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

Transforming health and social care in Kent and Medway

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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.

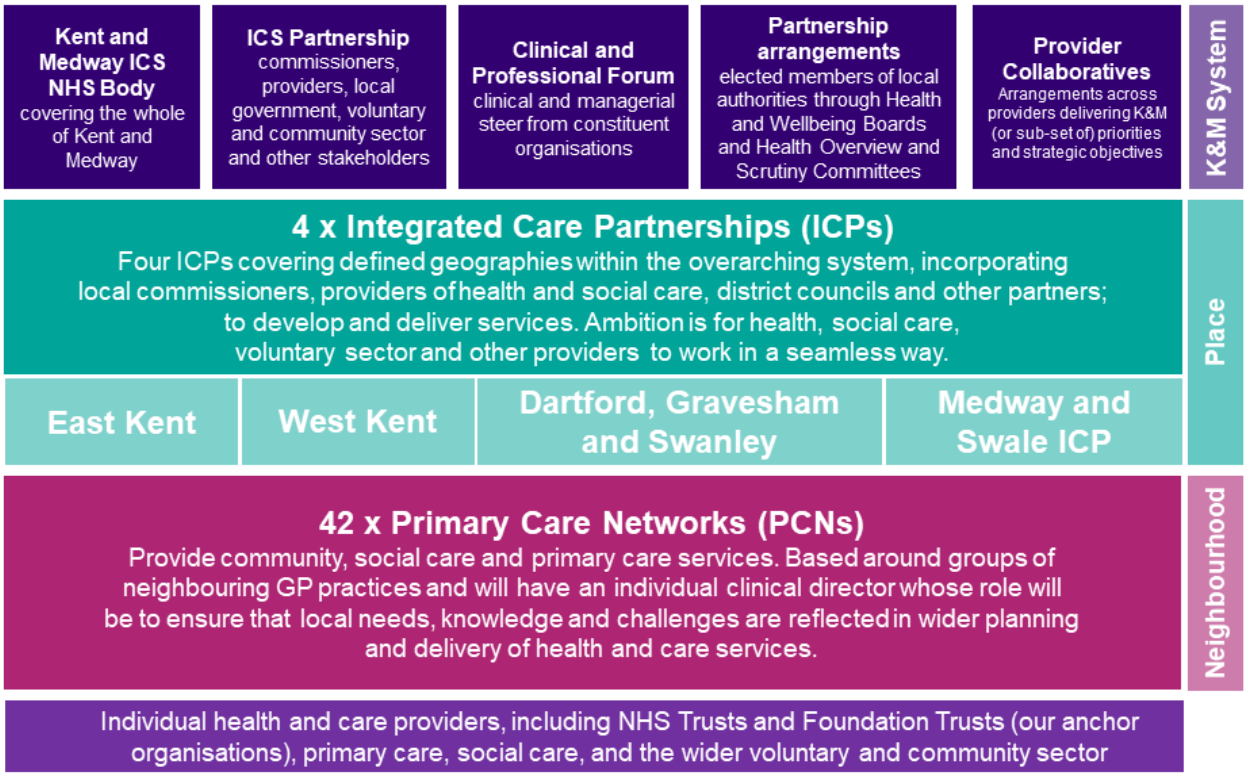
The system wide plans we are developing, as outlined in this plan and supporting documents, will secure the next stage of our transformation programme.

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.

