3.04pm to 4.00pm

Record of the meeting

Subject to approval as an accurate record at the next meeting of this committee

Present:

Mrs Clair Bell, Cabinet Member for Adult Social Care and Public Health, Kent County Council (Vice-Chairman)
Councillor David Brake, Portfolio Holder for Adults' Services, Medway Council (Chairman)
Jackie Brown, Assistant Director Adults' Social Care, Medway Council
Sir Paul Carter, CBE, Kent County Council
Mrs Sue Chandler, Cabinet Member for Integrated Children's Services, Kent County Council
Councillor Howard Doe, Deputy Leader and Portfolio Holder for Housing and Community Services, Medway Council
Mr Roger Gough, Leader, Kent County Council
Penny Graham, Heathwatch Kent
Pat Gulvin, Healthwatch Medway
Councillor Angela Harrison, Cabinet Member for Health and Wellbeing, Swale Borough Council
Councillor Mrs Jenny Hollingsbee, Deputy Leader and Cabinet Member for Communities, Folkestone and Hythe District Council
Councillor Alan Jarrett, Leader, Medway Council
Councillor Martin Potter, Portfolio Holder for Education and Schools, Medway Council
Councillor John Rivers, President, Kent Association of Local Councils
Andrew Scott-Clark, Director of Public Health, Kent County Council
Dr Robert Stewart, Clinical Designer, Design and Learning Centre for Clinical and Social Innovation
Ian Sutherland, Director of People - Children and Adults Services, Medway Council
James Williams, Director of Public Health, Medway Council

Substitutes:

Dr Bob Bowes, Governing Body Member, NHS Kent and Medway CCG (Substitute for Navin Kumta)
Stephen Fenlon, Medical Director, NHS Dartford and Gravesham NHS Trust (Substitute for Louise Ashley)
Dr Amanjit Jhund, Programme Director for West Kent ICP (Substitute for Miles Scott)
Chris McKenzie, Director of Adult Social Care and Health West

Kent, Kent County Council (Substitute for Richard Smith)
Caroline Selkirk, Executive Director of Health Improvement/ Chief Operating Officer, NHS Kent and Medway CCG (Substitute for Wilf Williams)
Mark Walker, Director for Special Educational Needs, Disabled Children and Young People, Interim, Kent County Council (Substitute for Matt Dunkley, CBE)

In Attendance: Donna Carr, Senior Programme Manager, Population Health, NHS Kent and Medway CCG
Karen Cook, Policy and Relationships Adviser (Health), Kent County Council
Jade Hannah, Democratic Services Officer, Medway Council
Dr Logan Manikam, Interim Public Health Consultant, Medway Council
Jacqueline Shicluna, Lawyer (Adults), Medway Council

788 Apologies for absence

Apologies for absence were received from Dr John Allingham (Kent Local Medical Committee), Louise Ashley (Dartford, Gravesham and Swanley ICP Senior Responsible Officer (SRO) Representative), Matt Dunkley CBE (Corporate Director, Children, Young People and Education, Kent County Council), Navin Kumta (Clinical Chair, NHS Kent and Medway CCG), Rachel Jones (Executive Director of Strategy and Population Health, NHS Kent and Medway CCG), Matthew Scott (Kent Police and Crime Commissioner), Miles Scott (West Kent ICP SRO Representative), Richard Smith (Corporate Director Adult Social Care and Health, Interim, Kent County Council) and Wilf Williams (Accountable Officer, NHS Kent and Medway CCG).

789 Chairman's Announcements

The Chairman informed the Joint Board that Ian Sutherland, Medway's Director of People - Children and Adults Services would shortly be leaving Medway Council. Mr Sutherland would be retiring after 38 years in public service; he joined Medway in 2014 as Deputy Director of Children and Adults and he was appointed as Director in 2017. The Chairman expressed that Mr Sutherland had worked tirelessly to improve services in both Children and Adults and had been invaluable to the Joint Board. On behalf of the Joint Board, he thanked him for his contribution to the Joint Board and wished him a very happy retirement.

The Chairman also announced that Dr Lee-Anne Farach, Medway's current Assistant Director, Children's Services had been appointed as Medway's new Director of People and would formally be taking up her new role at the beginning of April when Mr Sutherland retired. He looked forward to welcoming Dr Farach to the Joint Board in due course.

790 Record of Meeting

The record of the meeting held on 8 December 2020 was agreed and signed by the Chairman as correct.

791 Declaration of Disclosable Pecuniary Interests and other interests

Dr Bob Bowes, Governing Body Member, NHS Kent and Medway CCG advised the Joint Board that as a GP he was a member of a Primary Care Network and had received income as a result of the vaccination programme.

792 Urgent matters by reason of special circumstances

There were none.

793 COVID-19 Local Outbreak Control Plan

Discussion:

The Director of Public Health, Medway Council introduced this report which provided an update on action undertaken to mitigate rising cases of COVID-19 across both Kent and Medway as it related to the Local Outbreak Control Plan (LOCP). It also included a summary of LOCP-related questions received from members of the public and answers provided by Public Health Officers as set out in Appendix 1 to the report.

A detailed presentation was given by the Directors of Public Health, Medway Council and Kent County Council, which provided an epidemiological assessment of COVID-19 prevalence across Kent, Medway, and comparison districts. Overall, COVID-19 rates had fallen steadily in all districts since the latest lockdown began. An update was provided on asymptomatic testing as well as testing to understand the prevalence of novel strains within the community, particularly the recent targeted surge testing conducted in the ME15 postcode area. Finally, the presentation provided an update on the vaccination programme across Kent and Medway and the Government's 'roadmap' for leaving lockdown. The Joint Board was reassured about the additional measures put in place to enable the safe return to schools.

The Joint Board was advised that the LOCP was required to be updated and resubmitted to the National Contain Team by the 31 March 2021. A cautious approach to moving forward with the 'roadmap' was being undertaken in conjunction with the local resilience forum. There would be ongoing publicity to support the community to keep themselves safe as the locality moved through the phases of the 'roadmap' whilst the vaccination programme continued to be rolled out.

With respect to communication, the importance of continuing to communicate a strong message to the public was emphasised. A long period of difficulty was nearing an end and with vigilance and hard work, restrictions would ease later in the year but now was not the time to relax.

Asked whether data was collected on hard-to-reach cohorts and how these groups were supported to receive vaccinations, the Joint Board was assured that data was collected and monitored and that rates of vaccination uptake across Kent and Medway were very good. The importance of ensuring equity of vaccine access was acknowledged to control COVID-19. The more people vaccinated, the better.

With reference to an example of how homeless individuals had been supported to receive vaccinations, it was explained that there was a multi-agency 'vaccination board' which looked at issues of equity and a public health consultant was tasked to lead on this area of work. The Communications team at the NHS Kent and Medway CCG were also working extensively in this regard.

It was recognised that more support was required to reach some individuals within priority group 6, such as unpaid carers. It was important that these individuals were registered with the appropriate organisations for them to be called forward centrally, by the system, to receive their vaccinations.

Decision:

The Kent and Medway Joint Health and Wellbeing Board:

a) noted the update report and the questions submitted by members of the public on the Local Outbreak Control Plan together with the responses provided by stakeholders from both Kent and Medway Council (Appendix 1).

b) agreed that the questions submitted by members of the public on the Local Outbreak Control Plan together with the responses set out at Appendix 1 to the report are published on each Council's website in accordance with the agreed engagement strategy.

794 Strategic Plan to Mitigate the Impacts of COVID-19 on Health Inequalities: Progress Update

Discussion:

The Joint Board considered a progress update on the Strategic Plan to mitigate the impacts of Covid-19 on health inequalities, which was introduced by the Senior Programme Manager, Population Health, NHS Kent and Medway CCG.

A project plan had been drafted, with initial work to bring together existing data and intelligence underway. Although some data was already available, it was acknowledged that the COVID-19 pandemic was not over, and more and updated data would become available in the future. The mapping of existing activity to reduce widening inequalities was also underway in order to avoid duplication and enable initiatives and resources to be aligned where appropriate.

A small interim task and finish group had been established to provide direction and oversight. This group had met to agree the approach to and scope of the work. A second meeting of the group was planned for 8 April 2021, where an initial review of existing data would be undertaken and a plan for the proposed Joint Board development session on 10 June 2021 would also be discussed. It was noted that the development session had been expanded to include members of the Integrated Care System/STP Partnership Board.

It was recognised that the COVID-19 pandemic had focused attention on the need to address health inequalities. Indeed, a view was expressed that it was critical to address widening inequalities to ensure a sustainable health system going forward. It was added that much learning could be taken from the implementation of the COVID-19 vaccination programme which arguably was one of the first, big population health management programmes which had demonstrated that a lot could be achieved in a short timescale if the system worked together.

Acknowledging the range of organisations which were involved across health, social care, public health, and those dealing with wider determinants of health, the challenge of taking this work forward as a Joint Board and as individual organisations to give this important issue traction was highlighted. It was an area that the Joint Board could advance joint working.

Decision:

The Kent and Medway Joint Health and Wellbeing Board:

a) noted the initial progress made on the development of the joint strategic plan to mitigate the impacts of COVID19 on health inequalities.

b) agreed to hold a development session in private on 10 June 2021 to be informed about the emerging impact of COVID-19, understand the wider health inequalities found in Kent and Medway and recommend the priority areas for focus.

795 Work Programme

Discussion:

The Democratic Services Officer advised the Joint Board that an agenda setting meeting had taken place on 3 February 2021. Proposed amendments to the work programme were set out in section 2 of the report and reflected in the work programme attached at Appendix 1 to the report.

Decision:

The Kent and Medway Joint Health and Wellbeing Board agreed the work programme set out at Appendix 1 to the report.

Chairman

Date:

Jade Hannah, Democratic Services Officer

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KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD

20 JULY 2021

COVID-19 LOCAL OUTBREAK CONTROL PLAN

Report from: Allison Duggal, Director of Public Health for Kent County Council

James Williams, Director of Public Health for Medway Council

Author: Logan Manikam, Interim Public Health Consultant

Summary

This report provides an update on steps taken to mitigate rising cases of COVID-19 across both Kent and Medway as it relates to the Local Outbreak Management Plan (LOMP). It also includes a summary of LOMP-related questions received from members of the public and answers provided by Public Health Officers (located in Appendix 1).

1. Budget and Policy Framework

1.1. As part of the Department of Health and Social Care's COVID-19 response and recovery strategy, Upper Tier and Unitary Local Authorities in England were mandated to develop a COVID-19 Local Outbreak Management Plan (LOMP)- formerly known as the COVID-19 Local Outbreak Control Plan-to reduce the spread of the virus within the community.

1.2. On 28 February 2021, Department of Health and Social Care (DHSC) requested that the LOMP be updated to reflect the changed landscape of the pandemic and to consolidate best practice that has emerged locally in its first year through the creation of a Best Practice Document. The objectives of these updates are outlined below:

- to ensure that updated fit for purpose local outbreak management plans are in place across England;
- to identify any additional support Local Authorities may need from national or regional teams, particularly in relation to surge activity to detect new variants;
- to identify good practice at local and regional levels– most particularly in respect to Non-Pharmaceutical Interventions (NPIs) that can be used to reduce/prevent transmission of the virus and use this learning to inform regional and national policies;
- to ensure there is effective governance and clarity on roles/responsibilities at all levels of response; and
- to ensure LOMP reflect cross-cutting considerations, such as inequalities;

- to provide ongoing assurance and justification of the need for financial support from the COVID Outbreak Management Fund (COMF) and self-isolation fund.

1.2.1 On 22 February 2021, the Government announced the National Spring 2021 Roadmap out of Lockdown. This is a 4-step data-driven approach to enable the relaxation of restrictions. Before proceeding to the next step, the Government will examine the data to determine whether it is safe and feasible to progress to the next phase of opening. The four tests that inform the progress through each phase are:

- the rollout of the national vaccine programme continues successfully
- Evidence showing vaccines are sufficiently effective in reducing hospitalisations and deaths in those vaccinated.
- infection rates do not risk a surge in hospitalisations and therefore do not put unsustainable pressure on the NHS; and
- assessments of the risks is not changed fundamentally by new Variants of Concern (VOCs).

1.2.2 England is currently in Step 3 of the National Roadmap. This Step has removed a range of restrictions however there are still a number of control measures in place to reduce the risk of transmission. These include limiting the number of people who can congregate, with gatherings of over 30 people currenting still classed as being illegal at this time. Indoor entertainment venues must still apply the rule of 6 people or 2 households. Face coverings are also mandated in specific venues and public places. Step 4 will see the end of all legal limits on social contact and removal of all limits on major life events. The decision to move to Step 4 was deferred from the due date of 21 June 2021. This deferment was due to the rise in Variants of Concern, namely the Delta variant which has been shown to demonstrate increased transmissibility of COVID-19. The decision of moving to Step 4 and any related additional guidance that will inform this move is due to be taken on the 12 of July 2021. Step 4 is due to start no earlier than 19 July 2021.

1.3. Central government has provided significant funding to facilitate the delivery of LOMP to enable local authorities and their partners to put in place local measures to prevent, identify, and contain COVID-19 outbreaks. The Kent and Medway LOMP was published online on 30 June 2020; its most recent iteration was published on the 16 April 2021.

2. Background

2.1 Responding to the Rise in Cases Nationally & Locally

2.1.1. Transmission rates of COVID-19 in Kent and Medway have reduced considerably over the course of the months that followed the last convening of the Joint Health and Wellbeing Board; this was attributed to the success of the vaccination programme and asymptomatic testing at scale. However, in recent weeks there has been an increase in transmission rates due to the emergence of new variants of COVID-19. To date, four major VOCs (VoCs)

have shown signs of transmission within the population; most notably VOC B.1.1.7 (first potentially identified in Kent in December 2020). This variant went on to become the dominant form of COVID-19 in circulation nationally. Two subsequent variants, first identified in South Africa (VOC B.1.351) and Brazil (VOC P.1), have also been sequenced within UK borders. They are monitored closely due to their potentially vaccine resistant qualities. All novel variants have shown signs of being more transmissible and potentially more deadly compared to the original COVID-19 pathogen. The most recent VOC (B.1.617.2-Delta) was first identified in India on 21 April 2021. This variant has shown signs of being more transmissible, particularly amongst unvaccinated individuals. Detailed information on new variants can be found on the website for the Centres for Disease Control and Prevention (CDC)

2.1.2. More stringent restrictions have been placed on the public to contain these novel variants and protect NHS capacity; besides the travel restrictions, quarantine, and COVID-test requirements on travellers into the country.

2.2. Updates to Local Testing and Tracing Capabilities

2.2.1. Changes to Testing and Tracing protocols in Kent and Medway have been made to meet the constant changing nature in demand seen over the last few months. The roll-out of rapid symptom free testing and local tracing partnerships managed by local authorities, have successfully built on local knowledge and infrastructure to reduce community transmission levels. Locality based door-to-door testing has also contributed to national surveillance for novel variants.

2.2.2. Since the last JHWB meeting convened, Medway Council and Kent County Council have adopted new innovative ways to offer symptom free testing to the local community. This has meant a move away from solely using fixed permanent test sites. Testing is now more flexible and dynamic, comprising a hybrid model of outreach, home direct online testing, and community pharmacy access. These alternative, more holistic models, have enabled both authorities to better serve the needs of their communities. This has also led to greater efficiencies within the testing programme, facilitating a reduction of fixed sites from 5 in Medway and 24 in Kent to 1 and 2 respectively. Residents are able to access testing in more convenient ways, including online home test kits, workplace testing, and pharmacy collect options. Multiple pop-up sites are also available to meet local surge requirements.

2.2.3. Both programmes have been developed in partnership with the Department of Health and Social Care (DHSC) using local data on disease transmission and prevalence.

2.2.4. In partnership with NHS Test and Trace, both Kent and Medway have also launched their own Local Tracing Partnerships. These services verify the contact details of those whom national handlers are unable to trace using local data sources. These individuals are then followed by local test and

trace staff to ensure they comply with necessary self-isolation or testing measures.

2.2.5. Finally, surge testing was recently launched in the ME14 area of Kent (Canterbury, Dartford and Sevenoaks area) in response to the initial increase of the most recent VOC (B.1.617.2-Delta) to better understand the prevalence of the novel strain within the community.

2.3. The Vaccine Programme

2.3.1. The management and roll-out of the vaccination programme is the responsibility of the DHSC. Both Medway and Kent County Council are working closely with stakeholders from the DHSC to support them in meeting their vaccination targets for the local area. To date, the UK has vaccinated over 45 million people online with the prioritisation framework set out by the Joint Committee on Vaccination and Immunisation (JCVI):

- all residents in a care home for older adults and their carers;
- all those 80 years of age and over and frontline health and social care workers;
- all those 75 years of age and over;
- all those 70 years of age and over and clinically extremely vulnerable individuals;
- all those 65 years of age and over;
- all individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality;
- all those 60 years of age and over
- all those 55 years of age and over;
- all those 50 years of age and over.

2.3.2. As set in the prioritisation list in section 2.3.1 above, the first phase of the programme has been completed. Currently the programme is at phase 2 where the vaccine is being offered to those aged 18 and above in England, those at high risk of being infected with COVID-19, eligible frontline or social care workers, individuals with a learning disability and carers of those with high risk from COVID-19. Anyone who, for whatever reason, was missed in priority groups 1-9 (section 2.3.1) is also being offered the vaccine.

2.3.3. Vaccines are currently delivered by two types of vaccination sites:

1. Vaccination centres – using large-scale venues such as football stadiums; accessed via a national booking service
2. Local vaccination services – made up of sites led by general practice teams collaborating via pre-established primary care networks and pharmacy teams through community pharmacies

2.4. Local Outbreak Engagement Board (LOEB) Public Engagement Strategy

2.4.1. In accordance with the recommendations made by the Joint Board at its meeting on 17 September 2020, a form for residents to engage with the Joint Board regarding the LOMP will be made available online prior to each Joint Board meeting. For this meeting, the form was hosted online on the Medway Council website between 1 July 2021 and 15 July 2021; Kent residents were signposted to the link via the Kent County Council's COVID web pages.

2.4.2. Appendix 1 to the report sets out the questions falling within the agreed criteria that emerged during this process and have been answered by stakeholders from both Kent and Medway Council. The Joint Board are invited to discuss the key themes and public concerns in the upcoming meeting.

3. Risk Management

3.1. By running stress test exercises on a variety of scenarios related to the LOMP, as outlined in Section 2.6, we aim to minimise the risks associated with similar events occurring by: (i) identifying any gaps within the LOMP; (ii) creating awareness of the communication channels that exist between the agencies; (iii) creating awareness of the roles of different agencies; (iv) clarifying the escalation triggers and process; (v) identifying areas where additional support may be required; (vi) identifying any potential challenges and their solutions; and (vii) identifying actions that need to be taken and when.

4. Financial Implications

4.1. As a result of recent changes made to the Contain Outbreak Management Fund, additional resources are now available for eligible councils who need support in enforcing Local COVID Alert Levels in their communities.

4.2. Initial funding was provided through the Test, Track & Trace Support Grant using 2020/21 Public Health allocations as a basis for distribution. Additional funding of £8 per head of population for those Local Authorities in the highest tier of national restrictions was in place up to 2 December 2020. Since then, Funding allocations to local authorities is currently being managed through a variety of mechanisms. Resources for testing are being provided on a quarterly basis, based on a business case submitted by each local authority. Resources to support the activities of the Local Outbreak Management Plan are provided through arrangements with DHSC and MHCLG.

