From: Roger Gough, Leader of the Council

Clair Bell, Cabinet Member for Adult Social Care & Public Health

To: County Council, 16 December 2021

Subject: **Health and Care Partnership Working with the Kent and Medway Integrated Care System**

Classification: Unrestricted

Summary:

This report provides an update on the progress of the development of the Kent and Medway Integrated Care System. County Council last received a report on 23rd July 2021 and asked to be kept informed of developments.

Recommendation

County Council is asked to note and consider the content of this report.

1. Background

1.1 County Council will recall that Integrated Care Systems (ICS) are being established in all areas of the Country. Integrated Care Systems are the overall partnership of health and care organisations that plan and deliver joined-up services to improve the health and wellbeing of people in their area. Integrated Care Systems, which have been operating as voluntary partnerships, will be placed on a statutory footing from April 2022.

1.2 This paper provides a progress report on the emerging architecture of the system in Kent and Medway and the governance arrangements that are in development to support it. Most of the recent developments remain focussed on NHS to NHS business, working out how the different NHS structures and tiers will relate to each other.

1.3 At the July County Council Members requested an update to include more detail on where the reforms impact on delivery of services and current and future opportunities for democratic input and public participation across the Integrated Care System. Much of this is still in development, is being shaped by interim national guidance and will be subject to the Health and Care Bill's passage through Parliament. This is the current position and Members will continue to receive updates as clarity emerges. It is important to note that local partnership working between NHS and KCC is well established and changes to joint service delivery are, of course, subject to Member oversight. Highlights of recent operational progress feature in the report.

2. Current National Context

2.1 The second reading of the Health and Care Bill is due to take place in the House of Lords on December 7. The Bill gives effect to policies set out as part

of NHS England's recommendations for legislative reform following the Long Term Plan and the Integration and Innovation White Paper. It will abolish clinical commissioning groups and replace them with Integrated Care Boards to commission hospital and other health services. It will establish Integrated Care Partnerships that bring together Integrated Care Boards and local authorities to produce an integrated care strategy for their area. New powers would be given to the secretary of state, including the power to direct NHS England, to intervene earlier in the reconfiguration of local NHS services and the NHS would no longer be subject to competitive tendering requirements and enforced competition between NHS providers.

2.2 Parts of the Bill have proved controversial. Following a government amendment at report stage in the House of Commons, means-tested financial support provided by a local authority towards an individual's personal care costs would not count towards the new £86,000 cap on care costs. The Bill has also faced criticism for introducing a major reorganisation of the NHS while it is still dealing with the effects of the coronavirus pandemic, and for not doing enough to address staffing shortfalls in the NHS and the social care sector. The Government sought to address some of these concerns through amendments during its passage through the House of Commons. However, it is anticipated that these concerns may mean the Bill is delayed in the House of Lords, putting into doubt the April deadline for Integrated Care Systems to be functioning as statutory organisations. If the Bill passes smoothly through Parliament, it is expected to receive Royal Assent no earlier than March 1st making it imperative that Systems already have the major building blocks in place and are ready to function from April 1st.

2.3 Beyond the details of the Parliamentary process there is no doubt that a new legislative framework is required. COVID-19 has reinforced the need for closer collaboration between the NHS, local authorities and care providers to provide more joined up working. But at times in recent years the legal framework has made this more difficult, as it was not designed with this type of collaboration in mind. Reorganisation of the NHS is not new. However, the fragility of our Health and Social Care System has become clear as the country continues to respond to the pandemic and the increasing demands of an ageing population. The reforms laid out in the Health and Care Bill aim to balance the demands made on health services by moving services out of pressured hospitals into the heart of local communities with the purpose of preventing ill health and serving people as close to where they live as possible (population health management). Partnership working is fundamental to the success of these reforms because it is acknowledged that supporting wellbeing and broader social and economic issues cannot be achieved by health and care services alone.

2.4 It should be recognised that reorganisation is a particularly challenging agenda for the NHS at this time as Covid-19 is still affecting capacity to deliver existing and current demands and systems are stretched. Winter pressures are expected and planned for but are especially acute this year and

have arisen from a unique and unprecedented set of circumstances. The NHS has reported that there are long waits for some services due to suppressed demand that could not be met during the pandemic and at the same time workforce shortages are being felt across the system. Demand on hospitals is also being driven by the reducing numbers of GPs and a shortage of staff working in primary care-including nurses, physiotherapist, and pharmacists. Social Care services are similarly affected and are struggling with capacity to meet demand to support hospital discharges and resource increased need for care and support during winter.