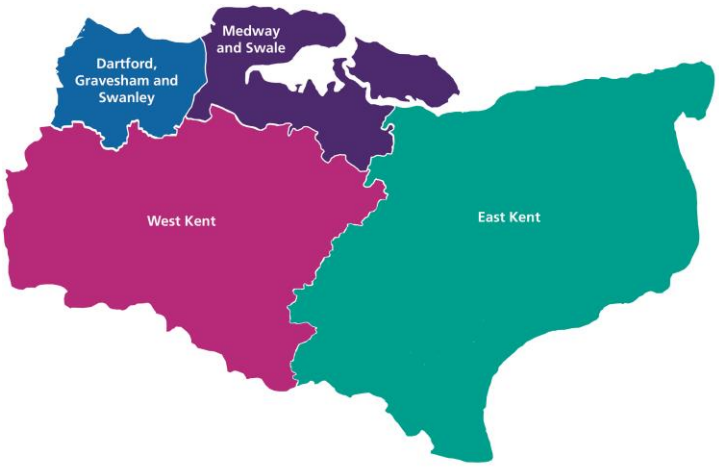
The **ICS NHS Body** is the statutory NHS organisation that will succeed Kent and Medway Clinical Commissioning Group (CCG). It will have the statutory responsibility for planning and securing services. However, it is not simply a replacement of the CCG: it will be a new organisation that brings together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

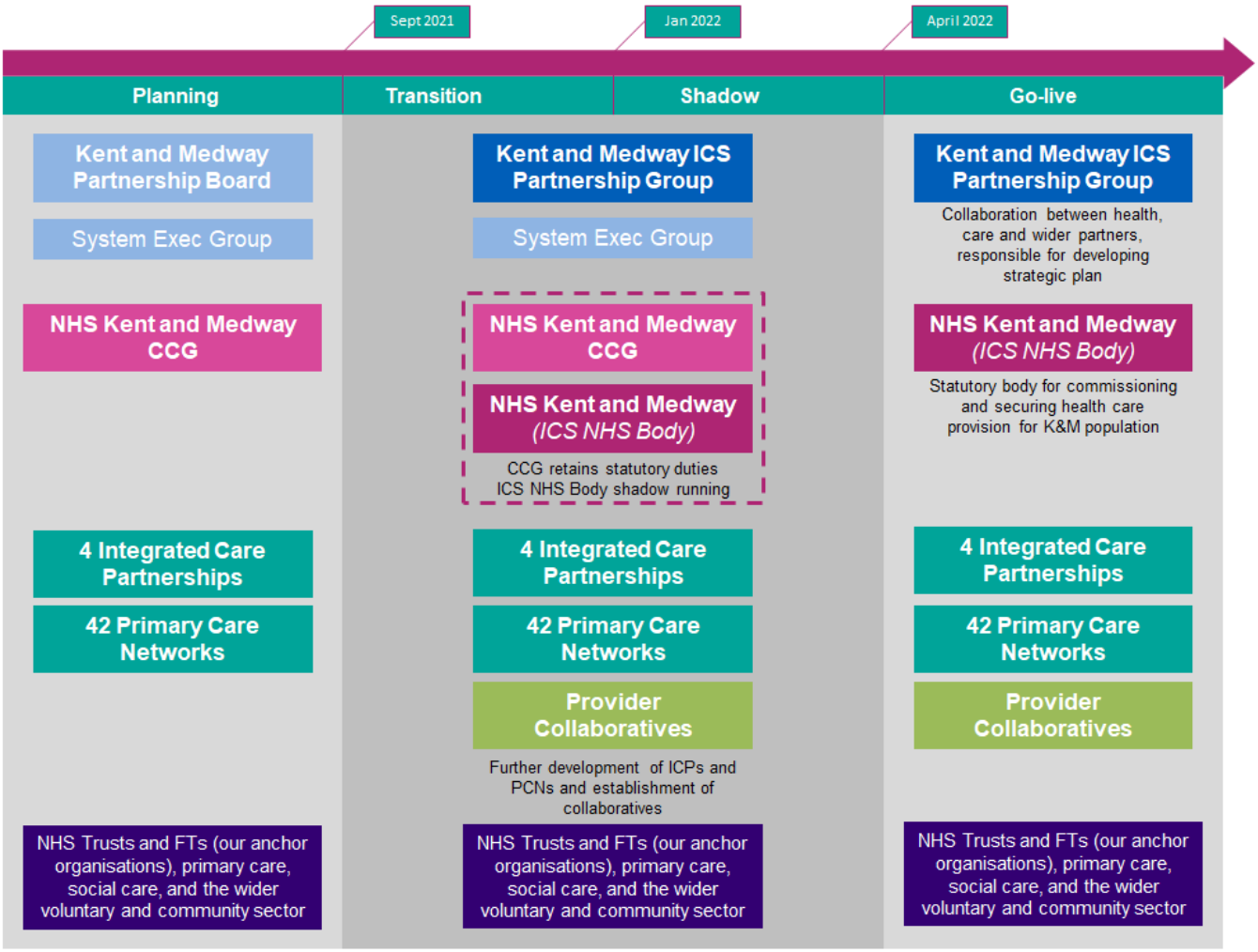
The ICS governance model is driven by the challenges we face and enables the solutions we need to succeed. The merger of the eight Kent and Medway CCGs in 2020 and the subsequent restructuring of the single organisation has been helpful for ICS transition and will support the requirement in the employment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