4.3. Monitoring and oversight of expenditure is managed via the Contain Programme Regional Convenor for the South East. There is a detailed framework that sets out the key areas that can be funded; these will evolve over time and are tailored to local need.

4.4. As mentioned in paragraph 1.2, the LOMP updates requested by the DHSC were made to inform how monies from the Council Outbreak Management Fund (COMF) should be allocated going forwards on a 'greatest need' basis.

5. Legal Implications

5.1 Kent County Council (KCC) and Medway Council, under the leadership of the Directors of Public Health, have a statutory duty to protect the population's health by responding to and managing communicable disease outbreaks which requires urgent investigation and presents a public health risk.

5.2 The legal context for the councils' response to COVID-19 sits within the following Acts:

- The Coronavirus Act 2020
- Health and Social Care Act 2012
- Public Health (Control of Disease) Act 1984

5.3 The Kent and Medway Joint Health and Wellbeing Board has been established as an advisory joint sub-committee of the Kent Health and Wellbeing Board and the Medway Health and Wellbeing Board under Section 198(c) of the Health and Social Care Act 2012 for a time limited period of four years from 1 April 2020.

5.4 The Joint Board seeks to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner and ensure collective leadership to improve health and well-being outcomes across both local authority areas.

5.5 The Joint Board is advisory and may make recommendations to the respective Kent and Medway Health and Wellbeing Boards.

5.6 As part of the DHSC's COVID-19 response and recovery strategy, Upper Tier and Unitary Local Authorities in England were mandated to develop a COVID-19 LOMP to reduce the viruses' spread.

5.7 The Health Protection (Coronavirus, Restriction) (Steps) (England) (No.364) Regulations 2021 has come into force as legislation for the National Spring Roadmap. These legislations give DsPH the authority to close individual premises and public outdoor places as well as restrict events with immediate effect if they conclude it is necessary and proportionate to do so without making representations to a magistrate. DsPH are required to notify the Secretary of State as soon as reasonably practicable after the direction is given and review to ensure that the basis for the direction continues to be met, at least once every 7 days. These regulations may be subject to review as part of the move to Step 4 of the Road Map. It is unclear at this time whether there will be additional regulatory powers provided to DsPH to manage COVID-19 once this move occurs.

6 Recommendation

6.1 The Kent and Medway Joint Health and Wellbeing Board is asked to consider and note this update report and the questions submitted by

members of the public on the LOMP together with the responses provided by stakeholders from both Kent and Medway councils (Appendix 1).

6.2 The Kent and Medway and Joint Health and Wellbeing Board is asked to agree that the questions submitted by members of the public on the LOMP Plan together with the responses set out at Appendix 1 to the report are published on each council's website in accordance with the agreed engagement strategy.

Lead Officer Contact

Dr Logan Manikam, Interim Public Health Consultant
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Appendices

Appendix 1 - Public questions on the Local Outbreak Control Plan and Answers

Background papers

None

Appendix 1 – Public questions on the Local Outbreak Control Plan and Answers

PLACEHOLDER – QUESTIONS ARE CURRENTLY BEING VETTED AND ANSWERED FOR PUBLICATION ON 15TH JULY 2021.

KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD
20 JULY 2021

Feedback from the Health Inequalities Workshop held on June 10 2021 and Next Steps

Report from: Rachel Jones, Executive Director of Strategy and Population Health, Kent and Medway CCG

Author: Karen Cook, Policy and Relationships Adviser KCC
Sharease Gibson Deputy Director Strategy and Population Health
Kent and Medway Clinical Commissioning Group

Summary
This report sets out the key findings from the Health Inequalities workshop held on the 10 June 2021 and proposes the next steps in the development of a Health Inequalities Action Plan for Kent and Medway Integrated Care System for approval by the Kent and Medway Joint Health and Wellbeing Board.

1. Introduction

1.1 On 17th September 2020 the Kent and Medway Joint Health and Wellbeing Board (The Joint Board) agreed to hold a development session about the emerging impact of Covid 19 and the wider health inequalities found in Kent and Medway. The development session took place on June 10th, 2021 and included the members of The Joint Board and the members of the Integrated Care System Partnership Board, bringing together the widest leadership of the Kent and Medway Integrated Care System for the first time.

1.2 The session was used as an introduction to the issues facing Kent and Medway and looked at how other areas in the Country had responded to health inequalities through a system wide approach. It was agreed that the System would develop agreed priorities out of the learning from that day and with further analysis and consideration.

1.3 This paper sets out next steps to consider our priorities. A Kent and Medway health inequalities action plan will then be developed to reflect areas of focus agreed by the Board and the wider system.

2. Background

2.1 As was set out in the paper on 17th September 2020 Covid 19 has impacted on our citizens and our workforce in ways that are becoming clearer. Certain populations have been affected more than others, such as people from black and minority ethnic backgrounds. Other issues are also known to have a

bearing on health inequalities. These include gender and age. People with underlying health conditions, for example diabetes, asthma and cardiovascular disease are known to have experienced worse physical and emotional outcomes during the pandemic. What is clear is that the wider determinates, poverty, housing conditions, job insecurity and worklessness, have played a pivotal role in terms of increasing inequalities during the pandemic. Some people are facing job loss, debt and homelessness, whilst others are facing new or more serious mental health illness. Our workforce has been tremendous in responding to the demands of the pandemic, but has faced traumatic and challenging events, particularly our front line health and social care staff. So, whilst there have always been health inequalities in Kent and Medway, the effect of Covid-19 will be to exacerbate and increase the inequalities experienced by our population.

2.2 Covid 19 response measures have also led to some services being stepped down. We know that latent demand has developed in the population. This could lead to poorer health outcomes as a result of delayed cancer screening, loss of herd immunity and an increase in vaccine preventable diseases arising from a reduction in population coverage of routine child and adult vaccination programmes. There will likely be an effect associated with the postponement of elective care procedures, or through people not accessing routine primary care for fear of visiting their GP during the pandemic.

2.3 Health inequalities are caused by much more than an individual's actions or access to traditional health care. Green spaces; social activities; education and employment opportunities; healthy food; good housing and transport services all play a hugely important role, and all have been disrupted by the pandemic.

2.4 The Kent and Medway Joint Health and Wellbeing Board remains in the unique position of having a wide partnership membership. Its purpose includes promoting health integration and supporting partners to address health inequalities.

2.5 In light of this the Joint Board agreed to take the broadest view of its purpose and to place an unrelenting focus on health inequalities. This includes more focus on children and young people, those with a learning disability, autism or mental health problems and those environmental and lifestyle factors (the wider determinants of health- such as housing, employment and education) that have the greatest impact on health outcomes.

On 17 September 2020 the Joint Board agreed to:

i. develop a plan to publicly set out its vision, strategic aims and ambitions regarding how the partnership could work together to tackle those areas of health inequalities identified as priorities for the system.

ii. hold a development session to better understand the emerging impact of Covid-19 and the wider health inequalities found in Kent and Medway to inform the plan. This took place on June 10th 2021.

iii. the Executive Director of Strategy and Population Health for Kent and Medway CCG being the lead officer for this work on behalf of the Joint Board, informed by the Public Health Directors of both Medway and Kent.

3 Outcomes of the Workshop: Key Findings

3.1 The content of the workshop set out the current headlines about Health Inequalities in Kent and Medway. Health inequalities are caused by many factors, most of which are beyond the gift of the individual to change.
COVID has shone a light on health inequalities and made them worse, but health inequalities will not simply disappear once COVID is over. Potentially, inequality gaps will widen as we emerge from the epidemic, with disadvantaged communities having disproportionately suffered from its impact.

3.2 In summary the workshop highlighted that:

a) Living in a deprived area negatively affects your health and wellbeing:
- If you live in the most deprived ward in Kent you are likely to die before someone who lives in the least deprived. In the most extreme case, there is a 25-year age gap between the average age of death for the least deprived and most deprived in our area.
- You are more likely to go into hospital as an emergency case if you live in a poorer ward. For example, there are more emergency admissions for chronic obstructive pulmonary disease and stroke for people in more deprived areas.
- You are more likely to have more than one thing wrong with you i.e. Diabetes AND high blood pressure if you live in a more deprived area.
- As deprivation increases school examination attainment decreases. Children from poorer areas receive far lower grades than those in less deprived areas.
- If you live in a deprived area, you were more likely than those living in more affluent areas to die from Covid

b) However not all inequality is related to poverty:

- If you have a mental illness, you are more likely than the general population to have a physical illness and to die younger.
- If you grow up and have experienced more than 4 adverse childhood events- such as parental separation, any kind of mental or physical abuse or experienced mental health problems - you are more likely as an adult to go on to use drugs, become involved in violence or go to jail than a child who has had no or fewer adverse experiences.
- The increase in mortality compared to before COVID was greater in people who were from Black and Asian minority ethnic backgrounds.

- If you eat a poor diet, smoke or drink too much alcohol or take drugs you are more likely to develop a preventable illness and your long-term health and wellbeing will be severely affected.

3.3 The workshop emphasised that life chances of individuals are severely impacted by the inequalities they face in their lives. Tackling the root causes of inequality is the right thing to do for any public sector organisation involved in serving, supporting and championing their communities. However, it will also provide wider benefits not just to the individuals affected but to wider society as there is an economic burden to be borne, not only in the costs of health and social care but also in years of working life lost to ill health and disability.

3.4 It must be recognised that not all the solutions to tackling inequalities are in the hands of local public sector organisations. National approaches are also needed to deal with income and benefits, planning and infrastructure, air quality and emissions, food quality and sugar content etc. But there is no doubt that there are opportunities through the power of our wider partnership to do more together and to focus unrelentingly on the things we can change to tackle d disadvantage in our community.

3.5 Reflections from system leaders on the event

a) Leadership

- Leadership is vital, however it has to be system wide and all recognised as equal partners to ensure this works well in order to ensure the best outcomes

- We need a sustained commitment to this and we must use our span of influence

- Deciding where to put resource is key. We need to be clear and confident in what we want to achieve.

- We need to challenge ingrained adverse culture and understand the importance of place-based context and know and act on how people could be empowered.

- Involving the local community is a key part of a number of the key points we have raised today.

- Find one small thing that we can do together (with thought and based on data) and DO IT!

- Focus on staff inequalities as much as community inequalities.

b) Areas of Priority for system working

- Collectively driving cultural change and holding each other to account.

- Using and understanding our own data and developing it to give us better access across the whole system.

- Focus on mental health and multi-morbidity

- We know the interventions that work, we need to do them at scale. The selection of interventions and how they are implemented needs to be worked out within the community.

- Our leadership needs to be aligned across all levels – we need to commit to that alignment and hold each other to account.

- We need to both enable local pilots with multiple partners including voluntary sector, while building in the right enablers to scale things across the whole system – can't do one without the other.

- Get together as leaders around the shared purpose more often and trigger the conversations in our own organisations.

- We need to build health inequalities into our agenda and take a more integrated, proactive approach to our business to incorporate action to address health inequalities.

4. Next steps

a) To capitalise on the energy and motivation expressed by those senior leaders who attended the workshop.

b) To feed the outputs and views from the health inequalities workshop into the population health management (PHM) programme to develop a system wide understanding of the leadership required to make the best of this learning and development programme opportunity.

c) To support system wide development and planning a new programme of work is being launched on 22 July 2021 looking at PHM and how, as a system we understand and plan health and care services for our communities. This is a 22 week externally supported programme which works with each tier of the system to link local data, build analytical skills to find at risk cohorts and design and deliver new models of care. The aim of the programme is to accelerate changes to care delivery to achieve better outcomes and experiences for selected populations and secure the skills to spread the approach to other cohorts. This is a whole system programme, and the Directors of Public Health from Kent and Medway are joint chairs of the Kent and Medway Population Health and Prevention Group. The programme is being managed by the Strategy and Population Health Team in the CCG and local authority officers as well as Members are engaged in the programme.

d) A PHM roadmap for Kent and Medway will be developed throughout the 22 weeks and is a key deliverable at the end of the programme. This enables

systems to think about their own approach to spread the learning and build on PHM capabilities within and across partner organisations. It is important that the learning from this programme influences the priority setting for the Health Inequalities Action Plan and the two link together to provide a coherent strategic approach for joint planning and working going forward.

5. Recommendations

The Joint Board is asked to agree to receiving a discussion paper at the December meeting of the Joint Health and Wellbeing Board that sets out the learning from the PHM programme and the proposed priority areas for the health inequalities action plan to focus on

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Transforming health and social care in Kent and Medway

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From: Wilf Williams, Senior Responsible Officer, Kent and Medway ICS

Lisa Keslake, Executive Director of System Development and Assurance, NHS Kent and Medway

To: Kent and Medway Joint Health and Well-Being Board, 20 July 2021

Subject: **Update on the establishment of a Kent and Medway Integrated Care System**

Summary:

Major changes are taking place in the way health and care is organised in England as the emphasis of national policy continues to shift towards promoting collaboration within local health and care systems. Integrated care systems (ICSs), of which Kent and Medway is one, are being established in all areas of the country to drive change intended to lead to better, more joined-up care for patients and improvements in population health. In November 2020 NHS England published *Integrating care: Next steps to building strong and effective integrated care systems across England*. It described the core purpose of an ICS being to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

It emphasised that the next phase of ICS development should be rooted in underlying principles of subsidiarity and collaboration. It also described common features that every system is expected to have and develop, as the foundations for integrating care, with local flexibility in how best to design these to achieve consistent national standards and reduce inequalities.

This was further defined in February of this year, when the Department of Health and Social Care published its legislative proposals in the White Paper: *Integration and Innovation: working together to improve health and social care for all*. The White Paper promotes service integration with each area being led through new statutory ICS bodies, bringing together health and local government to plan and coordinate care and well-being. Subject to legislation being passed later this year, the plan is to implement these proposals from April 2022, placing ICSs on a statutory footing. However, April 2022 is not end-state, but simply a major milestone in the evolution and development of collaborative partnership working.

This paper provides a summary of latest national guidance relating to ICS establishment, along with details of the evolving Kent and Medway plans and operating model.

This paper is for INFORMATION

The National ICS Design Framework

In June 2021 NHS England (NHSE) published the much awaited design framework to guide next steps in developing ICS's in line with the White Paper. (The NHS Confederation have published a helpful summary of the whole framework - www.nhsconfed.org/publications/ics-design-framework). It should be noted that until this is taken through the Parliamentary process the move to create new statutory bodies remains a proposal. The following narrative provides the key headlines.

The ICS Design Framework sets out expectations for the next stage of system development. It sets out the core features of every ICS, while emphasising the need for local flexibility and determination. It also outlines the expectations NHSE has in terms of

- ICS roles and accountabilities
- governance and management arrangements
- financial allocations
- models for clinical and professional leadership and
- working with people and communities

Further national guidance is yet to be published on:

- detailed membership and governance arrangements of the ICS NHS Body – see below - as defined in a model constitution
- the national HR framework
- management of conflicts of interest guidance
- provider governance and collaborative arrangements

Integrated care systems will include two core elements, alongside existing partnerships and statutory organisational arrangements:

- An **ICS Partnership** as the collective of all local partners including NHS organisations, local authorities and other key stakeholders.

- A single **ICS NHS Body** as the statutory NHS organisation that will take on the responsibilities of Clinical Commissioning Groups, which will be dissolved on 1 April 2022, and any further responsibilities delegated by NHSE, for example the commissioning of dentistry and pharmacy services.

<u>The ICS Partnership</u>

Each ICS will have a Partnership group or board, responsible for **agreeing an integrated care strategy** for improving health and well-being across the totality of the population it serves, using the best insights from data available, built bottom-up up from local assessments of needs and assets identified at place level, and focusing on reducing inequalities and addressing the consequences of the pandemic for communities.

The ICS Partnership will be established locally and jointly by the relevant local authorities and the ICS NHS body, evolving from existing arrangements and with mutual agreement on its terms of reference, membership, appointment of Chair, ways of operating and administration.

The Partnership will be a forum rather than a standalone statutory organisation. Its terms of reference will be determined locally and any decision making responsibilities (if any) outside of developing the integrated care strategy will be delegated by partner organisations.

Membership will include local authority and ICS NHS body representation plus representatives as agreed from health and wellbeing boards; other statutory organisations; voluntary, community and social enterprise (VCSE) sector partners; social care providers; and organisations with a relevant wider interest such as employers, housing and education providers. The membership may change as the priorities of the partnership evolve.

The ICS NHS body

The ICS NHS body will be a statutory organisation established from 1 April 2022. As a minimum, all CCG functions and duties will transfer to the ICS NHS body, along with all CCG assets and liabilities, including commissioning responsibilities and contracts. NHSE may also delegate functions and responsibilities currently undertaken by them. The ICS NHS body will be responsible for:

- Establishing joint working arrangements with partners that embed collaboration as the basis for delivery of joint priorities. The ICS NHS body may choose to commission jointly with local authorities across the whole system; at place where that is the relevant local authority footprint.

- Developing a plan to meet the health needs of the population within their area, having regard to the partnership's strategy and the local health and wellbeing strategy.

- Arranging for the provision of health services in line with the allocated resources across the ICS footprint through a range of collaborative leadership activities, including: putting contracts and agreements in place to secure delivery of its plan by providers; convening and supporting providers to lead major service transformation programmes; and putting in place personalised care.

- Allocating resources to deliver the plan by deciding how its national allocation will be spent across the system.

- Leading system implementation of the People Plan by aligning partners across each ICS to develop and support the 'one workforce'.

- Leading system-wide action on digital and data to drive system working and improved outcomes. This includes using joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvement in performance and outcomes.

- Working alongside councils to invest in local community organisations and infrastructure and, through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, ensuring that the NHS plays a full part in social and economic development and environmental sustainability.

- Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support these wider goals of development and sustainability.

- Establishing governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations, to ensure the plan is implemented effectively within a 'system financial envelope' set by NHSEI.

The ICS NHS body will have a unitary board providing strategic leadership. All members of the board will have collective and corporate accountability for delivery of the functions and duties of the ICS and the performance of the organisation. The statutory **minimum** membership of the board will be confirmed in legislation, but is expected to include:

- An independent Chair plus a minimum of two other independent non-executive directors. (These individuals will normally not hold positions or offices in other health and care organisations within the ICS footprint.)

- One member drawn from NHS trusts who provide services within the ICS area

- One member drawn from general practice from within the area

- One member drawn from the local authority or authorities, with statutory social care responsibility within the area

- Four executive directors: Chief Executive, Director of Finance, Director of Nursing and a Medical Director

Beyond these positions, the ICS NHS body may establish other specific executive or non-executive members to ensure that the board is well governed, can meet its statutory duties and objectives, and can effectively manage conflicts of interest.

<u>Other local partnerships/organisations</u>

- Place-based partnerships, or '**Integrated Care Partnerships**', are collaborative arrangements between health and care partner organisations, that provide local services across a defined geography (usually between 250,000 and 750,000 people). In K&M we have four ICPs that have been evolving over the past couple of years. ICPs will be the engine room for local planning and delivery of services. Once fully

developed, decisions will be increasingly made at place level (rather than system) to enhance integration, improve local outcomes and focus on pathways redesign so that individuals get the best care from the most appropriate local services.

- **Primary Care Networks** (PCNs) play a fundamental role in improving health outcomes and joining up services within small neighbourhoods (circa 30,000 people). Led by groups of local GP practices with community, social and voluntary care involvement, they have a close link to local communities, enabling them to identify priorities and address health inequalities. There are currently 42 PCNs covering the whole population of our 198 practices.

