From: Roger Gough, Leader of the Council
Clair Bell, Cabinet Member for Adult Social Care & Public Health

To: County Council 26 May 2022

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

Classification: Unrestricted

Summary: KCC is committed to work in partnership to improve the health outcomes of our residents through stronger integrated working arrangements that focus on wellbeing and the prevention of ill health.

Achieving the scale of ambition set out in the Health and Care Act requires substantial and long-term commitment not only from Government but from local government and NHS leaders at every level – national, regional, system, place and neighbourhood.

This paper provides the latest in a series of progress reports setting out how KCC will work with the Kent and Medway Integrated Care System and how it intends to act as a partner at both System and Place level. It builds on the extensive partnership working that has taken place to prepare for 1st July 2022, when the Kent and Medway Integrated Care System becomes fully operational.

The paper focuses on strategic arrangements and aims to put in place the correct foundations for joint working, decision making and Governance at a System level. These foundations are captured in the Draft Terms of Reference attached for approval by County Council.

This work will underpin how the Statutory Partners, KCC, NHS and Medway Council will work together moving forward. It creates a framework in which we can come together to fundamentally rethink the way health and social care services are provided and to deliver more preventative, coordinated care to the population we support.

Recommendations:

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

County Council is asked to approve the draft Terms of Reference for the Integrated Care Partnership Committee as found at Appendix 2

1. Background

1.1 The Health and Care Bill is now an Act of Parliament after it received Royal Assent on 28 April. County Council will recall that Integrated Care Systems (ICS) are being established in all areas of the Country as set out in the Act. Integrated Care Systems are partnerships of health and care organisations that plan and deliver joined-up services to improve the health and wellbeing of people in their area. The planned implementation date is 1st July 2022.

1.2 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.

1.3 The structure of the emerging Kent and Medway Integrated Care System is shown in Figure One below. Creating the architecture and governance arrangements for the Integrated Care System continues to be a complex and challenging agenda with a great deal of technical detail involved. KCC is legally required to participate in the Integrated Care System as an equal and significant partner. However, it is also vital for KCC to be fully engaged in the development of its operating framework to influence and shape the priorities, activity and commissioning decisions that will play a major part in the future health and wellbeing of our residents.

1.4 There are two parts to an Integrated Care System. The first part is the integrated care partnership, or ICP: a broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS. The second part is a statutory body, the integrated care board, or ICB: the ICB will be responsible for the commissioning of healthcare services in that ICS area, bringing the NHS together locally to improve population health and care.

1.5 The roles of the ICP and the ICB are distinct and complementary in supporting the objectives of the ICS. The ICB is an organisation designed to align the planning and operation of NHS care and is accountable for NHS expenditure. The ICP will provide a forum for NHS leaders and local authorities to come together, as equal partners, with important stakeholders from across the system and community. Together, the ICP will generate an integrated care strategy to improve health and care outcomes and experiences for their populations, for which all partners will be accountable.

1.6 The Integrated Care Partnership is also expected to highlight where coordination is needed on health and care issues and challenge partners to deliver the action required. These include, but are not limited to:

- helping people live more independent, healthier lives for longer
- taking an overview 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

2 Latest National Context

2.1 The Health and Care Act is part of the wider set of mutually reinforcing reforms that include the Integration White Paper, *Health and Social Care Integration: joining up care for people, places and populations* and the adult social care reform white paper. A white paper tackling Health Disparities is also expected later this year.

2.2 The Integration White paper is significant as it sets out plans to join up care for:

- patients and service users
- staff looking for ways to better support increasing numbers of people with care needs
- organisations delivering these services to the local population

2.3 The White Paper proposals are summarised in Appendix 1. These proposals give added significance to the role of Places: in Kent and Medway Places equate to our 4 Health and Care Partnership areas.