2.5 The Government has provided additional funding to the NHS and Social Care and is making plans to reform Social Care. The Government have introduced a 1.25% Health and Social Care Levy through increased National Insurance contributions. In the next 3 years the NHS is the main beneficiary to deal with the backlog of demand with £1.8bn of the £12bn expected to be raised going to Social Care annually. In Kent if we apply an illustrative 2.5% share of this investment, we could receive in the region of £135million in total over the next 3 years. Alongside this the Better Care Fund has been increased this year to continue driving integration between the health and social care system. The NHS contribution to the BCF is increasing by 5.3% in England. For KCC this meant an additional £1.9m for 2021/22.

2.6 However, public health has barely been mentioned in recent funding announcements, even though Covid-19 has highlighted health inequalities and the public health system has a role in tackling them as part of the recovery from the pandemic.

2.7 Alongside the Health and Care Bill and Social Care Reform, an Integration White Paper, expected by the end of the year, is likely to announce further moves to escalate the scale and pace of integration; this may introduce a national requirement to pool budgets with joint responsibility and accountability. There has been press speculation of the possibility of a single leader for the NHS and local care services, but this is not confirmed and would need careful consideration given the statutory duties placed on the Director of Adult Social Services.

3. Local response

3.1 In response to this challenging national and local context the Council and the NHS continue to work together to ease pressure in the system: - delivering integrated services, undertaking joint commissioning, and pooling funding as they have done for many years. At the July County Council meeting the Leader confirmed that joint working that benefitted residents continued to be a priority and would be overseen through the relevant Member governance routes. Activity since July is described below:

3.1.1 Winter planning, discharge from hospital, bed brokerage. The Adult Social Care Cabinet Committee received the Adult Social Care Pressures Plan 2021-2022 on 1 December 2021 detailing the

interdependencies with the NHS and the mitigating actions to cope with the expected challenges of Winter. The paper reports that the Directorate is managing increased waiting lists for services due to increasing demand and the workforce pressures which are being seen across multiple sectors, but which are particularly acute in health and social care. It describes several funding streams that have been made available to support the Adult Social Care Pressures Plan and winter resilience activities. Both the Infection Control Fund and Hospital Discharge Funding will continue until 31 March 2022 and will be used to support Kent's provider market and provide additional capacity in services. To date, KCC has received £10.3m for 1st April 2021 – 30 June 2021 and £7.7m for 1 July 2021 to 30 September 2021. Central government has made £11.9m available for 1st October to 31st March and has recently announced a further £4.2m to Kent from the Workforce Recruitment and Retention Fund. The purpose of this allocation is to support local authorities to address adult social care workforce capacity pressures in their geographical area through recruitment and retention activity this winter.

3.1.2 Mental health support for children and adults, including suicide prevention. A report came to the Kent and Medway Joint Health and Wellbeing Board on 7 December 2021 updating the Board on actions post Covid-19. The suicide prevention strategy has been presented at Health Reform and Public Health Cabinet Committee on 12 October. Work has started on the renewal of the jointly commissioned Community Mental Health and Wellbeing Services contract to start in 2023 and this was reported at the Adult Social Care Cabinet Committee on 29 September.

3.1.3 Improving neuro developmental pathways for children and young people. The latest development in this programme of work is a new service to support families build resilience and self-supporting strategies, which the NHS is contributing to. A report went to Children's, Young People and Education Cabinet Committee on 14 September 2021 for approval.

3.1.4 Developing population health management and a plan for tackling health inequalities. The first wave of the population health management programme is coming to an end and the learning from that programme will now be taken forward to inform the wider system. A report came to the Kent and Medway Joint Health and Wellbeing Board on 7 December 2021 detailing the next steps including the development of a system wide health inequalities strategic action plan. It is also expected that co-production will be a key principle underpinning this action plan and that local communities will be involved in its design and delivery.

3.1.5 Workforce planning. Workforce shortages will require a longer term solution to attract and train skilled staff. Health Overview and

Scrutiny Committee received a paper on 11 November 2021 detailing the workforce capacity issues that the System is facing in primary care and have asked for a follow up paper in March 2022.

3.1.6 Kent and Medway Care Record is established with plans to enable people to access their summary care record from April 2022.

3.1.7 The ongoing work that continues in response to the pandemic is reported at the Kent and Medway Joint Health and Wellbeing Board.