- '**Provider Collaborative**' describes partnerships involving two or more NHS trusts working across multiple places at an appropriate scale to realise mutual benefits and/or benefits for the wider system. It will be up to providers, working with partners, to decide on the specific model and best governance arrangements for their collaboratives. Whilst we do not currently have any formal collaboratives in place in Kent and Medway, it is expected that by the end of this year every acute provider and mental trust in the country will be part of at least one collaborative.

- **Individual providers** of care are of course the **foundation** of our local health and care system. They include, NHS Trusts and FTs, independent sector community and voluntary care providers, GP practices, social care providers, and other primary care services such as pharmacies, dentists and optometrists. Whilst they are key partners across the Kent and Medway system, each remains directly accountable for the services they deliver, in terms of both regulatory and contractual accountability.

<u>People and culture</u>

From April 2022, ICSs will be expected to shape the approach to growing, developing, retaining and supporting the people employed by the ICS and its constituent organisations, ensuring the delivery of high-quality services and care for the population. ICS NHS bodies will be expected to adopt a 'one workforce' approach and develop shared principles and ambitions for people and culture with local authorities, the VCSE sector and other partners.

<u>Employment commitment</u>

Whilst the national HR framework is awaited, NHSE has published guidance on the 'employment commitment' made by the Government in the White paper. This is intended to provide people in organisations directly affected by the proposed legislative changes with employment stability throughout the transition period while minimising uncertainty as much as reasonably possible. The employment commitment asks all organisations not to carry out significant internal organisational change or to displace people during the transition period. It also states that NHS people (below board level) affected directly by these legislative changes, will receive continuity of terms and conditions (even if not required by law) to enable all affected colleagues to be treated in a similar way despite any variation in current

contractual relationships. It is designed to provide stability and remove uncertainty during transition.

Quality governance

ICS NHS bodies will be required to resource quality governance arrangements appropriately, including leading system quality groups and ensuring that clinical and care professional leads have capacity to participate in quality oversight and improvement.

Operational support will be provided through NHSE regional and national teams in line with National Quality Board guidance, namely the refreshed *Shared Commitment to Quality and the Position Statement*. This sets out the core principles and consistent operational requirements for quality oversight that ICSs are expected to embed during the transition period (2021/22) and beyond.

Voluntary, community and social enterprise partners

The framework stipulates that VCSE partnership should be involved in governance structures and system workforce, population health management and service redesign work, leadership and organisational development plans. By April 2022, ICSs will be required to have developed a formal agreement for engaging and embedding the VCSE sector in system level governance and decision-making arrangements.

Clinical and professional leadership

All ICSs should develop a model of distributed clinical and care professional leadership, and a culture which actively encourages and supports such leadership to thrive. Specific models for clinical and care professional leadership will be for ICSs to determine locally, but the emphasis is on care professional from across the health and wider care sector being actively involved, rather than historic arrangements which have largely focused on clinical and medical leadership.

Working with people and communities

ICSs will need to build a range of engagement approaches into their activities at every level and to prioritise engaging with groups affected by inequalities. It is expected this will be supported by a legal duty for ICS NHS bodies to make arrangements to involve patients, unpaid carers and the public in planning and commissioning arrangements.

Working with a range of partners such as Healthwatch, the VCSE sector and experts by experience, the ICS NHS body should assess and where necessary strengthen public, patients' and carers' voice at place and system levels. Arrangements in a system or place should not just provide commentary on services, but should be a source of genuine co-production and a key tool for supporting accountability and transparency of the system.

NHSE has set out seven principles for how ICSs should work with people and communities. These principles should be used as a basis for developing a system-wide strategy for engaging and involving people and their communities. As part of this the ICS NHS body will be required to work with partners to develop arrangements for:

- Ensuring the ICS partnership, and place-based partnerships have representation from local people and communities in priority setting and decision-making forums; and

- Gathering intelligence about the experience and aspirations of people who use care and support, using these insights to inform decision-making and quality governance.

Primary care in integrated care systems

The framework emphasises the role of primary care in decision-making at all levels of the ICS, including strategic decision-making forums at place and system level. In particular, ICSs should ensure primary care professionals are involved in the development of shared plans at place and system, ensuring they represent the needs of their local populations at the neighbourhood level of the ICS, including with regards to health inequalities and inequality in access to services.

ICSs and place-based partnerships should also consider the support that PCN clinical directors, as well as the wider primary care profession, may need to develop primary care and play their role in transforming community-based services.

Accountability and oversight

Building on the relationships and ways of working that have developed to date, system partners (including local government) will need to maintain a working principle of mutual accountability, where, irrespective of their formal accountability, all partners consider themselves collectively accountable to the communities they serve, and to each other for their contribution to the ICS's objectives.

Financial allocations and funding flows

Funding allocations will be made via the ICS NHS body for the delivery of functions across the whole system. This will include the budgets for acute, community, mental health and primary care services and the running costs of the NHS ICS body. It will be for the ICS body to agree with partners the allocation of this funding across the system. Increasingly, funding will be expected to link to population need with allocations based on longstanding principles of supporting equal opportunity of access for equal needs and contributing to the reduction of health inequalities.

The Kent and Medway Integrated Care System Development Plan

System partners have already demonstrated their commitment to work together to improve the quality of our services, the care people receive and the experience of our combined workforce. Indeed, over the past eighteen months in particular, have evidenced both the benefits and our willingness to collaborate and integrate services more than ever before. We will do this as part of our commitment to delivering the NHS triple aim:

- better health for everyone
- better care for all
- efficient use of NHS resources

The **Kent and Medway System Development Plan** and **draft Operating Model** maps our programme of work over the next year and beyond towards achieving our ambition. The current document, which has recently been approved by the current Partnership Board and submitted to NHSE, is attached at **Appendix A.**

It should be noted that this is a dynamic and evolving set of plans, given the considerable pace that we are having to work to, alongside delivering current operational priorities, and moreover, the fact that much of the national guidance is yet to be published: whilst it will be for systems to determine many of the local arrangements put in place, we will need to constantly revise our plans as further guidance is published.

The proposals outlined in our Operating Model are founded first and foremost on the need to tackle health inequality and improve health and well-being across the whole of our population. The Operating Model, governance framework and architecture will be developed and refined based on this core principle, ensuring the way we go about our work will be inclusive, fair, consistent, transparent and efficient.

The merger of the eight Kent and Medway CCGs in 2020 and the subsequent restructuring of the single organisation puts us in a good position in terms of ICS transition, whilst recognising that the ICS will be different from the existing CCG. The future architecture will build on existing arrangements in place across the system where they are working well and be further informed by:

- The ICS NHS body model constitution
- Local functional design work, taking place from July to September and
- Completion of the local system governance review which has just commenced

Our plans will continue to be refined over the summer and autumn months, building on the key national guidance, including the ICS Design Framework and model NHS Body Constitution. This is in the context that the accountability for delivering services within available resources remains with individual partner organisations of the ICS. Thus we need to align system and place responsibilities with the continued responsibilities of those organisations.

The expectation is that from January 2022 we will move to shadow running the new ICS framework and associated arrangements alongside the existing statutory bodies until planned go-live in April 2022.

Recommendations:

The Joint Health and Well-Being Board is asked to NOTE this update for information

Authors:

Lisa Keslake, Executive Director of System Development and Assurance, NHS Kent and Medway

Mike Gilbert, Executive Director of Corporate Affairs, NHS Kent and Medway

Appendices:

Appendix A: Kent and Medway, Integrated Care System Development Plan, 30 June 2021

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Transforming health and social care in Kent and Medway

Kent and Medway Integrated Care System Development Plan

30 June 2021

Incorporating:

Our Draft Operating Model and Next Steps

Contents

Appendices

1. Stakeholder engagement: Key Issues relating to the establishment of an ICS
2. The K&M System and ICS Body Transition and Development Plan
3. Our draft ICS NHS Body functional model
4. ICS development excerpt from our nine system priorities - Plans on a Page
5. Additional documents and products development plan

Glossary

CCG	Clinical Commissioning Group
H&WBB	Health and Well-Being Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
KM	Kent and Medway
NHSEI	NHS England and Improvement
OD	Organisational Development
PCN	Primary Care Network
PHM	Population Health Management
QI	Quality Improvement
SOF	System Oversight Framework
SQG	System Quality Group

1 Introduction and context

Our Vision:

We will work together to make health and wellbeing better than any partner can do alone

By doing this, we will:

- **Give children the best start in life** and work to make sure they are not disadvantaged by where they live or their background, and are free from fear or discrimination.
- **Help the most vulnerable and disadvantaged in society** to improve their physical and mental health; with a focus on the social determinants of health and preventing people becoming ill in the first place.
- **Help people to manage their own health and wellbeing** and be proactive partners in their care so they can live happy, independent and fulfilling lives; adding years to life and life to years.
- **Support people with multiple health conditions** to be part of a team with health and care professionals working compassionately to improve their health and wellbeing.
- **Ensure that when people need hospital services**, most are available from people's nearest hospital; whilst providing centres of excellence for specialist care where that improves quality, safety and sustainability.
- **Make Kent and Medway a great place** for our colleagues to live, work and learn.

As we progress our plans to be a thriving Integrated Care System, our vision and ambition will drive everything we do. All system partners will work together to improve the quality of our services, the care people receive and the experience of our combined workforce. We will do this as part of our commitment to delivering the triple aim:

- better health for everyone
- better care for all
- efficient use of NHS resources.

The Kent and Medway System Development Plan and Operating Model map our programme of work over the next year towards achieving this ambition. This plan is not a stand-alone document and is aligned to the following:

- K&M System Priorities
- The Kent and Medway Operating Plan
- NHS Long Term Plan (2021)
- ICS Accreditation Submission
- The Kent and Medway CCG merger application

To support our journey to becoming a thriving system, we have an agreed a set of principles which describe how we will work together including, making decisions as close to communities as possible, listening and acting on the views of our staff and developing our digital capabilities to provide one version of the truth.

Alongside existing challenges and health inequalities, we recognise the impact that the COVID-19 pandemic has had on our population and workforce. We are therefore currently focussing on priority areas that both support our individual organisations and provide system leadership in key areas where working together will get better results.

This document outlines our proposals for the development of the Kent and Medway Integrated Care System and in particular our plans relating to the ICS Operating Model and the transition to an ICSNHS Body in April 2022 (subject to parliamentary approval of the NHS Bill).

The draft proposals outlined for the ICS Operating Model are founded first and foremost on the need to tackle health inequality and improve health and well-being across the whole of our population. The Operating Model, governance framework and architecture will be developed and refined based on this core principle, ensuring the way we go about our work will be inclusive, fair, consistent, transparent and efficient.

Our plans will continue to be refined over the summer and autumn months, building on the key national guidance, including the ICS Design Framework and model NHS Body Constitution. This is in the context that the accountability for delivering services within available resources remains with individual partner organisations of the ICS. Thus we need to align system and place responsibilities with the continued responsibilities of those organisations.

The Kent and Medway context

The Kent and Medway System has much to be proud of and the vast majority of our population receives good care and treatment. There are many services that provide high quality care day after day and will continue to do so. Indeed, since the establishment of CCGs in 2013 and the sustainability and transformation partnership in 2016 the NHS and social care in Kent and Medway have had a number of successes improving local services and improving patient outcomes. Many of our providers within community, mental health and primary care services are now rated good or outstanding and we have seen sustained improvement in cancer pathways, the delivery of diagnostic and elective activity and, of course, the monumental effort of all of our staff pulling together during the COVID-19 pandemic, vaccination and recovery

programmes. This has already brought real benefits to the way we plan and deliver services at a system, place and neighbourhood level; and, we are working closer than we have ever done before.

We recognise that whilst we have many achievements to be proud of, there are fundamental challenges that we have not yet been able to fully tackle and which have impacted negatively on individual patient experience, care and well-being. Not least that we need to focus more on working together to support people so they don't get ill in the first place.

Indicators of the challenges we must address together

- Only 2% of health and social care funding is spent on public health interventions to reduce the risk of avoidable disease and disability.
- Around 1,600 early deaths each year could have been avoided with the right early help and support.
- There are stark health inequalities across Kent and Medway. This is a particular issue for people who live in deprived areas and those with severe mental illness more likely to be affected.
    - There is wide variation in life expectancy across Kent and Medway, for example life expectancy for women in Weald East ward is 35% higher than for men in Margate Central ward, a 25 year difference.
    - Emergency admissions for COPD are higher in people from the most deprived 10% of our population compared to the least deprived 10% in almost all districts.
    - Emergency admission rates for stroke and TIA are 43% higher in the most deprived 10% of the population compared to the least deprived 10%.
    - People in the most deprived 10% of the population have multiple morbidities equivalent to people 10 years older in the least deprived 10%.
- There are significant workforce issues across a range of health and care roles. Coastal areas in particular, have additional recruitment and retention challenges. Whilst workforce challenges are seen across the country, Kent and Medway is behind the national average.

To respond to these challenges, and deliver our vision, we have identified nine improvement and development priorities for 2021/22 which map directly back to our purpose and principles.

These priorities formed a key part of our ICS accreditation process in February 2021. Each of the priorities has an assigned system Senior Responsible Officer (SRO) and lead Director, working together to ensure progress, alignment and oversight.

The nine Kent and Medway system improvement and development priorities

We are committed to tackling health inequalities and improving health and well-being across the totality of our population. We will do this through:

- **Greater collaboration and integration of our partners across various levels of the system:** this will lead directly to better quality of care and better outcomes for local people. Whilst a primary design principle is one of subsidiarity and local autonomy, we also recognise that together, the system can be more than the sum of the parts and we will maximise the potential for improved health and well-being outcomes through integrated delivery.
- **Clinical and professional system leadership**: Strategic, tactical and operational initiatives should be led by clinical and professional experts from across health and care, based on shared learning and improvement founded in a desire to eliminate unwarranted variation and maximise quality, safety and patient experience.
- **A principle focus on population health** and being data and quality driven.
- **Engaging and meaningfully supporting** the wider voluntary and community sector, which plays a vital role in care delivery and is a critical link to local communities.
- **Greater meaningful involvement of local people, local government and other stakeholders** in the development and delivery of strategies and plans that improve the quality of life, reduce health inequalities and deliver the best outcomes.

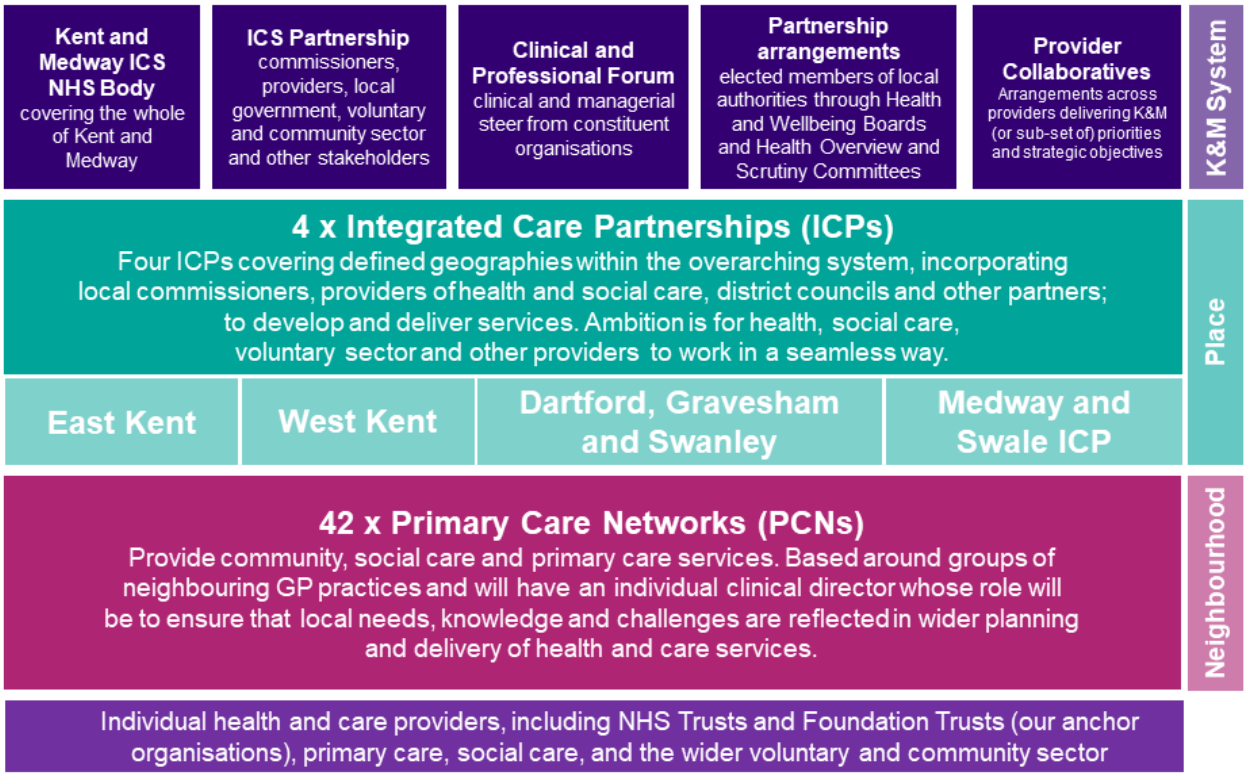
The system wide plans we are developing, as outlined in this plan and supporting documents, will secure the next stage of our transformation programme.

2 The proposed Kent and Medway system architecture

The Kent and Medway System is responsible for leading, improving and transforming population health and well-being and for delivering high quality, accessible health and care services that meet the needs of local people. As well as reducing health inequalities, improving productivity and contributing to the broader economic and social development of Kent and Medway.

The system that is expected to be formally in place from April 2022 will be made up of the two upper tier councils' Health and Wellbeing Boards, an ICS Partnership, an ICS NHS Body, our four Integrated Care Partnerships (ICPs), our 42 Primary Care Networks (PCNs), provider collaboratives (yet to be defined) and our individual NHS and independent provider organisations. Stakeholder representation across the system will come from all of our health and care organisations, upper and lower tier local government, the voluntary and community sector, health and care regulators, other public services and of course our local people.

Likely high level K&M system architecture from April 2022



The **ICS Partnership** will succeed the current ICS Partnership Board. It will have a wider remit and membership. Its primary responsibility will be to develop and oversee achievement of an integrated care strategy, alongside developing health and well-being outcomes for the whole population. It will be established jointly by our two upper tier local authorities, the ICS NHS Body, and partner organisations. It will likely operate through a Joint Committee arrangement. The ICS Partnership will include a broad range of partners from the wider care and well-being system. The relationship between the ICS Partnership and two Kent and Medway Local Authority Health and Well-being Boards (H&WBBs) will be further defined over the summer.

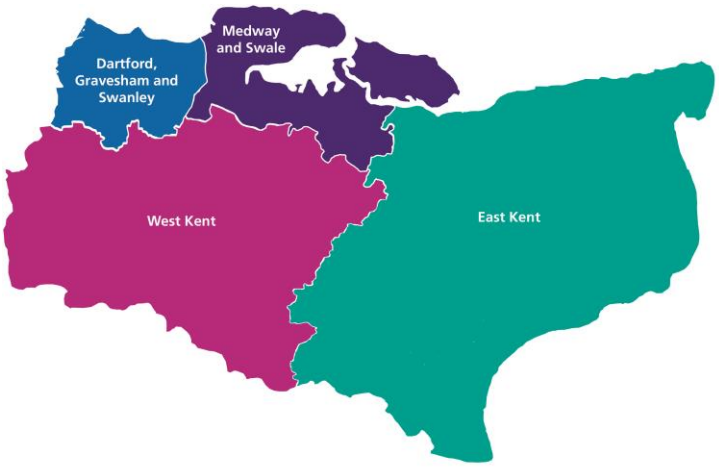
The **ICS NHS Body** is the statutory NHS organisation that will succeed Kent and Medway Clinical Commissioning Group (CCG). It will have the statutory responsibility for planning and securing services. However, it is not simply a replacement of the CCG: it will be a new organisation that brings together all health partners working alongside social care and other partners.