- Dartford, Gravesham and Swanley
- West Kent
- East Kent
- Medway and Swale

2.4 The Integration White Paper will shape how the Kent and Medway System will operate and it provides both opportunities and challenges for KCC. For example:

i. The focus on a geographical Place as the key delivery mechanism. The expectation set out in the White Paper is that all local areas should aim to manage services and have associated budgets by 2026. In Kent this could provide opportunities for KCC to work in new ways with the 4 Health and Care Partnerships to build local pathways of care and encourage investment in community and preventative services.

ii. To achieve this Places are expected to accelerate the routine pooling and alignment of “a significant and in many cases growing proportion” of NHS and social care budgets. Places will need to develop ambitious plans to increase the scope and proportion of health and care activity and spend to be overseen by and funded through ‘place-based’ arrangements. While the paper states that “eventually” pooled budgets and aligned financial arrangements will cover much health and care funding at place level, the Government says it will not, at this stage mandate how this is achieved.

iii. The hope is for a widespread shift in spending and prioritisation from the treatment of illness towards preventing it in the first place. This provides KCC with opportunities to consider potential innovative joint funding arrangements to drive forward improvement. The White Paper has clear ambitions regarding the future of joint resourcing arrangements at a local level. However, to meet the scale of the ambitions described considerable work needs to be undertaken at a national and local level to determine how this might work. Indeed, it may well need further/additional primary legislation regarding local authority funding arrangements to enable this.

iv. Mechanisms do already exist to support limited pooled funding arrangements and there are plans to make it easier for local systems to enter into such agreements. The Better Care Fund was created in 2013 by Government and requires the NHS and local government to create a local single pooled budget to incentivise closer working around people, placing their wellbeing as the focus of health and care services, and shifting resources into social care and community services for the benefit of the people, communities and health and care systems. Later this year, the Government will set out a new policy framework for the Better Care Fund from 2023, including how the programme will support the implementation of integration at place level, it will also review regulations underpinning section 75 arrangements and publish revised guidance. Section 75 agreements are made between local authorities and NHS bodies and can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partner/s.

v. The government expects all places to have "a single person, accountable for shared outcomes" by Spring 2023. This person will be agreed by the relevant Local Authorities and the integrated care board and could be an individual with a dual role across health and care or an individual lead for a place-based Board. Local authority and NHS accountabilities remain unchanged. In Kent and Medway there would be 4 individuals. The role, responsibility and accountability of these posts will need to be carefully considered to make them meaningful and trusted resources for the System. This may be a particular challenge for the Medway and Swale Health and Care Partnership which is not co-terminous with the Local Authority boundaries of Medway Council and KCC.

vi. The expanding role of CQC will task CQC with considering progress on outcomes agreed at place level as part of its assessment of Integrated Care Systems. KCC will be expected to be a strong and significant partner in delivering against these agreed outcomes

3 Latest Developments in Kent and Medway

Since the last report to County Council the Integrated Care System has been developing its governance arrangements and structures to enable it to fulfil its purposes. Progress includes arrangements for:

3.1 The Integrated Care Partnership Committee (ICP). It has been agreed that

i. It will be chaired by KCC and Medway Council Leaders on a rotational basis of 2 years at a time, with the Leader who is NOT the chair acting as Vice-chair. It has been agreed that KCC's Leader will act as chairman for the first two years with Medway Council's Leader acting as Vice-chair. Along with the ICB Chair Designate they will form a coherent leadership group setting the vision and purpose for the Integrated Care Partnership.

ii. The draft Terms of Reference for the Integrated Care Partnership Committee must be presented to the 3 statutory partners, KCC, Medway Council, and the NHS Integrated Care Board for approval. They are attached at Appendix 2 for approval by Full Council.

iii. There will be a shadow meeting of the Committee in June 2022. The Integrated Care Partnership Committee will then meet monthly until December 2022 to support the development of the Integrated Care Strategy. Government has set a deadline that integrated care strategies should be published by December.