4. Latest Structural and Governance Developments in the Kent and Medway Integrated Care System

4.1 There have been several milestones set by NHS England which systems have been expected to meet, with initial focus on developing the operating environment for the new organisation. The Integrated Care System and its component parts must be ready to operate by April 2022.

4.2 The four core purposes of the Integrated Care System are:

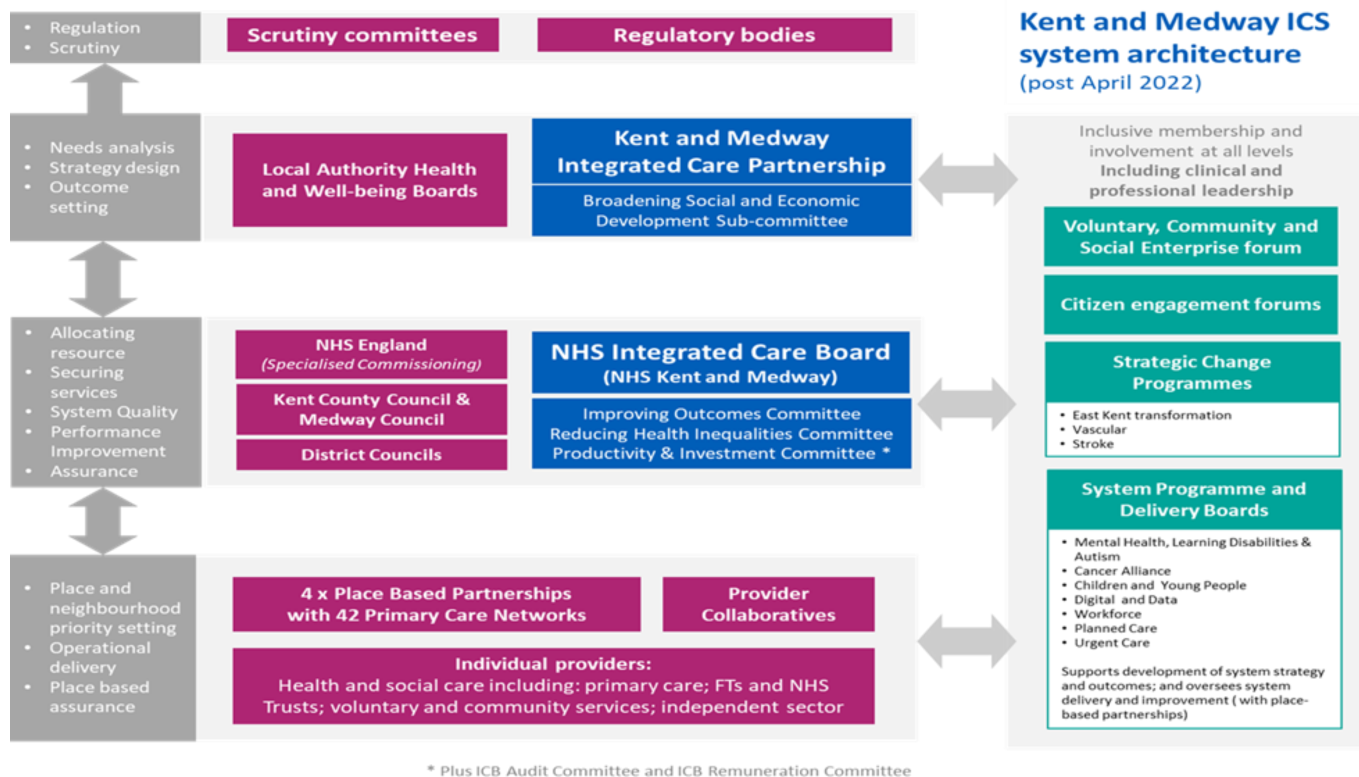
- Improving outcomes in population health and healthcare
- Tackling inequalities in outcomes, experience, and access
- Enhancing productivity and value for money
- Supporting broader social economic development.

To enable it to fulfil its core purposes the Integrated Care System will have:

- An Integrated Care Partnership (ICP) responsible for promoting health, care, and wellbeing.
- An NHS focussed Integrated Care Board (ICB).
- 4 Partnerships at place level.
- 42 Primary care networks operating at neighbourhood level.