Subject to local agreement, we expect the current functions of KM CCG to transfer to the new body in April 2022, alongside some functions that may be delegated or assigned from NHS England. At a later date functions may then be delegated to ICPs or provider collaboratives.

A Kent and Medway **Clinical and Professional forum** or senate will be established over the course of summer 2021. It will replace the Clinical and Professional Board which was suspended at the start of the pandemic to enable clinicians to focus on the pandemic response. The forum is likely to have responsibility for overseeing clinical and professional input in the development of system strategies and outcome measures; providing objective clinical leadership and whole-system scrutiny to major strategic change and care pathway transformation; and reviewing delivery strategies, to ensure they are effectively addressing system and place based priorities.

Place-based partnerships, or **Integrated Care Partnerships** are collaborative arrangements agreed between the ICS NHS Body, Local Authorities and organisations that provide local health and care services across a defined geography.
In Kent and Medway we have four ICPs[1].

Membership varies based on the local context, but typically incorporates representation of local people, service users, social care providers and commissioners, public health, local government functions, voluntary sector, general practice (represented by the LMC and primary care networks) and providers of community, mental health and acute healthcare.



Provider Collaboratives describes partnerships involving two or more NHS trusts working across multiple places at an appropriate scale to realise mutual benefits and/or benefits for the wider system. Collaboratives are expected to contribute to the strategic planning of the system and may cover one or more place-based partnership. Our approach to provider collaboratives is in development and will be agreed and shared by the end of September 2021. This will confirm our arrangements for collaboration across acute, community and mental health providers.

[1] Dartford, Gravesham and Swanley ICP; East Kent ICP; Medway and Swale ICP; and West Kent ICP

Primary Care Networks (PCNs) play a fundamental role in improving health outcomes and joining up services. They operate at the level of local communities, enabling them to identify and address local health priorities and address health inequalities and are developing integrated multi-disciplinary teams that include staff from community services and other NHS providers, local authorities and the voluntary sector to support effective care delivery. There are currently 42 PCNs covering the whole population of our 198 practices.

Individual providers of care are of course the foundation of our local health and care system. They include, NHS Trusts and Foundation Trusts, independent sector community and voluntary care providers, GP practices, social care providers, and other primary care services such as pharmacies, dentists and optometrists. Whilst they will be key partners across various levels of the Kent and Medway system, they will each remain directly accountable for the services they deliver, in terms of both regulatory and contractual accountability.

At all levels of our system, partnership working will shape better planning and improved services for the residents of Kent and Medway.

3 Stakeholder engagement - defining the end state

Whilst recognising our considerable achievements in developing an ICS across Kent and Medway, including the merger and subsequent restructure of the CCG, there remain some outstanding important issues that need to be agreed as part of our critical path to achieving the April 2022 milestone and then moving beyond to a thriving system. This is an evolutionary journey that all of our partners are involved with and have a clear 'line of sight' on developments.

Through April and May 2021 we began an extensive engagement programme across a wide range of stakeholders to develop our design principles, the system operating model and the governance framework and architecture. Further engagement will continue throughout the summer and autumn months focusing more on the detail of key 'knotty issues'.

Appendix 1 outlines the results from the engagement discussions along with a number of proposed recommendations that have since been agreed. The following provides a headline summary and highlights the strong commitment from all partners to drive greater collaboration and integration to deliver our collective vision:

1. **A cultural shift of hearts and minds is needed**, away from traditional relationships and ways of working, to stronger partnership working and a real move towards improving population health and well-being outcomes is critical. This 'shift' in culture should not be under-estimated in terms of the organisational development required across the system.

2. **We need to up the pace on tackling health inequalities and reducing unwarranted variation in quality** as well as developing PCNs, ICPs and provider collaboratives, noting that all three of these 'layers' will determine how care and well-being services are to be effectively delivered to local people. Furthermore, system wide 'Organisational Development' is needed to support all partners with the shift of responsibilities, relationships and culture.

3. **All elements of our system should be inclusive**, with appropriate engagement with local people and our staff as well wider sector stakeholder involvement in design and decision making.

4. **ICP frameworks should be permissive** and not prescriptive with a mixed economy of approaches and pace determined locally. There needs to be broader collaboration than just health that captures the culture within the local area and addresses the need for greater partnership engagement.

5. **The four ICPs have differing approaches on future levels of ambition and future accountability**. This is understandable and will be a conscious decision of partners with no model being seen as superior over the other. Regardless of approach, there is a broadly supported view that the ambition should be for subsidiarity, local autonomy and self-management.

6. **There is a unanimous view that primary care core GMS commissioning and contracting should remain at an ICS level**, whether or not legislation allows for delegation.

7. **There is an absolute willingness from both Kent County Council (KCC) and Medway Councils to be full partners** in the ICS and at a place level.

8. **There is consensus that partnerships at system, place and neighbourhood level need to include a 'broader church' of partners** from the wider well-being and care system, potentially including welfare, housing, leisure, education; alongside population health, professional and local people representation.

9. **There is unanimous praise for the clinical and professional response to the recent pandemic** and a view that many of the achievements over the past fifteen months should be 'locked in' going forward.

10. **There is a consistent view that future strategies and outcomes need to focus more on addressing the wider determinants of well-being and good health** and less (albeit important) through a clinical lens.

11. **There is a strong consensus on the importance of effective involvement of local people** in order to influence discussion and decision making at all levels. An ICS engagement framework is being developed later this year. There was clear articulation that non-executive directors, lay and independent members and other patient and public representatives are a valuable resource that could be better utilised to champion collaborative working and break down barriers.

Recognising the evolutionary nature of the system's development, the feedback also highlighted a strong sense of needing to map out the functional design of the system to determine which functions are likely to remain at a system level and which might be assigned or delegated to a place or collaborative, from April 2022 and the future. Initial work on this is detailed in a later section and will be completed by September 2021 alongside a detailed review of the existing and future governance framework and architecture.

Further detailed actions plans relating to the specific recommendations from the engagement are now being finalised and implemented.

4 Design Principles

The ICS Partnership is where the leadership from partner organisations come together to:

- understand problems and create the solutions to address them
- set the vision and long-term objectives for the system as a whole
- develop governance and accountability arrangements which support effective delivery of strategy at system, place and neighbourhood; and
- assure and self-manage achievement of improved outcomes for the population.

On this basis, the following agreed design principles will inform the operating model, functional design and governance framework that will enable planned shadow-running of the system from January 2022 and go-live on 1 April 2022. This recognises that much of what is currently in place, particularly in relation to service improvement and delivery frameworks, will require refinement rather than starting from scratch:

1. Improving the health and well-being of local people, addressing health inequalities and reducing unwarranted variation in the most effective and efficient way will be at the heart of every decision we make: our operating model, functional design and governance framework should honour this commitment.

2. The strategy of the system and the setting of outcomes and priorities will be co- designed with care and well-being professionals and informed by the experiences of local people in concert with robust population health information.

3. The establishment of the ICS will represent a fundamental move away from historic commissioner provider relationships with a move to more integrated and collaborative working across system partners and stakeholders.

4. The system needs to be data and quality improvement driven. This will be at the heart of all strategies and priorities. We will also ensure that we better join up digital and data priorities with the clinical strategy and with initiatives in general practice and social care.

5. The principle of subsidiarity will apply to decision making with the following four tests (as included in our ICS accreditation process) applied to assist in deciding when we need to work together as a system on a particular challenge / area of opportunity:

    a. Are we likely to need a critical mass of scale or expertise beyond the place level to deliver the safe and sustainable services which achieve the best outcomes?

    b. Is this a programme or responsibility where all places or more than one place or provider, are experiencing similar challenges (potentially to different degrees) which may benefit from collective problem solving?

    c. Do we believe that working together on a particular issue will create greater power / influence / impact than working alone?

    d. Is this a problem not amenable to local solution?

6. Place and collaboratives are the engine rooms of our system – they are responsible for delivering improved outcomes and driving continuous improvement. They are founded from our individual NHS trusts and foundation trusts (our anchor organisations), primary care, social care, and the wider voluntary and community sector.

7. Neighbourhoods play the most crucial role in improving health and care outcomes within individual communities. Outcomes will only improve if the priorities for and delivery within our neighbourhoods align with our ambitions at place and system level.

8. The system is where our strategic direction of travel and our ambitions around transformation and improvement will be set. Our architecture will reflect this.

9. Trust and mutual respect are at the heart of effective system, place, collaborative and neighbourhood level working. Whilst recognising our ICPs and collaboratives are in a developmental phase, especially in 2021/22 and into 22/23 with a key focus on delivering local priorities and strengthening the relationships, they will nonetheless hold all partners to account for collective delivery of agreed priorities with formal oversight and assurance being carried out by the ICS NHS Body.

10. The ICS NHS Body will proactively support ICPs and provider collaboratives to deliver their priorities and develop their infrastructure including taking further steps to align resources and increase the amount of resource working to and with the ICPs. Existing ICP facing teams within the CCG and new ICS NHS Body will need to maintain an appropriate balance between supporting the pathway and performance improvement work on the ground while also holding other commissioning and oversight functions. This particularly applies to health improvement, quality, safety, safeguarding and finance.

11. The ICS Partnership will develop wider health and well-being strategies and outcomes. It will include a broad range of partners from the wider care and well-being system. Partnerships will need good mechanisms for ensuring strategies are developed with people and communities, drawing on best engagement practice.

12. We will not seek to pre-empt the outcome of the learning from the Wave 3 population health management (PHM) programme. However, a key working assumption is that the ICS NHS Body will develop the strategy and the key frameworks and tools for PHM.

13. Membership of, and involvement in, system and place-based fora should depend on the local context, but we expect they will typically incorporate representation of local people and service users; social care providers local and district authority commissioners; public health leaders; primary care, community, mental health and acute providers; and the voluntary and community care sector.

5 System Development Plan

Our system development plan is detailed in **Appendix 2** with core work streams identified and deliverable and milestones for each set out. The plan supports a number of our nine improvement and development priorities and spans critical areas such as population health management, development of ICPs, PCNs and collaboratives, system organisational development, digital and analytics, and confirmation of our functional models.

The System Development Plan pulls all of these programmes together under one umbrella, where they relate to system development, to enable a coordinated and consistent approach in respect of delivering agreed critical activities during the course of this year and beyond. The system priority programmes that relate to system development are:

Development Programme	System SRO / System Chair
PHM and strategic commissioning	**SRO – James Williams / Alison Duggal** (Public Health Dirs) **Chair – Joanne Palmer** (Chair MFT)
Provider collaboratives	**SRO – Paul Bentley** (CEO KCHFT) **Chair – David Highton** (Chair MTW)
Digital and analytics transformation	**SRO – Susan Acott** (CEO EKHUFT) **Chair – David Highton** (Chair MTW)
Quality and Service Improvement Strategy and Leadership	**SRO – Wilf Williams** (AO KMCCG /ICS SRO) **Chair – Navin Kumta** (Clinical Chair KMCCG)
Implementing the Integrated Care System ICP development	**SRO – Wilf Williams** (AO KMCCG /ICS SRO) **Chair – John Goulston** (Chair KM ICS / KCHFT)

We have detailed plans and headline 'plans on a page' for each of the nine system priorities, including for each of the above programmes. The relevant plans on a page are included at **Appendix 4** for information. They set out our ambition to become a thriving ICS with each plan providing:

- a high level overview of work under each theme,
- critical deliverables and
- expected outcomes to be achieved.

Each of these programmes has its own Senior Responsible Officer and Chair from across the system, as well as an Executive Lead.

6 The Draft Operating Model

6.1 The Kent and Medway ICS Governance Model

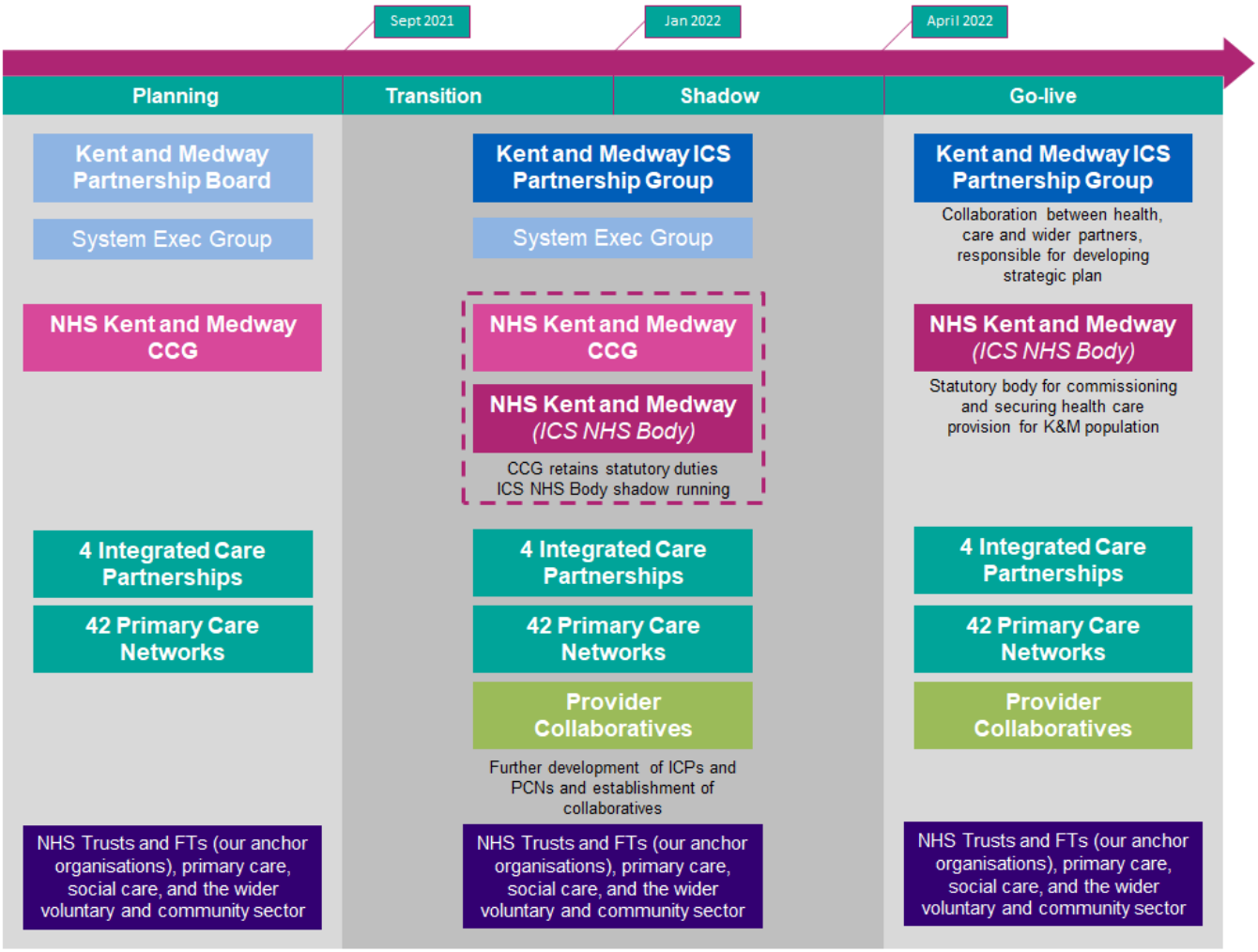
The ICS governance model is driven by the challenges we face and enables the solutions we need to succeed. The merger of the eight Kent and Medway CCGs in 2020 and the subsequent restructuring of the single organisation has been helpful for ICS transition and will support the requirement in the employment commitment for minimum restructuring. However,

the ICS is and will be different from the CCG. The future ICS governance framework and architecture will build on existing arrangements in place across the system where they are working well and be further informed by:

- National ICS Design Framework
- The ICS NHS Body Model Constitution requirements
- The KM functional model work, taking place locally from June to September
- Completion of the system governance review and redesign work currently underway

The expectation is that during Q3 and the beginning of Q4 we will move to shadow running the new ICS framework and associated arrangements.

Kent and Medway ICS - simplified transitional system governance plan



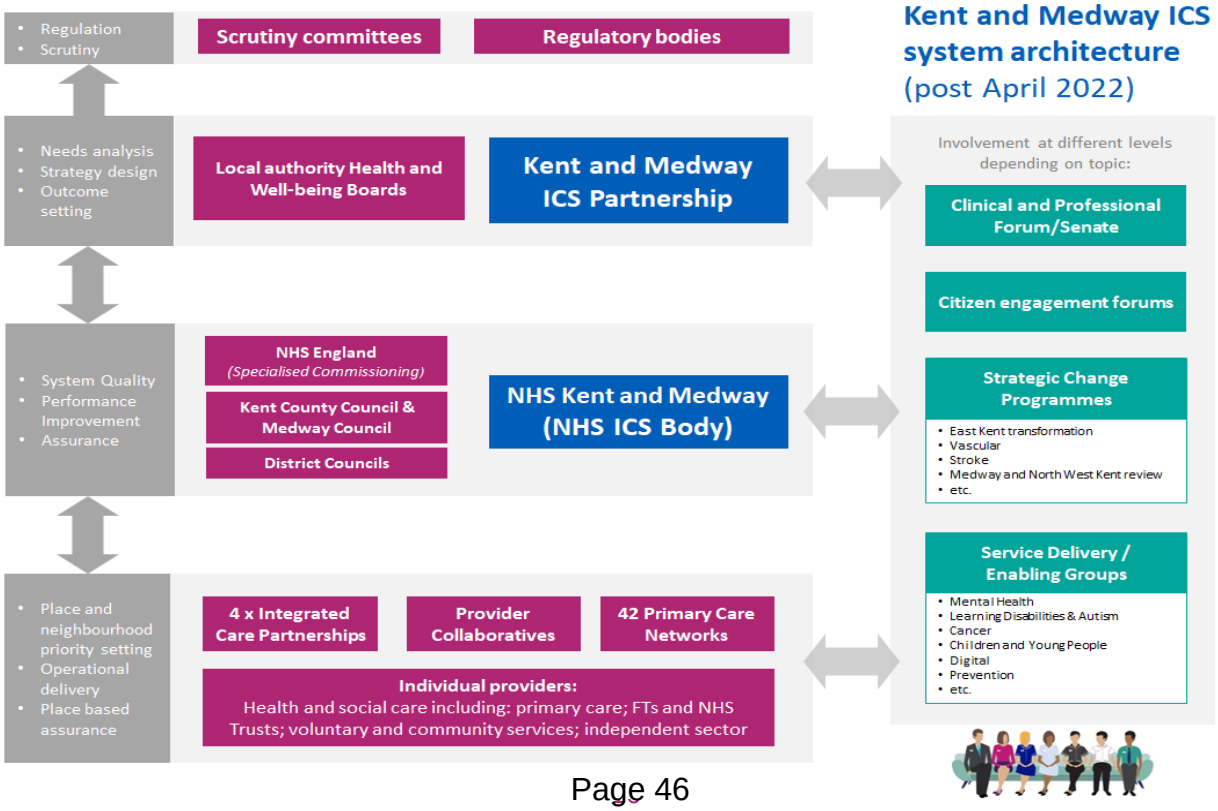
Critical path actions

The **functional model work** will determine which functions are expected to remain at a system level and which might be assigned to a place or collaborative from April 2022: recognising the evolutionary nature of ICP and provider collaborative development, it is likely that significant functions and responsibilities will remain at an ICS level in the first instance, with a longer term plan to delegate or assign responsibilities over the following 12 to 24 month period as partnerships mature. The initial functional model work is planned to be completed by the end of September 2021.