iv. Integrated Care Partnerships are encouraged to form relationships with a range of other stakeholders appropriate to the places they cover, by either inviting them to be members of the ICP committee or engaging with them in other ways. This is because only 10 to 20 percent of good health is considered to come from medical interventions. The other 80 to 90 percent is associated with health-related behaviours, socioeconomic factors, and environmental factors. Therefore, without the involvement of the district, borough, town and parish councils a huge opportunity will be missed to truly improve the health and wellbeing of our population.

v. To take account of this requirement to include the broadest Membership the ICP Committee will also include the Voluntary Sector and Healthwatch. However, there is also a consensus that a subcommittee will be established to inform the development of the integrated care strategy and address the wider determinants of health such as economic and social wellbeing. It is planned that Membership of this subcommittee will include a wide range of partners with expertise including employment, community safety, housing, economic development, environment, leisure and planning.

3.2 The Integrated Care Board (ICB).

The NHS are developing the operationally focussed ICB, taking on the functions of the current CCG with additional responsibilities passed down from NHS England/Improvement. The Corporate Director for ASCH and the Director of Public Health are expected to be members of the ICB. One will be a voting Member and one will be a participant or non-voting member. The ICB will also have a subcommittee focussed on population health outcomes and health inequalities that will work closely with the Integrated Care Partnership and its planned subcommittee on the social and economic causes of inequality.

3.3 Health and Care Partnerships and Provider Collaboratives: In development

i. Partnerships at place level are known in Kent and Medway as Health and Care Partnerships. These are in development and over time will become the engine room for delivering more joined up integrated care and tackling local health inequalities. The details are still in development and will be the subject of further progress reports to County Council. Currently it is expected that the local Area Director for Adult Social Care and Health and a Public Health Consultant will attend these Boards.

ii. Children's services and services for people with learning disabilities, mental health problems or autism may be delivered through county wide arrangements called Provider Collaboratives – this is still very early thinking- as is KCC's involvement and representation. Provider collaboratives are

partnerships that bring together two or more NHS trusts (public providers of NHS services including hospitals and mental health services) to work together at scale to benefit their populations. While providers have worked together for many years, the move to formalise this way of working is part of a fundamental shift in the way the health and care system is organised, moving from an emphasis on organisational autonomy and competition to collaboration and partnership working. From July 2022, all NHS trusts providing acute and mental health services will need to join a provider collaborative. NHS community and ambulance trusts and non-NHS providers, such as voluntary, community and social enterprise (VCSE) sector organisations or independent providers, will be offered the opportunity to take part where this will benefit patients and makes sense for the providers. Individual providers may be involved in more than one collaborative. This is different from previous initiatives because collaboration is now mandated, rather than encouraged, and provider collaboratives will become a universal part of the health and care landscape across England.

iii. However, how these arrangements develop will vary significantly across the country. They may take different forms and will vary in their scale and scope: some will be 'vertical' collaboratives involving organisations that provide different services (e.g., collaboratives bringing together primary care, community, local acute, mental health and social care providers); others will be 'horizontal' collaboratives that bring together providers that offer similar services (e.g., a chain of acute hospitals or mental health services)

iv. Guidance is clear that it is up to members of the proposed collaborative to decide which arrangement will work best for them in the context of their 'shared purpose and objectives'. This permissive approach recognises that the form and function of the newly mandated provider collaboratives will in many ways be determined locally; influenced by the history of collaboration, the local provider context and the relationships in that area. KCC will need to consider if working through a Provider Collaborative improves care pathways providing new models of care that benefit the people who use those services.

v. The important role of Members is also being developed by Health and Care Partnerships to work out how there will be both KCC and District Member involvement in setting local priorities for tackling health inequalities that will relate to the Integrated Care Partnership and the Integrated Care Strategy.