4.3 Senior leadership appointments have started to be confirmed with Mr Cedi Frederick confirmed as Chair of the Integrated Care Board, and Mr Paul Bentley (currently CEO of Kent Community Health Foundation Trust) appointed as Chief Executive of the Integrated Care Board.

4.4 The Kent and Medway proposed system architecture is as shown in the diagram below. The name of each tier has been discussed by the Integrated Care System Partnership Board since the July County Council meeting and the names proposed here are expected to be the final ones.



4.5 Integrated Care Partnership: This is expected to be known publicly as Kent and Medway Health and Care Partnership Committee

4.5.1 Integrated Care Partnerships are statutory joint committees to be established by the NHS Integrated Care Board and both Kent and Medway local authorities as equal partners. The role of the Integrated Care Partnership is to bring together, as a minimum, partners from health, adult social care, public health, the voluntary and community sectors, and the views of people who use health and care services and communities. Its primary responsibility will be to develop and oversee the delivery of an integrated care strategy to address the health, social care and wellbeing needs of the local population**.**

4.5.2 The Integrated Care Partnership meeting of the system leaders will be known locally as the Kent and Medway Health and Care Partnership Committee. This committee will incorporate two existing Boards- the Kent and Medway Joint Health and Wellbeing Board and the Integrated Care System Partnership Board.

4.5.3 Membership of the Committee has been **proposed** as follows (to be agreed by NHS Integrated Care Board, Kent County Council and Medway Council):

- Rotational (KCC / Medway) local authority elected member chair
- Inclusive membership of all stakeholders who have a vested interest in the development and oversight of the Integrated Care Strategy. Whilst membership options are being considered this will likely include:
    - Elected Members of the Local Authorities (upper and lower tier)

- Clinical and professional leaders including Social Care and Public Health
- Place-based partnerships
- Integrated Care Board, NHS and other healthcare partners, including primary care and Primary Care Networks
- Voluntary, Community and Social Enterprise sector
- Patient and Public representation, including Healthwatch
- Representatives from other sectors that directly impact on population well-being, such as housing, leisure, education, etc

4.5.4 There will be further work to agree local terms of reference and an operating framework for this committee remembering that the Integrated Care Partnership's central role is in the planning and improvement of health and care. Its role should be to support place-based partnerships and coalitions with community partners which are well-situated to act on the wider determinants of health in local areas. The Integrated Care Partnership should bring the statutory and non-statutory interests of places together.

4.5.5 The Integrated Care Partnership will be required to develop an integrated care strategy to address the broad health and social care needs of the population within the area, including the wider determinants of health such as employment, environment, and housing issues. The Integrated Care Board, Kent County Council and Medway Council will be required by law to have regard to the Integrated Care Strategy when making decisions, commissioning, and delivering services.

4.5.6 The Integrated Care Partnership is expected to highlight where coordination is needed on health and care issues and challenge partners to deliver the actions required. These include the following areas which also reflect the priorities of KCC and the Health and Wellbeing Strategy and are therefore welcomed as system wide priorities:

- helping people live more independent, healthier lives for longer
- taking a holistic view of people's interactions with services across the system and the different pathways within it
- addressing inequalities in health and wellbeing outcomes, experiences and access to health services
- improving the wider social determinants that drive these inequalities, including employment, housing, education environment, and reducing offending
- improving the life chances and health outcomes of babies, children and young people
- improving people's overall wellbeing and preventing ill-health

4.5.7 The Integrated Care Partnership should complement place-based working and partnerships, developing relationships and tackling issues that are better addressed on a bigger area. As part of the development of the Integrated Care System, places are expected to play a central role in population health

management, the planning and improvement of health and care, joined up service provision, and to build broader coalitions with community partners to promote health and wellbeing. The principle of subsidiarity should be a driving force to ensure that decisions are taken at the most appropriate geography.

4.5.8 The role of Health and Wellbeing Boards in the new system architecture is not clearly defined but it is expected that the Health and Wellbeing Board will develop working arrangements with the Integrated Care System and particularly work with the Integrated Care Partnership. This is especially important where there is more than one Health and Wellbeing Board in the system as there is in Kent and Medway. Effective collaboration is important so that joint strategic needs assessments and joint health and wellbeing strategies can shape the integrated care strategy. Health and Wellbeing Boards also have a role to ensure that the voices of people who use services and carers, local communities, and the voluntary and community sector, are included in the Integrated Care Partnership and its strategy. The Kent Health and Wellbeing Board has delayed refreshing the Kent Health and Wellbeing Strategy in order to produce a timely document that reflects the significant learning and progress the system is making in understanding health inequalities. The population health management programme, the health inequalities action plan currently in development, the new integrated care strategy and the Health and Wellbeing Strategy should all come together to provide a suite of strategic documents that direct and drive the activity of the System and all partners to improve outcomes.