A comprehensive **review of system governance and architecture** has already commenced and a detailed timetable and programme plan for this work is being finalised. More detail on this plan is set out within **Appendix 2** - The K&M System and ICS Body Transition and Development Plan.

The review will consider the totality of the existing architecture and governance framework; refine this to meet the requirements for the new landscape; and ensure robust arrangements are in place for the smooth transition to April 2022. Again, the review will be completed by September 2021. Some elements of the architecture do not need to wait until the outcome of the review, such as the establishment of the clinical and professional forum, however, the main transition to the new ICS bodies will commence from October with full-shadow-running planned from January 2022.

The outcomes from our recent engagement exercise, alongside the design principles, will be effectively played in to the future governance framework, with a particular focus on: clear articulation of remit, roles and responsibilities; inclusive, equitable stakeholder involvement; and an architecture that is fit for purpose for the medium term and consistently defined.



In parallel, a **review of ICP governance frameworks** will also be completed, to ensure similar arrangements are in place and, where appropriate, consistently applied. Notwithstanding the governance review to be completed, the diagram above shows a potential high level governance framework that could be adopted based on refining the current operating model.

There is an absolute willingness from both Kent County Council (KCC) and Medway Council to be full partners in the ICS both at system and place level. In addition there is a willingness of our district councils to be integral to the work on the wider determinants of health. As previously noted, discussion with both local authorities are already underway to consider any new joint commissioning/partnership arrangements and confirm future H&WBB and Partnership Group relationships, which will then be played in to the governance design work.

Current working assumptions and principles

As we complete the next stages of ICS transition, the following working assumptions and principles apply:

- **Accountability and oversight:** The system oversight approach for Kent and Medway in 2021/22 is aligned with the proposed NHSEI System Oversight Framework (SOF) published in March 2021 and consists of four distinct strands:

  (i) oversight through the ICS governance structure – mainly focused on delivery of the system's nine improvement and delivery priorities
  (ii) oversight through the CCG governance structure – noting the statutory role of the Finance & Performance Committee, the Quality, Safety and Safeguarding Committee, and the Primary Care Commissioning Committee
  (iii) oversight at ICP level – focused on oversight of delivery of local ICP priorities and discussion of wider challenges/risks to the place
  (iv) oversight at provider level – noting that in 21/22 the primary accountability relationship remains between NHSEI and providers.

  Individual providers will have contractual accountability to the ICS NHS Body. NHS Trusts and FTs will be accountable for the discharge of their statutory duties to NHSEI with and through the ICS NHS Body. The ICS NHS Body will be accountable to NHSEI and NHSEI will be accountable to the Department for Health and Social Care (DHSC).

  NHSEI continue to lead on the intensive support process and accompanying oversight process for challenged providers but with the joint chairing of meetings. In addition, NHSEI and the ICS/CCG continue to jointly oversee the Recovery Support Programme approach in East Kent and Medway and Swale. NHSEI have already delegated responsibility for the Surveillance Quality Group (SQG) to the ICS/CCG meaning the ICS/CCG holds providers to account for the quality of their services unless there is an issue requiring escalation, whereby NHSEI are in the lead role.

- **Quality governance:** We are building on existing quality governance principles and mechanisms for delivery and will resource quality governance arrangements appropriately; including ensuring that clinical and care professional leads and staff have capacity to participate in quality oversight and improvement. In Kent and Medway the quality governance framework is being developed with Chief Nurses, Medical Directors and other clinical and professional colleagues and tested with the chairs of Quality Committees in individual providers over the next twelve weeks. Responsibility for the Quality Surveillance Group will be handed over from NHSEI to the CCG, with its first meeting taking place in July - membership going forward will include representation from all main healthcare providers. Other parts of the governance framework will likely include the requisite statutory groups for example system safeguarding; ICP quality forums and Quality Committees of Kent and Medway NHS providers; the Local Medical System Group; and potentially a quality and performance improvement committee. The key will be not to duplicate quality assurance by being clear on the purpose, scope and outputs of each assurance group.

- **Financial allocations:** The ICS NHS Body will agree how the allocation it receives will be distributed to perform its functions, in line with locally determined health and care priorities. Funding will flow from the ICS NHS Body to providers through contracts it holds with them for services and outcomes. Within Kent and Medway we will need to develop an agreed framework, building on the work of the existing System Finance Group, for collectively managing and distributing resources so they can be used to address the greatest need and tackle inequalities in line with the NHS system and health and care partnership plans. NHS trusts and foundation trusts remain accountable to the efficient and effective use of resources within the context of the need to meet overall system control totals for capital and revenue.

- **Services currently commissioned by NHS England:** Legislation will enable the direct commissioning functions of NHSEI to be jointly commissioned, delegated or transferred to ICS NHS bodies or NHS providers at an appropriate time. It is the intention of NHSEI to enable ICS NHS bodies to take on responsibility as soon as they are ready to do so after the enactment of legislation. Kent and Medway will need to consider in discussion with NHSEI both the opportunities and risks that this poses before taking on any additional responsibilities.
- **People function:** The ICS NHS Body will have a specific responsibility for leading system implementation of the NHS People Plan, by aligning partners across the system to develop and support the ‘one workforce’ approach as set out in national guidance. As part of this there will need to be clear arrangements in place between the work of the ICS Body, all NHS trusts and other employers of our workforce. In Kent and Medway there are a number of workforce challenges that we believe greater integrated working as a system will help us to tackle. We already have a People Board and have developed local plans setting out how we will deliver the ambition of having more people, working differently, in a compassionate and inclusive culture. Over the next few months these will

be aligned with the ICS Partnerships' plan and then refreshed annually taking into account national priorities.

- **Digital and analytics function:** a comprehensive review of data and analytics systems, capabilities and operating models across the ICS has recently been completed, with recommendations and next steps, which have now been signed off by the ICS Executive Group. This work will focus on developing a core resource across Kent and Medway to take forward the future strategic and operational priorities relating to both the analytical and digital functions. The Kent and Medway Digital Board will take ownership of the analytics strategy, reporting in to the NHS ICS Body. It will also ensure digital data and technology allows information to flow throughout the system; facilitating collaboration and enhancing population health focussed decision making. As an ICS we will build on innovation and underpin integration to:

    - Ensure adherence by partners to standard and processes to allow interoperability.
    - Cultivate a cross cutting system intelligence function.
    - Agree a plan for embedded Population Health Management capabilities.
    - Refresh the digital and data governance, to ensure better join up with the clinical strategy, and with initiatives in general practice and social care.
    - Implement clinically led programmes that support clinical transformation.
    - Invest in training and upskilling workforce.

- **Population Health Management:** Our work to develop PHM is progressing well, with involvement in wave three of the NHSEI development programme starting in July. We will build capacity and capability by working across all tiers of the system to transform service delivery around key population groups:

    - Supporting and sustaining changes to integrated care delivery - through PCNs, community, acute and mental health providers, public health and social care teams; to achieve demonstrably better outcomes and experience for selected population cohorts and support knowledge transfer to spread the approach to other cohorts.

    - Advancing the system's infrastructure and building sustainable capability across all tiers of the system which supports a focus on proactive population health management and tackling unwarranted risk and variation.

- **Other assumptions:**

    - At system and place we will need to continually demonstrate effective clinical, professional and public involvement in decision making within organisations and partnerships. Work is underway to develop our models of clinical and public engagement with plans to be agreed by September 2021 and implemented for April 2022.

- National guidance is awaited on the relationship between the ICS NHS Body and ICPs and provider collaboratives, including leadership roles and responsibilities. However, based on published guidance, it is anticipated that this may include provision for joint committees and/or committees of the ICS NHS Body where appropriate. Subject to guidance we will be developing an ICP framework that applies consistent core requirements across each of the four ICPs whilst enabling local flexibility where this is more beneficial. Notwithstanding any delegation or assignment of functions or responsibilities to ICPs or provider collaboratives, it is expected that the ICS NHS Body will remain accountable.
  As such, the governance and leadership arrangements will be designed to support effective delivery of these functions and responsibilities with clear arrangements in place for assurance.

6.2 The ICS Partnership

6.2.1 Responsibilities of the ICS Partnership

It is clear in the White Paper and NHSEI design framework that the ICS Partnership will have wider responsibilities than our current ICS Partnership Board. Similar to existing arrangements the new ICS Partnership will operate as a forum that brings partners together from across system, but membership will need to be wider to take account of the new mandated responsibilities:

- Agreement and oversight of delivery of an integrated care strategy for improving health and wellbeing across Kent and Medway, built bottom-up from local assessments of need and assets identified at place level, with a specific focus on reducing inequalities and addressing the consequences and lessons from the recent pandemic.

- Aligning partner ambitions through convening and involving all stakeholders across health, social care and more widely across sectors in developing strategy and action to improve health and wellbeing and wider socio-economic conditions for our population.

6.2.2 Partnership principles

Our ICS Partnership will play a key role in nurturing the culture and behaviours of a system that works together to improve health and care for local citizens. In line with current national thinking, the ICS Partnership will give due consideration to the ten key partnership principles:

- Come together under a distributed leadership model and commit to working together equally.

- Use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

- Operate a collective model of accountability, where NHS and local government partners hold each other mutually accountable for their respective contributions to shared objectives.

- Agree arrangements for transparency and local accountability, including for example meeting in public with minutes and papers available online.
- Focus on improving outcomes for people, including improved health and wellbeing and reduced health inequalities.
- Champion co-production and inclusiveness throughout the ICS.
- Support the triple aim, the legal duty on statutory bodies to collaborate and the principle of subsidiarity (that decision-making should happen at the most local level that is appropriate).
- Ensure place-based partnership arrangements are respected and supported, and have appropriate resource, capacity and autonomy to address community priorities, in line with the principle of subsidiarity.
- Draw on the experience and expertise of professional, clinical, political and community leaders.
- Create a learning system, sharing improvements across the ICS geography and with other parts of the country, crossing organisational and professional boundaries.

Importantly, the ICS Partnership will need to champion local engagement, inclusion, transparency and tackling inequalities in ways which deliver our collective ambition.

6.2.3 Accountability and leadership

As a mutual forum that brings partners together, the ICS Partnership will be formally accountable to member organisations, with decision making authority limited to that delegated to each member by their respective organisation.

The ICS Partnership will be established by Kent County Council, Medway Council and the ICS NHS Body, along with partner organisations. It will evolve from existing arrangements and with mutual agreement on its terms of reference and ways of operating and administration. Based on recently published guidance, this may be a Joint Committee of the three statutory bodies. A formal decision will be confirmed by September 2021.

Discussion with both councils are continuing during the summer in terms of the relationship between the ICS Partnership and the two existing Health and Well-being Boards, recognising the commitment between all partners for closer collaboration and integration where this benefits local people. This will also be dependent on further national guidance.

Early discussions have commenced about appointment of an ICS Partnership Chair. The local authorities and NHS partners will work together to select a Partnership Chair and define their role, term of office and accountabilities. To provide greater scope for democratic representation, the ICS Partnership Chair may not be the Chair of the ICS NHS Body.

In line with wider national expectation, membership of the Kent and Medway ICS Partnership is expected to include local government, healthcare organisations, voluntary, community and social enterprise sector partners; social care providers and organisations with a relevant wider interest, for example housing, education and leisure. For clarity, this has yet to be agreed by partners, as we are awaiting further national guidance. However, there is a commitment to ensure the ICS Partnership is fully inclusive. In addition, as a key forum for setting strategy and outcomes, the ICS Partnership will be transparent with formal sessions held in public.

Given the size and complexity of Kent and Medway, it is likely that the ICS Partnership will have a large membership. Our governance review over the summer and autumn will confirm how this can be most effectively established, possibly through the use of sub-groups and/or other networks, to ensure effective discussion and decision making within the remit of the ICS Partnership.

6.3 The ICS NHS Body

6.3.1 Responsibilities of the ICS NHS Body

The design of the ICS NHS Body functional model is being based on the key duties, functions and responsibilities as outlined by national guidance.

The board of the ICS NHS Body will be responsible for ensuring that the organisation meets its statutory duties, which will include supporting achievement of the triple aim, improving quality of services, reducing inequalities, ensuring public involvement, obtaining clinical and public health advice in strategic change and pathway developments, and promoting innovation and research. More specifically, responsibilities will include:

- Developing a plan to meet the health needs of the population within their area, having regard to the ICS Partnership's strategy.
- Allocating resources to deliver the plan across the system.
- Establishing joint working arrangements with partners that embed collaboration as the basis for delivery of joint priorities within the plan.
- Establishing governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations, to ensure the plan is implemented effectively within a system financial envelope set by NHS England and NHS Improvement.
- Arranging for the provision of health services in line with the allocated resources across the ICS through a range of activities including:
    - Putting contracts and agreements in place to secure delivery of its plan by providers.
    - Convening and supporting providers (working both at scale and at place) to lead major service transformation programmes to achieve agreed outcomes.
    - Working with local authority and VCSE partners to put in place personalised care for people.

- Leading system implementation of the People Plan by aligning partners across the ICS to develop and support a 'one workforce' approach, including through closer collaboration across the health and care sector, and with local government, the voluntary and community sector and volunteers.
- Leading system-wide action on data and digital: The ICS NHS Body will work with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services and ultimately transform care to put people at the centre of their care.
- Using joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvement in performance and outcomes.
- Working alongside councils to invest in local community organisations and infrastructure and, through joint working between health, social care and other partners ensuring that the NHS plays a full part in social and economic development and environmental sustainability.
- Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability.
- Planning for, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement.
- Functions NHS England and NHS Improvement will be delegating and transferring including commissioning of primary care services and appropriate specialised services.

Relevant statutory duties of CCGs regarding safeguarding, children in care and special educational needs and disabilities (SEND) will transfer to the ICS NHS Body. In addition, it is expected that all current, still relevant, CCG functions and duties, assets and liabilities will transfer to the ICS NHS Body.

Additionally, through the work we have done locally on system development, we have identified the following important features of how the ICS NHS Body will exercise the above responsibilities and add value (as detailed in our ICS accreditation submission):

- Defining population health priorities and outcomes for Kent and Medway and tackling health inequalities, starting with analysed data to develop an understanding of population needs, setting a strategy focused on those outcomes, working at a system level but recognising a need for tailoring at place level.
- Ensuring involvement with local people to set the priorities for outcomes planning.
- Ensuring strong clinical and professional leadership working with our staff and local people to improve services and outcome and reduce inequalities and unwarranted variations in quality.
- Management of finances within a collective control total and oversight of spend to ensure alignment to priorities (via Kent and Medway Finance Group).

- Working with NHSEI specialised commissioning teams to manage operating model and assurance framework for populations accessing services from outside of Kent and Medway.
- Facilitating and leading on the development of a system approach to Quality Improvement.

In advance of further system discussions during the summer and autumn, a draft ICS Body directorate functional model has been developed with an approach of mapping functions against the purposes of an ICS, to begin to further outline the ICS NHS Body's form. This is detailed at **Appendix 3**.

6.3.2 Leadership and accountability

Formal accountability will be to NHS England for the delivery of the organisation's duties and functions as set out in its Constitution, Standing Orders, Scheme of Delegation and other primary policies. Locally the ICS Partnership will hold the ICS Body and the ICPs, provider collaboratives and individual health and care providers to account for the delivery of the system's integrated care strategy.

Based on national guidance, it is likely that the Board of the Kent and Medway ICS NHS Body will be made up as a minimum of the following roles:

- Independent Chair
- Two Independent Non-Executive Directors
- Four members drawn from local partners:
  - one member, ideally at CEO level, drawn from NHS trusts who provide services within the ICS's area;
  - one member drawn from GP providers from within the area of the ICS NHS Body;
  - (two members) one drawn from each of KCC and Medway Council. This could be the CEO, Director of Social Services or the Director of Public Health
- A Chief Executive Officer
- A Chief Finance Officer
- A Medical Director
- A Chief Nurse

The final number of roles on the Board will be agreed with ICS partners during the summer.

The appointment of the Chair and Chief Executive Officer will be subject to national guidance. It is expected that both of these roles will be appointed to by October 2021. Other executive and director leadership roles will be appointed based on national ICS guidance, stipulations in the model Constitution and national and local HR frameworks.

Following ICS accreditation we have been developing a set of structured options for the new role of Medical Director within the ICS Body with a defined set of directorate responsibilities.

Stakeholders are currently being engaged on the appraisal of the options, with a view to advertising this role in the autumn as part of the leadership appointment process.

Outside of the committee structures, the day to day operational model and directorate working of the NHS Body will be for the Chief Executive to determine in consultation with members of the Board and wider partners.

The merger of the previous CCGs and subsequent restructuring during 2020, which recognised the direction of travel towards a single system with four ICPs, puts Kent and Medway in a stronger position than many other areas. Therefore, notwithstanding the discussions that need to take place over the summer regarding functional model in readiness for April 2022, current planning assumptions are that any need for significant reorganisation within the NHS ICS Body at this time will be minimal.

6.3.3 Committees and decision making

Membership of decision making and advisory groups within the NHS ICS Body and across the wider system, will depend on the local context and requirements. Where appropriate they will incorporate representation of clinical and professional leaders, local people and service users; and provider representation from across health, social care and the voluntary and community care sectors.

In particular, it is expected that legislation will allow ICS NHS bodies flexibility in how they establish committees and in particular, that we are likely to be able to appoint individuals who are not ICS Body Board members or staff of the organisation to be members of a committee. This would enable, for example, other clinical and professional leaders, ICP and collaborative directors, and local non-executive directors to become members of the ICP Body committees. We are proactively looking at these opportunities to ensure appropriate partnership involvement whilst maintaining effective and efficient governance.

The ICS NHS Body will maintain a ‘functions and decision making map’ articulating where accountability and decision making sits/flows, including any new commissioning functions delegated or transferred by NHS England. This may be required to form part of the organisation’s Constitution which will be formally approved by NHSEI.

Alongside the statutory committees of the Board (Audit and Remuneration committees):

- other decision making committees with responsibility for quality, performance and financial assurance will be established.
- advisory committees regarding the discharge of certain statutory duties, such as local people involvement are likely to be established.
- other system forums that provide direct influence in decision making, such as the clinical and professional forum, the People Board and system service improvement and delivery groups, will also link in to the ICS Body and Partnership governance structure.

- dependent upon the legislation and local discussions, ICPs may become committees of the ICS NHS Body with decision making responsibilities delegated through the scheme of delegation (see below).
- joint committees may also be established where joint decision making is required, for example with NHS England for other delegated services such as pharmacy and dentistry.

The governance review to be completed by the end of September will confirm these proposals.

As previously noted, the outcomes from the recent engagement exercise, alongside the design principles, will be actively played in to the future governance framework and committee structure, with a particular focus on clear articulation of remit, roles and responsibilities; interdependencies; and importantly inclusive, equitable stakeholder involvement.