3.4 Primary Care Networks

42 Primary Care Networks operating at neighbourhood level. Adult Social Care is working jointly at this level through multi-disciplinary teams focusing on identifying and supporting individuals at risk of going into crisis.

4. Local Delivery

4.1 This Paper is focussed on the development of the architecture and governance of the System, the Integrated Care Partnership, and its Sub Committees. However, front line planning and delivery remains firmly in focus. KCC and the NHS continue to strengthen joint working arrangements building on the opportunities provided through the structures of the emerging

Integrated Care System and the challenges that brought us together through the pandemic.

Here are a small number of examples:

i. Adult Social Services is working in collaboration with the NHS to support the flow from hospitals into the community. A joint commissioning management group had been established to agree initiatives with the NHS. Hospital trusts supported by Council staff had been running discharge events. KCC and NHS have also jointly commissioned services to strengthen support to individuals diagnosed with dementia.

ii. Children's Services continue to grow their joint commissioning function which is working to improve access to Speech and Language services and is currently developing a joint preventative project called the nurture programme where mental health teams provide training and support to school staff to identify and understand young people struggling with their mental health and wellbeing.

iii. Public Health continues to develop and focus partnerships on mental health initiatives- for example Kent and Medway Children and Young People Suicide and Self Harm Prevention Network is working across a wide range of partners developing and promoting resources such as the Flux programme which uses the arts and creativity to help young people feel positive about themselves and the Better U app that offers digital self-help tools to support emotional well-being.

iv. Health Overview and Scrutiny Committee have been raising concerns for some time regarding availability of access to GPs. The Chair of HOSC is supporting a project led by NHS to improve GP recruitment in Thanet, Swale and Medway. These areas have a low GP:patient ratio and the pilot aims to improve this and relieve pressures on the local health system. If it is successful, the intention is to roll it out across other areas in Kent.

5. Conclusion

The emerging Integrated Care System is proving to be a complex and technical subject. However, it is vital that Members are aware of the direction of travel and have oversight of the progress being made. At the heart of this work is the ambition to enable health and care organisations to apply their collective strength to tackle the health and care challenges faced by the population we all serve. Agreeing a strong framework for partnership working is the first step in officially setting the tone, purpose and priorities of our Integrated Care System as it matures.