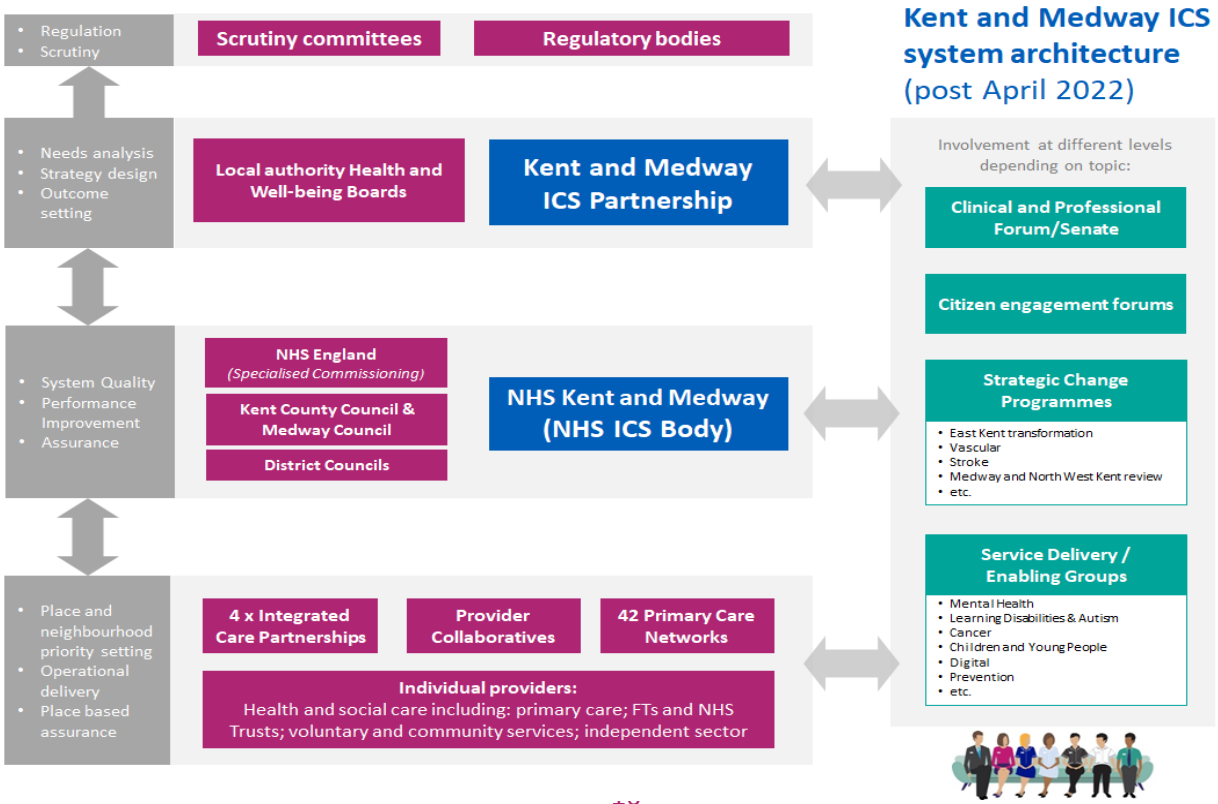
Critical path actions

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.