Transforming health and social care in Kent and Medway

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To: Kent and Medway Joint Health and Well-Being Board

Subject: **Update on the establishment of a Kent and Medway Integrated Care System – August 2021**

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 – note the Bill has gone through its first and second stage reading in Parliament - 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. It should be noted that national guidance is being published on a weekly basis from mid-August through to mid-September so further verbal updates on any new material information will be provided at the meeting.

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 being published during late August / early September and should include:

- detailed governance arrangements of the new NHS Body – see below - as defined in a model constitution
- the national people (workforce) framework
- management of conflicts of interest guidance
- NHS 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 statutory NHS organisation to be known as an **Integrated Care Board** (ICB) 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 Committee, 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 a Joint Committee established by the relevant local authorities and the ICB, 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 act as a forum rather than a statutory board or committee. 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 ICB representation plus representatives, yet to be 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.

<u>The Integrated Care Board (ICB)</u>

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

- Establishing joint working arrangements with partners that embed collaboration as the basis for delivery of joint priorities. The ICB 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 NHSE.

The ICB 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 ICB 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 ICB 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. Importantly, these members, along with members of the ICS Partnership and other ICS bodies or groups as outlined below, will be able to include individuals from respective partner organisations to act in both decision making and advisory capacities.

Other local partnerships/organisations

- Place-based partnerships, historically known as local '**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 place based partnerships that have been evolving over the past couple of years. These are the engine room for local planning and delivery of services. Once fully developed, decisions will be increasingly made at place (rather than system) level 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 financial 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. Their internal governance arrangements are not affected by the NHS Bill.

People and culture

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. The ICB 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.

Employment commitment

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

The ICB 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 ICBs 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 ICB 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 ICB 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

NHS funding allocations will be made via the ICB 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 Body. It will be for the ICB 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 reviewed by 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 ICB model constitution

- Local functional design work, taking place from July through to October and
- Completion of the local system governance review which is currently underway

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 ICB 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 during 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

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Appendices:

Appendix 1: Kent and Medway, Integrated Care System Development Plan, 30 June 2021