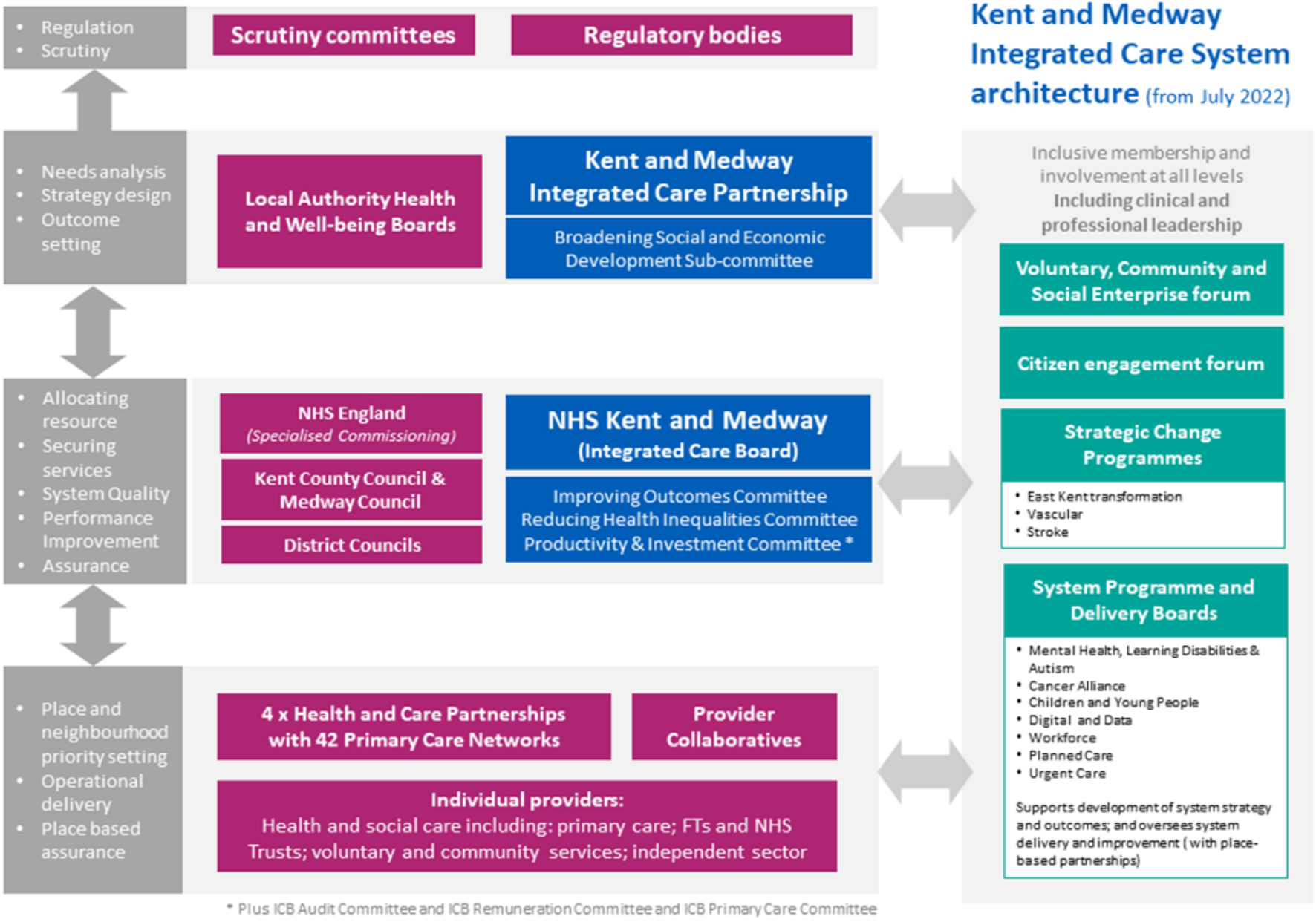
Recommendation:

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

2. County Council is asked to approve the draft Terms of Reference for the Integrated Care Partnership Committee as found at Appendix 2.

Author: Karen Cook, Policy and Relationships Adviser (Health) E-Mail: karen.cook@kent.gov.uk, Tel: 03000 415281

Figure One


Regulation
Scrutiny
Scrutiny committees
Regulatory bodies
Needs analysis
Strategy design
Outcome setting
Local Authority Health and Well-being Boards
Kent and Medway Integrated Care Partnership
Broadening Social and Economic Development Sub-committee
Allocating resource
Securing services
System Quality
Performance Improvement
Assurance
NHS England (Specialised Commissioning)
Kent County Council & Medway Council
District Councils
NHS Kent and Medway (Integrated Care Board)
Improving Outcomes Committee
Reducing Health Inequalities Committee
Productivity & Investment Committee *
Place and neighbourhood priority setting
Operational delivery
Place based assurance
4 x Health and Care Partnerships with 42 Primary Care Networks
Provider Collaboratives
Individual providers:
Health and social care including: primary care; FTs and NHS Trusts; voluntary and community services; independent sector
* Plus ICB Audit Committee and ICB Remuneration Committee and ICB Primary Care Committee
Kent and Medway Integrated Care System architecture (from July 2022)
Inclusive membership and involvement at all levels
Including clinical and professional leadership
Voluntary, Community and Social Enterprise forum
Citizen engagement forum
Strategic Change Programmes
East Kent transformation
Vascular
Stroke
System Programme and Delivery Boards
Mental Health, Learning Disabilities & Autism
Cancer Alliance
Children and Young People
Digital and Data
Workforce
Planned Care
Urgent Care
Supports development of system strategy and outcomes; and oversees system delivery and improvement (with place-based partnerships)

Appendix One: Health and Social Care Integration: joining up care for people, places and populations.