6.3.4 Relationship between ICS Body and ICPs

Following confirmation in the ICS design framework, the ICS NHS Body will agree with local partners the membership and form of governance that ICPs adopt, building on existing local configurations and arrangements. The NHS ICS Body will remain accountable for NHS resources deployed at place-level and governance and leadership arrangements will need to support safe and effective delivery of the Body's functions and responsibilities. The possible governance arrangements an ICS Body could establish for ICPs include:

- Consultative forum, *informing* decisions by the ICS NHS Body.
- A committee of the ICS NHS Body, with delegated authority.
- Joint committee of the ICS NHS Body and one or more statutory provider(s), where the relevant statutory bodies delegate decision making to the joint committee.
- Individual directors of the ICS NHS Body having delegated authority (the director could be a joint appointment with delegated authority from respective bodies).
- Lead provider arrangements.

As we work through the functional design and governance architecture during the summer, system leaders will consider how best to approach and adopt these arrangements, whilst maintaining the principle of subsidiarity and local autonomy.

7 The transition from CCG to ICS NHS Body

This section principally relates to the technical and administrative close down of the current CCG and transfer of responsibilities to the NHS ICS Body. Elements of this will be undertaken in partnership with stakeholders outside of the CCG, for example development of the constitution, functional architecture and governance framework; whilst other elements relate to critical internal operational and corporate deliverables, such as the transfer of staff and close down of financial ledgers.

The merger of the eight Kent and Medway CCGs in 2020 and subsequent restructuring has established a structure that includes system and place facing functions and directorates with system development responsibilities beyond core CCG statutory responsibilities. This minimal need to restructure and recent experience of closing down CCGs and transitioning staff to a new organisation puts us in a strong position for managing the transition. Key areas have been outlined and learning established from the merger, which will support the safe and successful transfer.

A significant amount of 'transactional' planning and implementation is underway to deliver a safe transition. This includes:

- Development of the ICS NHS Body Constitution, Standing Orders, Standing Financial Instructions, Schemes of Delegation, and primary corporate policies.
- Appointment to Board and leadership roles and review and alignment of directorate responsibilities.
- Establishment of the ICS NHS Body governance framework, including the Board, committees, sub-committees and associated arrangements.
- Transfer of all assets and liabilities including: all information, IT, HR, contracts, estate, litigations, etc.
- Establishment of all corporate governance arrangements, including for example indemnity, legal and constitutional, regulatory assurance, audit and risk and compliance obligations.
- TUPE transfer of staff and associated HR arrangements including HMRC and pension transfers.
- NHS Digital transfers, including transfer of arrangements for CCG and GP practice information
- Financial close down of CCG ledgers and re-opening of new accounts, including potential significant work with SBS, suppliers and contracts.
- Marketing, communications and engagement transfer, including website and intranet arrangements, signage, branding, etc.

We will manage this in the same way as our successful merger of the eight CCGs in April 2020. A working group has already been established with senior managers and subject matter experts from across all CCG directorates and a line-by-line implementation plan has been developed. The plan will continue to develop as more national guidance confirms requirements.

A detailed plan for each transition workstream will manage and track requirements to enable a safe transfer of people and services. The main work streams for the technical transition are:

Transition Theme (underpinned by detailed project plan)		Lead Executive Director
Governance and decision making changes and transition		Mike Gilbert, Corporate Affairs
ICS leadership, people processes and OD		Becca Bradd, People and OD
Functional model for the ICS body	Changes to commissioning	Wilf Williams, Accountable Officer
	Changes to analytics operating model	Morfydd Williams, Digital
	Creation of Medical Directorate	Wilf Williams/ Becca Brad
Digital and data transfer / transition		Morfydd Williams, Digital
Procurement and contracting		Ivor Duffy, Finance
Finance		Ivor Duffy, Finance
Oversight/assurance – set up		Lisa Keslake, System Development and Assurance
Engaging with staff and stakeholders on the transition		Becca Bradd / Tom Stevenson, People, OD / Communications

Notwithstanding the need to confirm system functional responsibilities by the end of September, our planning assumption for April 2022 is for minimal reorganisation/restructuring. Within this we will make sure the model we put in place is dynamic and able to respond to the developmental approach being taken by ICPs and provider collaboratives; which may at some point in the future result in greater formal delegation of responsibilities and ICS NHS Body resources (including staffing).

Having merged eight CCGs in April 2020 and undertaken a major restructure we are not envisaging any major structural changes within the transition period. We are working through the recently published guidelines on the 'employment commitment' for appropriate staff. We will be joining the South East HR partnership group to work with other organisations to affect the change to an ICS structure. We continue to work in partnership with our staff side colleagues and our HR Directors are due to meet again in early July.

8 Communications and Engagement

The Kent and Medway system has an established network across its NHS communications and engagement teams which has been strengthened by close joint working through the pandemic. We will use this network, together with a wider network covering all Local Resilience Forum partners, to make sure ICS transition communications and engagement activities reach all audiences.

A dedicated ICS transition bulletin is being established to share key progress and gather feedback from stakeholders through the next stages of transition. Our objectives for communications and engagement on the transition were agreed by the CCG Governing Body in May 2021:

1. Deliver timely and effective communications on the transition of K&M CCG to a new ICS NHS Body to all audiences.

2. Develop, agree and implement a patient and public engagement framework for the Integrated Care System that incorporates principles of co-design and co-production, community development and on-going dialogue with patients and the public.

3. Develop, agree and implement the approach to shared responsibility across ICS partners for resourcing communications and engagement requirement at all ICS levels.

4. Develop, agree and implement an overarching communications and engagement strategy for the ICS, focussed on supporting delivery of the nine ICS priorities.

5. Ensure smooth transition of statutory duties to engage and consult from the CCG to the new ICS NHS Body with no interruption to live engagement projects.

6. Establish communications and engagement tools and channels for new ICS NHS Body and ICS Partnership.

A list of core deliverables, timelines and measures of success has been developed. A further detailed action plan is being developed in July.

Internal Communications on CCG to ICS Body Transition

We have good internal communications and engagement channels in the CCG and through the communications teams of all ICS partners. Specifically for CCG colleagues facing the transition to a new organisation we will continue our:

- Monthly executive led webinars (regularly attended by 300 people)
- A leadership forum of 70+ service and team leaders with regular meetings and online discussion channel; with key messages shared for cascade across all teams
- Weekly news bulletin and fortnightly Accountable Officer blog
- Staff networks and a newly established People Partnership Board
- A staff portal (intranet)
- Executive video updates

9 Risks and the risk management approach

Risks directly relating to the CCG transition to the ICS NHS Body are managed through the CCG risk management framework, risk registers and board assurance process. Wider risks relating to ICS development and transition are managed through respective programme SROs and their teams up to the current System Executive Group.

A draft assurance framework for the transitional work is currently being developed and will be presented to the executive group in July and Partnership Board in early August. Alongside this, work is about to commence with an external partner to develop a long term system risk management and Partnership assurance framework. This is not a simple transfer of organisational risks and assurance challenges, but will require a shift in culture in terms of agreeing those material issues that will impact on system and place based priorities, and agreement of where risk 'sits' and who 'owns' this. This type of system-wide risk management and assurance framework has not yet been developed across any of the south east ICS': once developed, we expect to share the outcome with partnering systems.

With regard to transition and preparations for April 2022, the following headline risks and mitigations have been identified *(risk scores are impact if risk materialises x likelihood)*:

1. **Delays in approval of the Parliamentary Bill** and/or national guidance particularly relating to ICS Constitution, HR Framework and wider ICS mandated guidance leading to insufficient time to agree and implement final governance models and architecture.

   Amber / 12 *(4 x 3)* Current structures and programme arrangements are such that local decisions and implementation should not be adversely affected, unless material changes or a lack of fundamental guidance is extremely delayed

2. A **lack of clarity in national guidance** could impact on local partners reaching agreement on key governance and constitutional matters, leading to material delays in ICS implementation and/or a lack of clarity/consensus that will materially impact on future relationship and delivery arrangements

   Amber / 12 *(4 x 3)* Whilst there will inevitably be local discussions and some 'negotiation' on roles, responsibilities and associated governance arrangements, there is a growing level of maturity and partnership working in the system, that should highlight any key differences/issues and effectively work through these. The risk becomes greater if national guidance is delayed.

3. Key **leadership appointments to the ICS NHS Body are delayed** leading to growing unrest amongst existing system leaders and an inability to make important decisions on future working arrangements.

   Red / 16 *(4 x 4)* National guidance on the HR framework and appointment to the key leadership roles, such as ICS NHS Body Chair and CEO, are awaited. Whilst local discussion on potential mitigating actions is taking place and we are involved in the national engagement, the likelihood of this risk materialising is dependent on the national timetable and process.

4. There is a risk that **critical operational and tactical priorities** across the system – including a third wave of the pandemic and extended vaccination programme - will take priority and impact on the capacity of system leaders to effectively engage in the development of the ICS across all layers (system, place, collaborative, neighbourhood), leading to a lack of consensus and/or clarity on authority, remit and governance. This includes clinical and professional and wider system leadership capacity.

   Red / 15 *(5 x 3)* Staff recuperation remains an issue, with all organisations focusing on balancing operational delivery with staff recovery. Effective arrangements are in place to manage this risk within each organisation. However it remains an issue that needs close attention. Organisational development plans for system, ICPs and PCNs are in place and will be enhanced over the summer months. Targeted development and discussion on 'knotty issues' will be prioritised as these materialise.

5. There is concern about the **timing, scale and available resourcing** of those functions likely to be delegated to systems by NHSEI, leading to systems being delegated responsibilities with sufficient time, capability or resource to effectively manage these, resulting in an inability to effectively manage new services.

   Amber / 12 *(4 x 3)* Close discussions with regional NHS England colleagues will continue over the summer months to understand the timing and phasing of any delegation. Learning the lessons from GMS contract delegation, effective resourcing of these functions, particularly the availability of experienced subject matter experts is the primary risk, alongside management capacity and capability to manage issues and challenges as they are subsequently identified.

6. **Loss of key staff and clinical membership** during transition, leading to organisational instability, deterioration of assurance and a loss of corporate memory, resulting in the ICS NHS Body not being able to meet its statutory duties and corporate responsibilities.

   Amber / 12 *(4 x 3)* CCG transition programme in place with lead executives and functional leads; CCG and system development programme defined and played in to forward planners; People and OD plan and staff engagement plans developed; regular staff briefings; Regional approach on critical staff messaging and national workforce guarantee. Functional design (ICS/ICP/collaborative) yet to be completed – this will give staff further assurances once complete alongside senior leadership appointments. Continuous programme of staff involvement, engagement and communication, including GP membership; Pace of development programme for ICS, ICPs and PCNs to be increased; programming and completion of functional design during the summer.

7. There is a risk that the system partners do not engage in meaningful discussions about **forming and developing effective and innovative provider collaboratives**. This will impact on the governance development for the ICS as well as hindering the ability of the system to deliver parts of the operational strategy.

   Red / 16 *(4 x 4)* A National work stream focussing on provider collaboratives has been created and the CCG and its partners will receive guidance and direction from this.

10 Conclusion and next steps

The Kent and Medway system is progressing well in developing the new model of Integrated Care Systems. We are building on the excellent partnership working across the NHS and with wider health and care partners which has been so critical in responding to the pandemic.

As a sustainability and transformation partnership we made good progress with service transformations to improve health and healthcare for local people. As an ICS we are now taking this to the next level and as our shared vision states: **we will work together to make health and wellbeing better than any partner can do alone.**

Following the recent publication of the ICS Design Framework, local design and governance decisions will now be made to continue developing the system operating model. We are continuing our extensive engagement exercise with all ICS partners over the summer to ensure that we co-design a governance and operating model that supports all partners to work together to tackle our shared challenges and deliver on our agreed priorities.

At the end of September 2021, we expect to have completed the Kent and Medway governance review and have our approach to system architecture and governance signed off by the current ICS Executive Group and ICS Partnership Board.

As noted in earlier sections, critical programmes of work taking place in coming months include:

- Reconfirming the level of ambition at system, place and collaborative level and completion of the first phase of the **functional design** work in order to inform April 2022 architecture – to be completed by 30 September 2021.
- Comprehensive **review of the system governance framework** to be timetabled by the end of June and completed by 30 September 2021. This will include discussions with Kent County Council and Medway Councils on future working relationship and potential areas for greater joint working.
- Develop our HR framework and transition plan detailing a step by step approach to transition affected staff to the ICS NHS Body. This will also detail our plans for recruitment to the ICS NHS Body Chair, Chief Executive and other Executive Board roles. First draft by end July 2021.
- Re-establish a **Clinical and Professional Forum** with a clear articulation of remit, authority and the clinical and professional governance framework that will sit around it at place and service delivery level, by 30 August 2021.
- Establish a **patient and public engagement framework** by December 2021.
- Further development and prioritisation of the **Organisational Development programme** for all layers of the system from June 2021.

We will regularly review our transition and development plans to ensure key milestones are being met and decisions are made at the identified decision points.

Further detail on our progress so far and next steps for ICS transition in Kent and Medway are set out in the supporting documents:

- **Appendix 1 - Stakeholder engagement initial discussions**
  Summary of key issues relating to the establishment of an ICS gathered through extensive engagement with ICS partners through April and May 2021.

- **Appendix 2 - The K&M System and ICS Body Transition and Development Plan**
  High level overview of the transition work programme. Highlights key milestones for delivery and decision points between June 2021 and the end of March 2022. Detailed plans for each of the programme areas are available on request.

- **Appendix 3 - Our draft ICS NHS Body functional model**
  Initial views on functions that will be the responsibility of the ICS NHS Body, subject to any future decisions on delegation to ICPs or provider collaboratives.

- **Appendix 4 - ICS development excerpt from our nine system priorities**
  Plans on a Page covering the four system priorities that directly link to our ICS transition programme.

- **Appendix 5 - Additional documents and products development plan**
  Details of the Kent and Medway ICS key documents and products list that will be developed as part of our transition journey.

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From: Clair Bell, Cabinet Member for Adult Social Care and Public Health

To: Kent and Medway Joint Health and Wellbeing Board – 20 July 2021

Subject: The appointment of a representative to attend meetings of the Kent and Medway Primary Care Commissioning Group

Classification: **Unrestricted**

Past Pathway of report: None

Future Pathway of report: Medway Health and Wellbeing Board and Kent Health and Wellbeing Board.

Electoral Division: All

Summary: This report asks the Joint Board to consider recommending to the Kent and Medway Health and Wellbeing Boards the appointment of a representative to attend meetings of the Kent and Medway Primary Care Commissioning Group following a request from the Kent and Medway Clinical Commissioning Group (CCG).

Recommendation(s): The Kent and Medway Joint Health and Wellbeing Board is asked to recommend to the Kent Health and Wellbeing Board and the Medway Health and Wellbeing Board:

1) that a member of the Kent and Medway Joint Health and Wellbeing Board be nominated to attend meetings of the Kent and Medway Primary Care Commissioning Group's Primary Care Commissioning Committee (PCCC) in accordance with paragraph 4 of the terms of reference of the PCCC;

2) that James Williams, Director of Public Health at Medway attends the PCCC's meetings as the representative of the KAMJHWB; and

3) that this appointment is reviewed in 12 months' time in line with the development of the Integrated Care Systems boards.

1. Introduction

1.1 A request has been received from the Kent and Medway Clinical Commissioning Group (CCG) asking that a representative of the Kent and Medway Joint Health and Wellbeing Board (KAMJHWB) be nominated to attend meetings of the Kent and Medway Primary Care Commissioning Committee (PCCC), in accordance with the PCCC's terms of reference (attached at appendix 1 to this report). Paragraph 4.1 of the terms of reference requires the PCCC to invite a representative of the health and wellbeing board to attend its meetings. Paragraph 4.5.5 indicates that the representative of the health and wellbeing board can comment but not vote on matters considered at meetings of the PCCC.

1.2 The CCG is seeking one representative from the KAMJHWB to attend meetings in a non-voting capacity. They are particularly keen for the representative to be involved in discussions relating to strategy and population health.

1.3 It has been suggested that having one representative would enable engagement without creating a greater burden by asking a representative from each local authority to attend monthly three-hour meetings of the PCCC.

1.4 James Williams, Director of Public Health at Medway has indicated his willingness to attend these meetings subject to the agreement of Kent County Council.

1.5 The KAMJHWB has no delegated authority to make this appointment. The KAMJHWBB is therefore asked to recommend to the Kent HWB and the Medway HWB:

1) That a member of the Kent and Medway Joint Health and Wellbeing Board be nominated to attend meetings of the Kent and Medway Primary Care Commissioning Group's Primary Care Commissioning Committee (PCCC) in accordance with paragraph 4 of the terms of reference of the PCCC;

2) That James Williams, Director of Public Health at Medway attends the PCCC's meetings as the representative of the KAMJHWB and

3) That this appointment is reviewed in 12 months' time in line with the development of the Integrated Care Systems boards

2. Financial Implications

2.1 There are no financial implications arising from the implementation of the recommendation.

3. Legal implications

3.1 The legal and constitutional implications are set out in the paragraphs above.

4. Equalities implications

4.1 There are no equalities implications arising from this report.

5 Recommendations

5.1 The Kent and Medway Joint Health and Wellbeing Board is asked to recommend to the Kent Health and Wellbeing Board and the Medway Health and Wellbeing Board:

1) that a member of the Kent and Medway Joint Health and Wellbeing Board be nominated to attend meetings of the Kent and Medway Primary Care Commissioning Group's Primary Care Commissioning Committee) in accordance with paragraph 4 of the terms of reference of the PCCC;

2) that James Williams, Director of Public Health at Medway attends the PCCC's meetings as the representative of the KAMJHWB and

3) that this appointment is reviewed in 12 months' time in line with the development of the Integrated Care Systems boards

6. Background Documents

None.

7. Contact details

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Kent and Medway Clinical Commissioning Group
Primary Care Commissioning Committee
Terms of Reference

1. Introduction

1.1 In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended) (the NHS Act), NHS England delegated the exercise of the functions specified in Clause 3 to NHS Kent and Medway Clinical Commissioning Group (CCG).

1.2 The CCG has established the Primary Care Commissioning Committee (the Committee). The Committee is established as a Committee of the Governing Body in accordance with Schedule 1A of the NHS Act. The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

1.3 The Committee will consider local commissioning needs within its decision making. This will ensure that Integrated Care Partnerships (ICPs) and Primary Care Networks are able to co-ordinate through general practices, community services and hospitals to meet the needs of local people requiring care.

1.4 These terms of reference set out the membership, the remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the Constitution.

2. Statutory Framework

2.1 NHS England has delegated to the CCG the authority to exercise the primary care commissioning functions set out in Annex A in accordance with section 13Z of the National Health Service (NHS) Act. (for information, Annex B provides the definition and interpretation of terms in the Delegation Agreement between the CCG and NHS England)

2.2 Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

2.3 Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it) it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

2.3.1 Management of conflicts of interest (section 14O)

2.3.2 Duty to promote the NHS Constitution (section 14P)

2.3.3 Duty to exercise its functions effectively, efficiently and economically (section 14Q)

2.3.4 Duty as to improvement in quality of services (section 14R)

2.3.5 Duty in relation to quality of primary medical services (section 14S)

2.3.6 Duties as to reducing inequalities (section 14T)

2.3.7 Duty to promote the involvement of each patient (section 14U)

2.3.8 Duty as to patient choice (section 14V)

2.3.9 Duty as to promoting integration (section 14Z1)

2.3.10 Public involvement and consultation (section 14Z2)

2.4 In respect of the delegated functions from NHS England the CCG will need to specifically exercise those functions set out below in accordance with the relevant provisions of section 13 of the NHS Act:

2.4.1 Duty to have regard to impact on services in certain areas (section 13O)

2.4.2 Duty as respects variation in provision of health services (section 13P)

2.5 Members of the Committee acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

3. Role of the Committee

3.1 The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care medical services in the CCG, under delegated authority from NHS England.