4.6 Integrated Care Board: This will be known as NHS Kent and Medway

4.6.1 Integrated Care Boards are statutory bodies which bring NHS organisations and ‘partner members’ together to improve population health and care. The Integrated Care Board will succeed the CCG and it will be a new organisation. NHS national interim guidance says that their functions include allocating resources, financial accountability, establishing joint working arrangements with partners, and leading system-wide action on workforce, digital and data capabilities, estates, and procurement.

4.6.2 Development of the Integrated Care Board is progressing locally with agreement in principle that this will be a strategic health and care board responsible for overseeing the above functions. National guidance is clear that Elected Members cannot be members of the Integrated Care Board and recommends local authority membership is from a Chief Executive or Corporate Director. It should be noted however that whilst individuals will bring expertise from their field, each member will be required to demonstrate the strength and depth of understanding of the broader total health and care agenda at the requisite system leadership level to be able to undertake the role. All members will have role descriptions that include minimum essential criteria around system level leadership, knowledge and understanding and appointment will be through an agreed nomination and selection process including assessment against the role description and the fit and proper

persons' test. Integrated Care Board Members will not be appointed based on organisational or place representation: as a unitary Board, the expectation is that every member contributes and makes decisions based on the requirements of the entire health and care system.

In Kent and Medway membership from the Local Authority is proposed as the Statutory Director of Adult Social Care who will be a member and the Director of Public Health who will be a participant as described by the Bill. This arrangement may be mirrored by Medway Council and matches interim guidance. The difference between a member and a participant is to do with the definition of voting rights to ensure parity across the partners

4.6.3 The Integrated Care Board will have three primary committees (in addition to required statutory committees), aligned to reducing inequalities, improving performance and enhancing efficiency. There will also be system programme boards for key strategic service areas such as mental health, children and young people, cancer services and workforce and digital to support development of strategic priorities and outcomes and to oversee system implementation and delivery. This will provide further opportunities for health and care to explore and agree how more joined up service delivery and joint commissioning could be developed.

Membership of these committees is currently being discussed but some committees could include Elected Members as well as Chief Officers. The proposed responsibilities of the three primary committees are shown below but, again, it should be noted that the terms of reference as well as membership are still in development

i) Kent and Medway Integrated Care: Improving Outcomes Committee (Working Title)

This committee will play a significant role in performance measurement of the Integrated Care Board including

- Overseeing delivery of outcomes related to the wider integrated care strategy including clinical and performance outcomes as set by the system in the locally determined domain of the System Oversight Framework. The System Oversight Framework is used by the NHS to measure how Integrated Care Systems align to the five national themes of quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability.
- Reviewing system quality, safety, safeguarding and patient experience
- Reviewing system performance delivery, with a focus on the impact of unwarranted variation in access and waiting times on quality, patient experience, and outcomes
- Delegated authority from Integrated Care Board for decision making for related responsibilities

- Mandated quality and safety groups such as Local Maternity Services oversight, safeguarding, etc. could be sub-committees

ii) KM Integrated Care – Population Health and Inequalities Committee (working title).

This Committee will oversee the work described in the July paper and at paragraph 3 above relating to the development of a population health management approach. It is proposed that this Committee will also report to the Integrated Care Partnership and support the work to develop and deliver the Integrated Care Strategy.

Its proposed responsibilities will be to

- Develop and recommend strategy and outcomes to address the slope index of widening health inequalities
- Develop the framework for how population health management will be used at system, place, neighbourhood, and provider layer
- Develop, recommend, and oversee delivery of population health and prevention programmes
- Monitor place-based delivery of the above
- Include development of strategic transformation plans that sit outside of any other dedicated committee, where they impact on health inequalities
- Delegated authority from Integrated Care Board for decision making for related functions / programme areas

iii) KM Integrated Care - Productivity and Investment Committee (working title)

- Oversees system financial allocations and investment
- Oversees delivery of productivity and value for money
- Considers system investment cases where this is outside of another groups delegated authority
- Delegated Authority to make decisions on behalf of Integrated Care Board to an agreed limit