The White Paper defines successful integration as the planning, commissioning and delivery of co-ordinated, joined up and seamless services to support people to live healthy, independent and dignified lives. It emphasises improving outcomes for the population as a whole and states everyone should receive *the right care, in the right place, at the right time.*

It sets out the ambition for better integration across primary care, community health, adult social care, acute, mental health, public health and housing services which relate to health and social care. Children's services are not in scope of the White Paper, but it does state that they can be included if all local partners agree.

It focuses on 4 areas:

- Shared outcomes
- Leadership, accountability, and finance
- Digital and data
- Workforce and carers

Integrated Care Systems have the freedom to set up their own local arrangements – so what is reported here as a model is only for guidance and is being developed and agreed locally.

Summary of key proposals that the Government has committed to:

The key proposals of the white paper are summarised below.

The Government will:

- consult stakeholders and set out a framework for shared outcomes with a concise number of national priorities and approach for developing additional local shared outcomes, by Spring 2023
- ensure implementation of shared outcomes will begin from April 2023
- on leadership, accountability, and oversight, set an expectation that by Spring 2023, all places should adopt a model of accountability and provide clear responsibilities for decision making including over how services should be shaped to best meet the needs of people in their local area.
- review section 75 of the 2006 Act which underpins pooled budgets, to simplify and update the regulations
- work with partners to develop guidance for local authorities and the NHS to support going further and faster on financial alignment and pooling
- publish guidance on the scope of pooled budgets in Spring 2023

- work with the Care Quality Commission (CQC) and others to ensure the inspection and regulation regime supports and promotes the new shared outcomes and accountability arrangements at place
- develop a national leadership programme, addressing the skills required to deliver effective system transformation and place-based partnerships, subject to the outcomes of the upcoming leadership review
- publish a final version of the Data Strategy for Health and Care (Winter 2021/22)
- ensure every health and adult social care provider within an ICS reaches a minimum level of digital maturity
- ensure all professionals have access to a functionally single health and adult social care record for each citizen (by 2024) with work underway to put these in the hands of citizens to view and contribute to
- ensure each ICS will implement a population health platform with care coordination functionality, which uses joined up data to support planning, proactive population health management and precision public health (by 2025)
- develop a standards roadmap (2022) and co-designed suite of standards for adult social care (Autumn 2023)
- enable one million people to be supported by digitally enabled care at home (by 2022)
- on workforce, strengthen the role of workforce planning at ICS and place levels
- review barriers (including regulatory and statutory) to flexible movement and deployment of health and care staff at place level
- develop a national delegation framework of appropriate clinical interventions to be used in care settings
- increase the number of clinical practice placements in social care during training for other health professionals
- improve opportunities for cross-sector training and joint roles for adult social care and NHS staff in both regulated and unregulated roles

Key expectations in the White Paper include:

- Consulting with stakeholders to set out a framework with a defined set of national priorities and the approach for developing additional local shared outcomes, by Spring 2023, with expected implementation of shared outcomes from April 2023

- On place based leadership, accountability and oversight, an expectation that by April 2023, all places will adopt a model of accountability and provide clear responsibilities for decision making
- Working with partners to develop guidance for local authorities and the NHS to support going further and faster on financial alignment and pooling of budgets (at system and place level) from spring 2023
- Working with the CQC to ensure the inspection and regulation regime supports and promotes the new shared outcomes and accountability arrangements at a place level
- Developing a national leadership programme, addressing the skills required to deliver effective system transformation and place-based partnerships
- Ensuring all professionals have access to a single health and adult social care record for each citizen (by 2024)
- Ensuring each ICS implements a population health platform with care coordination functionality, that uses joined up data to support planning, proactive population health management and precision public health by April 2025 (K&M current plans to have this in place by 2024)
- Developing a standard roadmap during 2022 and co-designed suite of standards for adult social care by autumn 2023
- Reviewing barriers (including regulatory and statutory) to flexible movement and deployment of health and care staff at place level
- Developing a national delegation framework of appropriate clinical interventions to be used in care setting