3.2 In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and the CCG, which will sit alongside the delegation and terms of reference.

3.3 The functions of the Committee are undertaken in the context of a desire to improve the sustainability of primary care and promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

3.4 The Committee will have due regard to any relevant quality and safety issues which may arise as agreed by Committee members.

3.5 The role of the Committee shall be to carry out the functions relating to the commissioning

of primary medical services under section 83 of the NHS Act. This includes the following:

3.5.1 GMS, PMS and APMS contracts (including procurement of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract)

3.5.2 Decisions in relation to Enhanced Services

3.5.3 Decisions in relation to Local Incentive Schemes

3.5.4 Decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices

3.5.5 Decisions about 'discretionary' payments

3.5.6 Decisions about commissioning urgent care (including home visits as required) for out of area registered patients

3.5.7 The approval of practice mergers

3.5.8 Planning primary medical care services in the area, including carrying out needs assessments

3.5.9 Undertaking reviews of primary medical care services in the area

3.5.10 Decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the Care Quality Commission (CQC) where the CQC has reported non-compliance with standards. For clarity, this excludes any decisions in relation to the performers list

3.5.11 Management of delegated funds in the area

3.5.12 Premises costs directions functions

3.5.13 Oversee the implementation of the Kent and Medway primary care strategy as it relates to the remit of the Committee

3.5.14 Coordinating a common approach to the commissioning of primary care services with other commissioners in the area where appropriate

3.5.15 Such other ancillary activities that are necessary in order to exercise the Delegated Functions

3.6 The Committee will also carry out the following activities:

3.6.1 Plan, including needs assessment, primary medical care services in the CCG's geographical area

3.6.2 Undertake reviews of primary medical care services in the CCG's geographical area

3.6.3 Co-ordinate a common approach to the commissioning of primary care services generally

3.6.4 Approve the policies and operating procedures that the Primary Care Operational Groups will adhere to when considering routine business items, for example requests for a boundary change to a GP practice; and

3.6.5 Manage the budget for commissioning of primary medical care services in the CCG's geographical area.

4. Membership

4.1 This Committee is constituted with a lay and executive majority, and includes a requirement to invite a Health and Well-Being Board and Healthwatch representative to attend (as per paragraph 97 onwards of the Managing Conflict of Interest: Revised Statutory Guidance for CCGs 2017).

4.2 The voting membership of the Committee is as follows:

4.2.1 Independent Lay Member for Primary Care

4.2.2 Lay Member for Patient and Public Engagement

4.2.3 The Accountable Officer or their nominated deputy

4.2.4 The Executive Director for Health Improvement or their nominated deputy

4.2.5 The Chief Finance Officer or their nominated deputy

4.2.6 The Chief Nurse or their nominated deputy

4.2.7 The Governing Body independent secondary care specialist

4.2.8 The Governing Body independent registered nurse

4.3 The Chair of the Committee shall be the Governing Body Lay Member for Primary Care

4.4 The Vice-Chair of the Committee shall be the Governing Body Lay Member for Patient and Public Engagement.

4.5 The Committee shall have the following standing attendees who may be invited to comment but shall not vote:

4.5.1 One GP member from each of the Primary Care Co-Commissioning Operational Groups

4.5.2 The Chairs of Primary Care Commissioning Operational Groups (PCOGs)

4.5.3 An NHS England Primary Care representative

4.5.4 A Local Medical Committee Representative

4.5.5 A Kent and Medway Joint Health and Wellbeing Board representative

4.5.6 A Representative on behalf of Kent Healthwatch and a representative on behalf of Medway Healthwatch

4.5.7 Head of Primary Care commissioning (one per each PCOG)

4.6 Officers of the CCG may nominate deputies to represent them in their absence and make decisions on their behalf. Non-voting members may nominate deputies to attend in their absence.

4.7 As Chair of the Audit Committee, the Independent Lay Member for Governance shall receive all papers for the Primary Care Commissioning Committee meetings and shall have the right to attend any meeting of the Committee, but shall not be a voting member.

4.8 Whilst not part of the quorum, Committee members should have access to appropriate clinical and operational expertise in order to inform their deliberations, subject to the CCG's policies on business standards and conflicts of interest requirements.

4.9 GP members shall not vote on any matter considered by the Committee. However, GP members shall participate in Committee discussions, subject to the CCG's policies on business standards and conflicts of interest requirements.

4.10 The Committee may call additional individuals to attend meetings on a case by case basis to inform discussion. The Committee may also invite or allow additional individuals to attend meetings on a regular basis. Attendees and additional members may present at Committee meetings and contribute to discussions, but are not allowed to participate in any vote.

4.11 The Committee may invite or allow people to attend meetings as observers. Observers may not present or contribute to any Committee discussion unless invited by the Chair of the Committee, and may not vote.

5. Meetings and Voting

5.1 Meetings of the Committee will be open to the public unless the Chair resolves that the public be excluded from the meeting, whether for the whole or part of the proceedings on the grounds that publicity would be prejudicial to the public interest or the interests of the CCG by reason of the confidential nature of the business to be transacted or for other

special reasons stated in the resolution and arising from the nature of the business to be transacted or the proceedings.

5.2 Meetings held in public will be referred to as Part 1 meetings. Meetings or parts of meetings held in private will be referred to as Part 2 meetings.

5.3 Non-voting members, observers and the public may be excluded from all or part of a meeting at the Chair's absolute discretion whenever the business to be considered would be prejudicial to the public interest by reason of:

5.3.1 The confidential nature of the business to be transacted

5.3.2 The matter being commercially sensitive or confidential

5.3.3 The matter being discussed is part of an on-going investigation

5.3.4 The matter to be discussed contains information about individual patients or other individuals which includes sensitive personal data

5.3.5 Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings is to be discussed

5.3.6 Other special reasons stated in the resolution and arising from the nature of that business or of the proceedings

5.3.7 Any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time

5.3.8 To allow the meeting to proceed without interruption, disruption and/or general disturbance

5.4 The Committee will operate in accordance with the CCG's Standing Orders. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as they shall specify.

5.5 The aim of the Committee will be to achieve consensus decision-making wherever possible with the show of hands. Each member of the Committee shall have one vote. The Committee shall reach decisions by a majority of members' present, subject always to the meeting being quorate. The Chair shall have a second and deciding vote, where the vote is tied.

5.6 If an urgent decision is needed prior to the next scheduled meeting and or it is not considered possible to call a full meeting, the Committee Chair may decide to convene a virtual meeting. The arrangements for such meeting will be determined by the Chair in discussion with the Executive Director of Corporate Affairs, but will normally include the invitation of all voting and non-voting members. Where possible the details of the meeting will be publicised in advance of the meeting unless the meeting is confidential or of such an urgent nature that it would not reasonably be possible to do so. In all other

respects the meeting will be managed in accordance with these Terms of Reference, as if it were a planned meeting of the Committee, including the minute taking and decision making. Any decision made virtually will be noted at the next available and appropriate meeting of the Committee.

5.7 All members (voting and non-voting) and any other participant in the discussions are required to declare any interest relating to any matter to be considered at each meeting, in accordance with the CCG's Constitution and the CCG's policies on business standards and managing conflicts of interest. At the sole discretion of the Chair, individuals who have declared an interest may be allowed to participate in the discussion but will not participate in any vote and may be requested to leave the meeting for any or all of the items in question.

6. Quorum

6.1 A quorum shall be four voting members, two of whom shall be independent or lay members, one shall be a CCG officer and one shall be a clinician. The clinician members of the committee are the Independent Nurse member of Governing Body, the Independent Secondary Care Doctor member of Governing Body and the Chief Nurse. For the avoidance of doubt, any other voting member of the committee who may also be clinically qualified, will not count as a clinician for the purposes of this committee or its quorum. Deputies are invited to attend in the place of the regular members as required.

6.2 Deputies approved by the Chair count toward quorum requirements

6.3 Whilst not part of the quorum, the Committee shall endeavour to always have a GP representative or a representative from the LMC in attendance, unless conflicts of interest precludes this.

6.4 At the discretion of the Chair, members who are not physically present at a Committee meeting but are present through tele-conference or other acceptable media, shall be deemed to be present and count towards the quorum as appropriate. In this, the Chair will consider an appropriate balance between demands on committee members (for instance during any period of major incident management) and the sizeable geography of the CCG, whilst ensuring ease of access to the meetings proceedings for members of the press and public.

6.5 If any representative is conflicted on a particular item of business they will not count towards the quorum for that item of business. If this renders a meeting or part of a meeting non quorate, a non-conflicted person may be temporarily appointed or co-opted to satisfy the quorum requirements, subject to the agreement of the Chair.

6.6 If a group of members are temporarily excluded due to a conflict of interest, and this results in a failure to meet the requirements of paragraph 6.1, with the agreement of the chair the requirement for that category of member to be present may be relaxed.

6.7 Members of the Committee have a collective responsibility for the operation of the

Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

7. Frequency and Notice of Meetings

7.1 The Committee shall meet monthly unless circumstances necessitate the need to meet more frequently as agreed by the Committee. Meeting venues will where possible rotate across Kent and Medway in accordance with the local agenda items.

7.2 Notice of any Committee meeting must indicate:

7.2.1 Its proposed date and time, which must be at least seven (7) days after the date of the notice, except where a meeting to discuss an urgent issue is required (in which case as much notice as reasonably practicable in the circumstances should be given)

7.2.2 Where it is to take place

7.2.3 An agenda of the items to be discussed at the meeting and any supporting papers

7.2.4 If it is anticipated that members of the Committee participating in the meeting will not be in the same place, how it is proposed that they should communicate with each other during the meeting

7.3 Notice of a Committee meeting must be given to each member of the Committee in writing.

7.4 Failure to effectively serve notice on all members of the Committee does not affect the validity of the meeting, or of any business conducted at it.

7.5 Where Committee meetings are to be held in public the date, times and location of the meetings will be published in advance on the CCG's website.

Where appropriate meetings held in public will be divided into two sessions:

7.6.1 Part 1a – first session to discuss Kent and Medway system agenda items

7.6.2 Part 1b – second session with a local focus on specific geographical area

7.6.3 The Chair will ensure that critical items of business from any part of the county are not delayed should the item apply to an area that is not the specific local focus for any given meeting.

8. Secretary

8.1 The Executive Director of Corporate Affairs or their nominated representative shall be the Secretary to the Committee and will ensure the provision of administrative support and advice. The duties of the Secretary include but are not limited to:

8.1.1 agreement of the agenda with the chair of the Committee and attendees together with the collation of connected papers;

8.1.2 taking the minutes and keeping a record of matters arising and issues to be carried forward.

9. Agendas and Circulation of Papers

9.1 Before each Committee meeting an agenda and papers will be sent to every Committee member and where appropriate published on the CCG website no less than five (5) Business Days in advance of the meeting.

9.2 If a Committee member wishes to include an item on the agenda they must notify the Chair via the Committee's Secretary no later than ten (10) Business Days prior to the meeting. In exceptional circumstances for urgent items this will be reduced to five (5) Business Days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Chair.

10. Minutes and Reporting

10.1 Minutes of the Committee shall be prepared by the Committee's Secretariat and submitted for agreement at the following Committee meeting.

10.2 A copy of the minutes and or a summary of Committee meetings will be presented the CCG Governing Body as appropriate. The approved minutes will also be made available to NHS England on request.

11. Conflicts of Interest

11.1 Conflicts of Interest shall be dealt with in accordance with the CCG policy on business standards and managing conflicts of interest.

11.2 The Committee shall have a Register of Business Interests that will be presented as a standing item on the Committee's agenda.

11.3 In accordance with 5.3, at the absolute discretion of the Chair, non-voting members may be excluded from all or any part of a meeting where the business to be considered would be prejudicial to the public interest. This includes issues of confidentiality and commercial sensitivity that may require GP members to be excluded as a result of any potential or actual conflict of interest.

12. Confidentiality

12.1 Members of the Committee shall respect the confidentiality requirements set out in the CCG's Standing Orders, relevant corporate policies and these Terms of Reference unless separate confidentiality requirements are set out for the Committee in which event these shall be observed.

12.2 Committee meetings may in whole or in part be held in private. Any papers relating to these agenda items will be excluded from the public domain. For any meeting or any part of a meeting held in private all attendees must treat the contents of the meeting, any discussion and decisions, and any relevant papers as confidential.

12.3 Decisions of the Committee will be published by the Committee except where matters under consideration or when decisions have been made in private and so excluded from the public domain in accordance with Clause 5 above.

13. Conduct of the Committee

13.1 The Committee shall undertake a self-assessment of its effectiveness on at least an annual basis. This may be facilitated by independent advisors if the Committee considers this appropriate or necessary.

13.2 Members of the Committee should aim to attend all scheduled meetings, but must attend at least 75% of scheduled meetings in any financial year.

13.3 Having due regard to clause 14.1, the Chair will reserve the right to refer a matter to the Governing Body should an item or issue arise where it is judged that the view of the Governing Body would secure essential good corporate governance and decision making.

13.4 Committee members, members and/or invited observers must maintain the highest standards of personal conduct and in this regard must comply with:

13.1.1 The laws of England and Wales

13.1.2 The spirit and requirements of the NHS Constitution

13.1.3 The Nolan Principles

13.1.4 The standards of behaviour set out in the CCG's Constitution and supporting documents and policies, as they would be reasonably expected to know

13.1.5 Any additional regulations or codes of practice relevant to the Committee

14. Sub-Committees

14.1 The Committee may not delegate to a Committee or Sub-committee any functions or

statutory responsibilities delegated to it by NHS England. The Committee may, however, appoint Sub-committees and/or working groups to advise and assist it in carrying out its functions.

14.2 The Committee may appoint tasks to such Sub-committees, working groups or individual members as it shall see fit, provided that any such appointment is consistent with NHS England regulations and the CCG's Constitution and associated documents and policies, including but not limited to Standing Orders, the Overarching Scheme of Reservation and Delegation and the Scheme of Delegated Financial Limits. Any such appointment shall be appropriately recorded by the Committee.

14.3 One or more Primary Care Operational Groups (PCOGs) may be established as a Sub-Committee of the Committee. The PCOG(s) will:

14.4.1 Provide a strategic forum to develop commissioning plans and commissioning opportunities for the development and delivery of high quality local primary care services

14.4.2 Oversee and co-ordinate the operational delegated arrangements, supporting the delivery of the delegated responsibilities relating to the commissioning of primary care medical services under section 83 of the NHS Act, and

14.4.3 Assure the day to day business associated with the commissioning and contracting of primary care medical services in line with delegated arrangements, and delivery of the delegated functions in line with the statutory framework.

14.4 Separate terms of reference will be compiled to cover the scope of the PCOG(s) and will be approved by the PCCC.

14.5 Officers of the Primary Care Commissioning Committee, who have the appropriate level of delegated authority, may be able to approve PCOG recommendations outside of the Committee meeting so long as they comply at the time with any requirements of the Committee and any relevant operational policies in place. These decisions will subsequently be acknowledged at the next available Committee meeting.

15. Review of Terms of Reference

15.1 The terms of reference of the Committee will be approved by Governing Body and shall be reviewed by the Governing Body at least annually.

Approved: August 2020

Version Control:

Version No	Amendment	Amendment Owner	Date of Amendment
1.0	Original Draft	Company Secretary	Dec 2019
1.01	Final Draft – Post GP Members and NHSE	Company Secretary	Feb 20
2.0	Approved Governing Body		02 April 2020
2.1	Content updated; 6.0, 7.6 Approved by Governing Body on 30 April 2020	Company Secretary	30 April 2020
2.3	Change in director titles	Exec Director of Corporate Affairs	August 2020

Annex A to Appendix 8 to
NHS Kent and Medway Clinical Commissioning Group Constitution

Delegated Functions

The following narrative forms Schedule 2 to the Delegation Agreement between NHS England and the Kent and Medway Clinical Commissioning Group pertaining to the delegation of primary care medical services to the CCG.

"Schedule 2

Delegated Functions

Part 1: Delegated Functions: Specific Obligations

1. Introduction

1.1. This Part 1 of Schedule 2 *(Delegated Functions)* sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Medical Services Contract Management

2.1. The CCG must:

2.1.1. manage the Primary Medical Services Contracts on behalf of NHS England and perform all of NHS England's obligations under each of the Primary Medical Services Contracts in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England;

2.1.2. actively manage the performance of the counter-party to the Primary Medical Services Contracts in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches and serve notice;

2.1.3. ensure that it obtains value for money under the Primary Medical Services Contracts on behalf of NHS England and avoids making any double payments under any Primary Medical Services Contracts;

2.1.4. comply with all current and future relevant national Guidance regarding PMS reviews and the management of practices receiving Minimum Practice Income Guarantee (MPIG) (including without limitation the *Framework for Personal Medical Services (PMS) Contracts Review* guidance published by NHS England in September 2014 (http://www.england.nhs.uk/wp-content/uploads/2014/09/pms- review-guidance-sept14.pdf));

2.1.5. notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the CCG of its obligations to perform any of NHS England's obligations under the Primary Medical Services Contracts;

2.1.6. keep a record of all of the Primary Medical Services Contracts that the CCG manages on behalf of NHS England setting out the following details in relation to each Primary Medical Services Contract:

2.1.6.1. name of counter-party;

2.1.6.2. location of provision of services; and

2.1.6.3. amounts payable under the contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.2. For the avoidance of doubt, all Primary Medical Services Contracts will be in the name of NHS England.

2.3. The CCG must comply with any Guidance in relation to the issuing and signing of Primary Medical Services Contracts in the name of NHS England.

2.4. Without prejudice to clause 13 *(Financial Provisions and Liability)* or paragraph 2.1 above, the CCG must actively manage each of the relevant Primary Medical Services Contracts including by:

2.4.1. managing the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance;

2.4.2. assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.4.3. managing variations to the relevant Primary Medical Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.4.4. agreeing information and reporting requirements and managing information breaches (which will include use of the HSCIC IG Toolkit SIRI system);

2.4.5. agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.4.6. conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.4.7. complying with and implementing any relevant Guidance issued from time to time.

Enhanced Services

2.5. The CCG must manage the design and commissioning of Enhanced Services,

including re-commissioning these services annually where appropriate.

2.6. The CCG must ensure that it complies with any Guidance in relation to the design and commissioning of Enhanced Services.

2.7. When commissioning newly designed Enhanced Services, the CCG must:

2.7.1. consider the needs of the local population in the Area;
2.7.2. support Data Controllers in providing 'fair processing' information as required by the DPA;
2.7.3. develop the necessary specifications and templates for the Enhanced Services, as required to meet the needs of the local population in the Area;
2.7.4. when developing the necessary specifications and templates for the Enhanced Services, ensure that value for money will be obtained;
2.7.5. consult with Local Medical Committees, each relevant Health and Wellbeing Board and other stakeholders in accordance with the duty of public involvement and consultation under section 14Z2 of the NHS Act;
2.7.6. obtain the appropriate read codes, to be maintained by the HSCIC;
2.7.7. liaise with system providers and representative bodies to ensure that the system in relation to the Enhanced Services will be functional and secure; and
2.7.8. support GPs in entering into data processing agreements with data processors in the terms required by the DPA.