Integrated Care Boards will be expected to delegate functions and budgets to place-based partnerships whilst maintaining overall accountability for NHS resources. The Integrated Care Board will have a statutory duty to meet the system financial objectives which will require financial balance to be delivered. This will require collaborative working to develop a shared financial framework and system wide plan. The internal NHS contractual arrangements will continue to require Integrated Care Boards and Places to sign and act in accordance with an overarching system collaboration and financial management agreement, which sets out how they will work together to achieve system financial balance. In Kent and Medway, a System Finance Group has been established and is working on developing the system financial plans for 22/23 including the proposed management of the potential

risks and implementing an agreed financial framework and set of principles to enable resource management and ownership at place based footprints. This will need to be delivered whilst maintaining the NHS system control total. The financial framework will need to balance core business activity and transformation work. It will need to determine how to:

- distribute funds to address inequality,
- distribute funds across settings such as primary care, mental health and acute or secondary care and
- distribute funds across issues and disease profiles such as tackling diabetes or prevention work

This committee will be predominantly, in the first instance, NHS to NHS business as it deals with NHS core funding. Further work will progress to the collective management and distribution of 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.

For example, as part of the agreed principles the Kent and Medway System has proposed that a place based partnership can move up to £1m around in the base budget to align to priorities or pressures and agree new schemes up to £500k without further governance. This is referring to NHS budgets only but provides an indication of how subsidiarity of decision making, deciding as close to those communities affected as possible, is being considered and acted on.

5. The 4 geographical place based partnerships from which most health services will be planned and delivered are expected to be called:

- East Kent Health and Care Partnership
- Medway and Swale Health and Care Partnership
- West Kent Health and Care Partnership
- Dartford, Gravesham and Swanley Health and Care Partnership

5.1 There will be four established partnerships at place level, all with locally agreed priorities and a local governance architecture that has been evolving in most cases since 2019. Places are the engine room for delivering more joined up integrated care and tackling local health inequalities - increasingly we will see joint working around a place to enhance integration and improve outcomes with clinical and public input at the heart of these decisions

5.2 Places are defined as consisting of all relevant local partners who have a valuable role to play in integrating care and improving health and well-being within a defined geography at place level, incorporating neighbourhoods/Primary Care Networks. It will be for local partners to determine local membership and each place will be undertaking further work on their detailed governance architecture, membership and representation models between now and the end of March.

5.3 There are currently 42 Primary Care Networks covering the whole population of 194 GP practices. They 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, KCC and the voluntary sector to support effective care delivery. They are a key building block in the place based agenda.

5.4 More detail has emerged since July on the role of places. Their purpose is to work collaboratively to:

- Set local priorities. The setting of local priorities and the coordination of place level planning will be an integrated process, involving all Place level partners alongside engagement with local people.
- Integrate care locally. Places will focus on redesigning pathways so that patients get the best care from the most appropriate services within the partnership, delivered in the right place. Decision making around service delivery should take place as close as possible to local communities.
- Deliver plans to address health inequalities. Places will deliver new models of care focused on addressing health and care inequalities that join up services across boundaries and follow the person
- Contribute to the transformation of commissioning. The Place level will support the development of new approaches to commissioning with the focus on service improvement, pathway redesign and transformation of delivery

6. Developing Public Participation in the Integrated Care System

6.1 The Integrated Care System is currently co-designing an Engagement Framework with partners, including the public and voluntary and community sector:

- A Kent and Medway Health and Care Public Engagement Forum will be established.
- There will be involvement from, and representatives of the public and voluntary and community sector voice, at system, place and neighbourhood level.
- The voice of people in Kent & Medway will be played into:
  - The Integrated Care Partnership
  - The Board of the Integrated Care Board
  - Committees of the Integrated Care Board, including Primary Care Commissioning Committees
  - Place-based partnerships
  - ICS programme boards

7. Conclusion

7.1 The delivery of health and care partnership working will always need to be underpinned by strong relationships, shared ambition, and agreed priorities

with a focus on improving patient outcomes and the overall health and wellbeing of local populations. The transition to the new Integrated Care System arrangements will take time and new relationships will need to be established and mature**.** The ambition is for health and social care providers to work in a seamless way - partnerships will require strong joint working with both upper tier authorities and borough councils to deliver joined up care. This paper has described the emerging formal foundations that will underpin those strong joint working relationships and take us into the future. We are making good progress at a challenging time but there is more to do.

Recommendation:

County Council is asked to note and consider the content of this report

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