Appendix Two; *DRAFT – V5 (Final, pre-approval)*

Kent and Medway Integrated Care Partnership
Joint Committee

Terms of Reference

1. Introduction

1.1. In accordance with the powers set out under Section XXXX of the National Health Service Act 2006 (as amended), and the Local Government and Public Involvement in Health Act 2007, the following organisations have established an Integrated Care Partnership (ICP) Joint Committee:

1.1.1 Kent and Medway Integrated Care Board (ICB)

1.1.2 Kent County Council (KCC) and Medway Council, together known for the purposes of this terms of reference as the Local Authorities

1.2. The Integrated Care Partnership is established as a Joint Committee of the above parties, to whom they are accountable. The Joint Committee is authorised to act within these Terms of Reference, which set out the membership, remit, responsibilities, authority and reporting arrangements of the Joint Committee.

2. Principles

2.1. The ICP is founded, first and foremost, on the principle of equal partnership between the NHS and local government to work with and for the communities of Kent and Medway

2.2. The ICP plays a key role in nurturing the culture and behaviours of a system that works together to improve health and well-being for local people. In undertaking its work, the Joint Committee will respect the nine key partnership principles:

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

2.2.2. 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

2.2.3. Operate a collective model of accountability, where partners hold each other mutually accountable for their respective contributions to shared objectives within the remit of the Joint Committee

2.2.4. Agree arrangements for transparency and local accountability, including for example meeting in public with minutes and papers available online

2.2.5. Focus on improving outcomes for people, including improved health and

wellbeing and reduced health inequalities

2.2.6. Ensure co-production and inclusiveness throughout the Integrated Care System (ICS) is championed

2.2.7. Support the triple aim (improved population health, quality of care and cost control), the legal duty on statutory bodies to collaborate and the principle that decision-making should happen at a local level (including provider collaboratives) where that is the most appropriate approach

2.2.8. Draw on the experience and expertise of professional, clinical, political and community leaders

2.2.9. Create a learning system, sharing improvements across the system geography and with other parts of the country, crossing organisational and professional boundaries

2.3. In undertaking its work, the ICP will also ensure it continually champions the four purposes of an integrated care system as defined by NHS England:

2.3.1. To improve outcomes in population health and healthcare

2.3.2. To tackle inequalities in outcomes, experience and access

2.3.3. To enhance productivity and value for money

2.3.4. To help the NHS support broader social and economic development

3. Purpose

3.1. The purpose of the Joint Committee is:

3.1.1. To produce an Integrated Care Strategy, developed with respective system partners and stakeholders, which covers the needs of the whole population of Kent and Medway

3.1.2. To influence improvement in the wider determinants of health and broader social and economic development, in areas such as housing, climate, transport, sport and leisure, etc

3.1.3. In developing the strategy, this should include development of a plan to address the broad health and social care needs of the population within Kent and Medway

3.1.4. Aligned to the Integrated Care Strategy, to develop and agree a suite of corresponding outcome measures - based on robust data, intelligence, research and innovation - to improve the health and well-being of the population at large

3.1.5. To seek on-going assurance in delivery of the strategy and associated outcome measures and, where required, agree actions to secure this assurance

3.1.6. To support the bringing together of health and care partnerships and

coalitions with community partners which are well-situated to act on the wider determinants of health in the local area

3.2. The Joint Committee may from time to time have other responsibilities given to it by the Local Authorities and or the ICB, subject to compatibility with legislation and compliance with the decision making process of the relevant body.