Design of Local Incentive Schemes

2.8. The CCG may design and offer Local Incentive Schemes for GP practices, sensitive to the needs of their particular communities, in addition to or as an alternative to the national framework (including as an alternative to QOF or directed Enhanced Services), provided that such schemes are voluntary and the CCG continues to offer the national schemes.

2.9. There is no formal approvals process that the CCG must follow to develop a Local Incentive Scheme, although any proposed new Local Incentive Scheme:

2.9.1. is subject to consultation with the Local Medical Committee;
2.9.2. must be able to demonstrate improved outcomes, reduced inequalities and value for money; and
2.9.3. must reflect the changes agreed as part of the national PMS reviews.

2.10. The ongoing assurance of any new Local Incentive Schemes will form part of the CCG's assurance process under the CCG Assurance Framework.

2.11. Any new Local Incentive Scheme must be implemented without prejudice to the right of GP practices operating under a GMS Contract to obtain their entitlements which are negotiated and set nationally.

2.12. NHS England will continue to set national standing rules, to be reviewed

annually, and the CCG must comply with these rules which shall for the purposes of this Agreement be Guidance.

Making Decisions on Discretionary Payments

2.13. The CCG must manage and make decisions in relation to the discretionary payments to be made to GP practices in a consistent, open and transparent way.

2.14. The CCG must exercise its discretion to determine the level of payment to GP practices of discretionary payments, in accordance with the Statement of Financial Entitlements Directions.

Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients

2.15. The CCG must manage the design and commissioning of urgent care services (including home visits as required) for its patients registered out of area (including re-commissioning these services annually where appropriate).

2.16. The CCG must ensure that it complies with any Guidance in relation to the design and commissioning of these services.

3. Planning the Provider Landscape

3.1. The CCG must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to:

3.1.1. establishing new GP practices in the Area;
3.1.2. managing GP practices providing inadequate standards of patient care;
3.1.3. the procurement of new Primary Medical Services Contracts (in accordance with any procurement protocol issued by NHS England from time to time);
3.1.4. closure of practices and branch surgeries;
3.1.5. dispersing the lists of GP practices;
3.1.6. agreeing variations to the boundaries of GP practices; and
3.1.7. coordinating and carrying out the process of list cleansing in relation to GP practices, according to any policy or Guidance issued by NHS England from time to time.

3.2. In relation to any new Primary Medical Services Contract to be entered into, the CCG must, without prejudice to any obligation in Schedule 2, Part 2, paragraph 3 *(Procurement and New Contracts)* and Schedule 2, Part 1, paragraph 2.3:

3.2.1. consider and use the form of Primary Medical Services Contract that will ensure compliance with NHS England's obligations under Law including the Public Contracts Regulations 2015/102 and the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 taking into account the persons to whom such Primary Medical Services Contracts may be awarded;

3.2.2. provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

3.2.3. for the avoidance of doubt, Schedule 5 *(Financial Provisions and Decision Making Limits)* deals with the sign off requirements for Primary Medical Services Contracts.

4. Approving GP Practice Mergers and Closures

4.1. The CCG is responsible for approving GP practice mergers and GP practice closures in the Area.

4.2. The CCG must undertake all necessary consultation when taking any decision in relation to GP practice mergers or GP practice closures in the Area, including those set out under section 14Z2 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the Local Medical Committee.

4.3. Prior to making any decision in accordance with this paragraph 4 *(Approving GP Practice Mergers and Closures)*, the CCG must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on the GP practice's registered population and that of surrounding practices. The CCG must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the GP contractor as to how any closure or merger will be managed.

4.4. In making any decisions pursuant to paragraph 4 *(Approving GP Practice Mergers and Closures)*, the CCG shall also take account of its obligations as set out in Schedule 2, part 2, paragraph 3 *(Procurement and New Contracts)*, where applicable.

5. Information Sharing with NHS England in relation to the Delegated Functions

5.1. This paragraph 5 *(Information Sharing with NHS England)* is without prejudice to clause 9.4 or any other provision in this Agreement. The CCG must provide NHS England with:

5.1.1. such information relating to individual GP practices in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the performances of GP practices;

5.1.2. such data/data sets as required by NHS England to ensure population of the primary medical services dashboard;

5.1.3. any other data/data sets as required by NHS England; and

5.1.4. the CCG shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

5.2. The CCG must use the NHS England approved primary medical services dashboard, as updated from time to time, for the collection and dissemination of information relating to GP practices.

5.3. The CCG must (where appropriate) use the NHS England approved GP exception reporting service (as notified to the CCGs by NHS England from time to time).

5.4. The CCG must provide any other information, and in any such form, as NHS England considers necessary and relevant.

5.5. NHS England reserves the right to set national standing rules (which may be considered Guidance for the purpose of this Agreement), as needed, to be reviewed annually. NHS England will work with CCGs to agree rules for, without limitation, areas such as the collection of data for national data sets and IT intra-operability. Such national standing rules set from time to time shall be deemed to be part of this Agreement.

6. Making Decisions in relation to Management of Poorly Performing GP Practices

6.1. The CCG must make decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list).

6.2. In accordance with paragraph 6.1 above, the CCG must:

6.2.1. ensure regular and effective collaboration with the CQC to ensure that information on general practice is shared and discussed in an appropriate and timely manner;
6.2.2. ensure that any risks identified are managed and escalated where necessary;
6.2.3. respond to CQC assessments of GP practices where improvement is required;
6.2.4. where a GP practice is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and
6.2.5. take appropriate contractual action in response to CQC findings.

7. Premises Costs Directions Functions

7.1. The CCG must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

7.2. In particular, but without limiting the generality of paragraph 7.1, the CCG shall make decisions concerning:

7.2.1. applications for new payments under the Premises Costs Directions (whether such payments are to be made by way of grants or in respect of recurring premises costs); and

7.2.2. revisions to existing payments being made under the Premises Costs Directions.

7.3. The CCG must comply with any decision-making limits set out in Schedule 5 *(Financial Provisions and Decision Making Limits)* when taking decisions in relation to the Premises Costs Directions Functions.

7.4. The CCG will comply with any guidance issued by the Secretary of State or NHS England in relation to the Premises Costs Directions, including the Principles of Best Practice, and any other Guidance in relation to the Premises Costs Directions.

7.5. The CCG must work cooperatively with other CCGs to manage premises and strategic estates planning.

7.6. The CCG must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.

Part 2 – Delegated Functions: General Obligations

1. Introduction

1.1. This Part 2 of Schedule 2 *(Delegated Functions)* sets out general provisions regarding the carrying out of the Delegated Functions.

2. Planning and reviews

2.1. The CCG is responsible for planning the commissioning of primary medical services.

2.2. The role of the CCG includes:

2.2.1. carrying out primary medical health needs assessments (to be developed by the CCG) to help determine the needs of the local population in the Area;

2.2.2. recommending and implementing changes to meet any unmet primary medical services needs; and

2.2.3. undertaking regular reviews of the primary medical health needs of the local population in the Area.

3. Procurement and New Contracts

3.1. The CCG will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS

England from time to time.

3.2. In discharging its responsibilities set out in clause 6 *(Performance of the Delegated Functions)* of this Agreement and paragraph 1 of this Schedule 2 *(Delegated Functions)*, the CCG must comply at all times with Law including its obligations set out in the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 and any other relevant statutory provisions. The CCG must have regard to any relevant guidance, particularly Monitor's guidance *Substantive guidance on the Procurement, Patient Choice and Competition Regulations*

(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283505/SubstantiveGuidanceDec2013_0.pdf).

3.3. Where the CCG wishes to develop and offer a locally designed contract, it must ensure that it has consulted with its Local Medical Committee in relation to the proposal and that it can demonstrate that the scheme will:

3.3.1. improve outcomes;
3.3.2. reduce inequalities; and
3.3.3. provide value for money.

4. Integrated working

4.1. The CCG must take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Professional Networks, local authorities, Healthwatch, acute and community providers, the Local Medical Committee, Public Health England and other stakeholders.

4.2. The CCG must work with NHS England and other CCGs to co-ordinate a common approach to the commissioning of primary medical services generally.

4.3. The CCG and NHS England will work together to coordinate the exercise of their respective performance management functions.

5. Resourcing

5.1. NHS England may, at its discretion provide support or staff to the CCG. NHS England may, when exercising such discretion, take into account, any relevant factors (including without limitation the size of the CCG, the number of Primary Medical Services Contracts held and the need for the Local NHS England Team to continue to deliver the Reserved Functions)."

NHS Kent and Medway Clinical Commissioning Group Constitution

Definitions and Interpretation

The following narrative forms Schedule 1 to the Delegation Agreement between NHS England and the Kent and Medway Clinical Commissioning Group pertaining to the delegation of primary care medical services to the CCG. This provides the definitions used in Schedule 2 to the Delegation Agreement.

"Schedule 1

Definitions and Interpretation

In this Agreement, the following words and phrases will bear the following meanings:

Agreement	means this agreement between NHS England and the CCG comprising the Particulars, the Terms and Conditions and the Schedules;
Agreement Representatives	means the CCG Representative and the NHS England Representative as set out in the Particulars;
APMS Contract	means an agreement made in accordance with section 92 of the NHS Act;
Assigned Staff	means those NHS England staff as agreed between NHS England and the CCG from time to time;
Caldicott Principles	means the patient confidentiality principles set out in the report of the Caldicott Committee (December 1997 as amended by the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*) and now included in the NHS Confidentiality Code of Practice, as may be amended from time to time;
Capital	shall have the meaning set out in the Capital Investment Guidance or such other replacement Guidance as issued by NHS England from time to time;
Capital Expenditure Functions	means those functions of NHS England in relation to the use and expenditure of Capital funds (but excluding the Premises Costs Directions Functions);

Capital Investment Guidance	means any Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to: - the expenditure of Capital, or investment in property, infrastructure or information and technology; or - the revenue consequences for commissioners or third parties making such investment;
CCG Assurance Framework	means the assurance framework that applies to CCGs pursuant to the NHS Act;
Claims	means, for or in relation to the Primary Medical Services Contracts (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;
Claim Losses	means all Losses arising in relation to any Claim;
Complaints Regulations	means the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009/309;
Contractual Notice	means a contractual notice issued by NHS England to the CCG or all CCGs (as the case may be) from time to time and relating to the manner in which the Delegated Functions should be exercised by the CCG, in accordance with clause 24.3;
CQC	means the Care Quality Commission;
Data Controller	shall have the same meaning as set out in the GDPR;
Data Processor	shall have the same meaning as set out in the GDPR;
Data Subject	shall have the same meaning as set out in the GDPR;
Delegated Functions	means the functions delegated by NHS England to the CCG under the Delegation and as set out in detail in this Agreement;
Delegated Funds	shall have the meaning in clause 13.1;

Enhanced Services	means the nationally defined enhanced services, as set out in the Primary Medical Services (Directed Enhanced Services) Directions 2014 or as amended from time to time, and any other enhanced services schemes locally developed by the CCG in the exercise of its Delegated Functions (and excluding, for the avoidance of doubt, any enhanced services arranged or provided pursuant to the Section 7A Functions);
Escalation Rights	means the escalation rights as defined in clause 16 *(Escalation Rights)*;
Financial Year	shall bear the same meaning as in section 275 of the NHS Act;
GDPR	means the General Data Protection Regulation
GMS Contract	means a general medical services contract made under section 84(1) of the NHS Act;
Good Practice	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
Guidance	means any protocol, policy, guidance or manual (issued by NHS England whether under this Agreement or otherwise) and/or any policy or guidance relating to the exercise of the Delegated Functions issued by NHS England from time to time, in accordance with clause 24.4;
HSCA	means the Health and Social Care Act 2012;
HSCIC	means the Health and Social Care Information Centre;
Information Law	the GDPR, the Data Protection Act 2018, regulations and guidance made under section 13S and section 251 of the NHS Act; guidance made or given under sections 263 and 265 of the HSCA; the Freedom of Information Act 2000; the common law duty of confidentiality; the Human Rights Act 1998 and all other applicable laws and regulations relating to processing of Personal Data and privacy;

Law	means any applicable law, statute, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including, for the avoidance of doubt, the Premises Costs Directions, the Statement of Financial Entitlements Directions and the Primary Medical Services (Directed Enhanced Services) Directions 2014 as amended from time to time);
Local Incentive Schemes	means an incentive scheme developed by the CCG in the exercise of its Delegated Functions including (without limitation) as an alternative to QOF;
Local Terms	means the terms set out in Schedule 7 *(Local Terms)*;
Losses	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges;
National Variation	an addition, deletion or amendment to the provisions of this Agreement mandated by NHS England (whether in respect of the CCG or all or some of other Clinical Commissioning Groups) including any addition, deletion or amendment to reflect changes to the Delegation, changes in Law, changes in policy and notified to the CCG in accordance with clause 22 *(Variations)*;
National Variation Proposal	a written proposal for a National Variation, which complies with the requirements of clause 22.7;
Need to Know	has the meaning set out in paragraph 6.2 of Schedule 4 *(Further Information Sharing Provisions)*;
NHS Act	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 or other legislation from time to time);
NHS England	means the National Health Service Commissioning Board established by section 1H of the NHS Act, also known as NHS England;
Non-Personal Data	means data which is not Personal Data;
Operational Days	a day other than a Saturday, Sunday or bank holiday in England;
Particulars	means the Particulars of this Agreement as set out in clause 1 *(Particulars)*;

Party/Parties	means a party or both parties to this Agreement;
Personal Data	shall have the same meaning as set out in the General Data Protection Regulation and shall include references to Special Category Personal Data where appropriate;
Personal Data Agreement	means the agreement governing Information Law issues completed further to Schedule 4 *(Further Information Sharing Provisions)*;
Personnel	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
PMS Contract	means an arrangement or contract for the provision of primary medical services made under section 83(2) of the NHS Act (including any arrangements which are made in reliance on a combination of that section and other powers to arrange for primary medical services);
Premises Agreements	means tenancies, leases and other arrangements in relation to the occupation of land for the delivery of services under the Primary Medical Services Contracts;
Premises Costs Directions	means the National Health Service (General Medical Services Premises Costs) Directions 2013, as amended;
Premises Costs Directions Functions	means NHS England's functions in relation to the Premises Costs Directions;
Primary Medical Care Infrastructure Guidance	means any Guidance issued by NHS England from time to time in relation to the procurement, development and management of primary medical care infrastructure and which may include principles of best practice;

Primary Medical Services Contracts	means: - PMS Contracts; - GMS Contracts; and - APMS Contracts, in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements but excluding any Premises Agreements;
Prime Minister's Challenge Fund	means the Prime Minister's challenge fund announced in October 2013 to help improve access to general practice and stimulate innovative ways of providing primary care services;
Principles of Best Practice	means the Guidance in relation to property and investment which is to be published either before or after the date of this Agreement;
QOF	means the quality and outcomes framework;
Relevant Information	means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "To Share or Not to Share?");
Reserved Functions	means the functions relating to the commissioning of primary medical services which are reserved to NHS England (and are therefore not delegated to the CCG under the Delegation) and as set out in detail in clause 8.2 and Schedule 3 *(Reserved Functions)* of this Agreement;
Secretary of State	means the Secretary of State for Health from time to time;
Section 7A Functions	means those functions of NHS England exercised pursuant to section 7A of the NHS Act relating to primary medical services;
Section 7A Funds	shall have the meaning in clause 13.18.1;
Special Category Personal Data	shall have the same meaning as in GDPR;

Specified Purpose	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the CCG's Delegated Functions and NHS England's Reserved Functions as specified in paragraph 2.1 of Schedule 4 *(Further Information Sharing Provisions)* to this Agreement;
Statement of Financial Entitlements Directions	means the General Medical Services Statement of Financial Entitlements Directions 2013, as amended or updated from time to time;
Statutory Guidance	means any applicable health and social care guidance, guidelines, direction or determination, framework, standard or requirement to which the CCG and/or NHS England have a duty to have regard, to the extent that the same are published and publicly available or the existence or contents of them have been notified to the CCG by NHS England from time to time;
Survival Clauses	means clauses 10 *(Information Sharing and Information Governance),* 13 *(Financial Provisions and Liability),* 14 *(Claims and Litigation)* 17 *(Termination),* 18 *(Staffing),* 19 *(Disputes)* and 20 *(Freedom of Information)*, together with such other provisions as are required to interpret these clauses (including the Schedules to this Agreement); and
Transfer Regulations	means the Transfer of Undertakings (Protection of Employment) Regulations 2006, as amended."

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From: Clair Bell, Cabinet Member for Adult Social Care and Public Health

To: Kent and Medway Joint Health and Wellbeing Board – 20 July 2021

Subject: **Kent and Medway Joint Health and Wellbeing Board – Co-option of Members**

Classification: **Unrestricted**

Past Pathway of report: None

Future Pathway of report: None

Electoral Division: All

Summary: This report asks the Joint Board to consider re-appointing Dr Bob Bowes as a non-voting member for a further year to July 2022.

Recommendation(s):

The Joint Board is asked to consider and agree the re-appointment of Dr Bob Bowes as a non-voting member for a further year to July 2022.

1. Introduction

1.1 The Kent and Medway Joint Health and Wellbeing Board was established as a joint advisory committee of the health and wellbeing boards of Kent County Council and Medway under Section 198(c) of the Health and Social Care Act 2012 for a time limited period of two years commencing on 1 April 2018. On 18 February and 26 February 2020, the Health and Wellbeing Boards of Medway Council and Kent County Council respectively agreed to the continuation of the Joint Board together with the terms of reference and procedure rules set out in Appendix 1 of this report**.**

1.2 Paragraph 5(e) of the terms of reference of the Joint Board provide that it may appoint other persons to be non-voting members as it considers appropriate. In addition, paragraph 5(f) of the terms of reference provides that with the agreement of the Joint Board, voting or non-voting members from the new structures that are emerging in Health may also be included.

1.3 In accordance with this provision the Joint Board at its meeting on 28 July 2020 agreed that Dr Bowes be appointed in a non-voting capacity for a year to July 2021 to support to the clinical chair of the Kent and Medway CCG and in recognition of the work he had done on system transformation and with the Joint Board. (minute number 133 refers) This followed an earlier decision of the Joint Board on 14 December 2018 to appoint Dr Bowes as a voting member of

the Joint Board, in his capacity as Chairman of the Strategic Commissioner Steering Group. (minute number 645 refers)

1.4 This report asks the Joint Board to consider re-appointing Dr Bob Bowes as a non-voting member of the Board for a further year to July 2022.

2. Financial Implications

2.1 There are no financial implications arising from the implementation of the recommendation.

3. Legal implications

3.1 The legal and constitutional implications are set out in the paragraphs above.

4. Equalities implications

4.1 There are no equalities implications arising from this report.

5. Recommendation(s):

The Kent and Medway Joint Health and Wellbeing Board is asked to consider and agree the re-appointment of Dr Bob Bowes as a non-voting member of the board for a further year to July 2022.

6. Background Documents

6.1 Minutes of the meeting of the Kent and Medway Joint Health and Wellbeing Board held on 14 December 2018 and 28 July 2020.

6.2 Minutes of the Medway Health and Wellbeing Board 18 February 2020 and minutes of the Kent Health and Wellbeing Board 26 February 2020.

7. Contact details

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