4. Responsibilities:

4.1. The Joint Committee is expected to facilitate coordination on health and well-being issues that no one part of the system can address alone and instead requires action by all partners. These include, but are not limited to:

4.1.1. Helping people live more independent, healthier lives for longer;

4.1.2. Addressing inequalities in health and wellbeing outcomes, experiences and access to health services;

4.1.3. Improving the wider social determinants that drive these inequalities, including employment, housing, education and environment;

4.1.4. Improving the life chances and health outcomes of babies, children, and young people; and

4.1.5. Improving people's overall wellbeing and preventing ill-health

4.2. Members of the Joint Committee will engage with stakeholders at system, place, and community levels in order to achieve the remit of the ICP.

4.3. In achieving its role, the Joint Committee will:

4.3.1. Develop and oversee delivery of an Integrated Care Strategy and a suite of corresponding outcome measures, for improving health and wellbeing across Kent and Medway. The Joint Committee will recommend approval of the Strategy and outcome measures to the ICB and Local Authorities for approval.

4.3.2. Ensure the Integrated Care Strategy:

a. Is built bottom-up from population health management data and local assessments of need (including local authority joint strategic needs assessments), with a specific focus on reducing inequalities and improving population health
b. Considers communities that have or may have specific and or unique characteristics
c. Takes account of any local health and wellbeing strategies, prepared under section 116A of the Local Government and Public Involvement in Health Act 2007

d. Addresses those challenges that the health and care system cannot address alone, especially those that require a longer timeframe to deliver, such as tackling health inequalities and the underlying social determinants that drive poor health outcomes

e. Includes (as part of any mandatory requirements):

- integration strategies, for example, setting of a strategic direction and work plan for organisational, financial, clinical and informational forms of integration
- a joint workforce plan, including the NHS, local government, social care and VSCE workforce
- arrangements for any agreed pooled funding and Section 75 agreements[1]

f. is published and made widely available

g. is reviewed annually

4.3.3. Receive from local authority partners on an agreed basis, updated assessments of need and, on receipt, consider whether the current Integrated Care Strategy should be revised, based on the updated information

4.3.4. Take account of available clinical and social research, innovation, and best practice, drawing on the expertise of appropriate academia and other stakeholders

4.3.5. Align 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 the Kent and Medway population

4.3.6. Bolster its understanding of need and expected outcomes, particularly for the most vulnerable and groups with the poorest health and well-being; through insights gained from engagement and collaboration with various sectors, for example the voluntary community and social enterprise (VCSE) sector, Healthwatch, the criminal justice system and service users

4.3.7. Produce, publish and annually review an engagement strategy that emphasises the work of the ICP and the key priorities and expected outcomes in the Integrated Care Strategy

4.3.8. As a Joint Committee between the ICB and Local Authorities, ensure intelligence is shared in a timely manner that enables the evolving needs of the local health and care services to be widely understood and opportunities for at scale collaboration, maximised

4.3.9. Receive information as is required to enable review and on-going assurance

[1] This may also include any other local funding and resourcing arrangements that may be agreed between the parties from time to time.

regarding delivery of the strategy and expected outcomes

4.3.10. Within the agreed levels of any delegated authority of the Joint Committee, agree appropriate action amongst partners to secure the required assurances

4.3.11. Undertake any other responsibilities that may be agreed by the Local Authorities and or the ICB

5. Delegated authority and cooperation

5.1. The Joint Committee is authorised by and accountable to Kent and Medway ICB, Kent County Council and Medway Council.

5.2. All partner members agree to co-operate with any reasonable request made by the Joint Committee to enable it to fulfil its responsibilities, insofar as respective partner member organisational governance arrangements allow..

5.3. In line with the requirements of the Health and Care Act 2022, the Joint Committee shall:

5.3.1. Develop an Integrated Care Strategy, and related outcome measures and assurance arrangements that cover the needs of the whole population. The Strategy and outcome measures will be recommended by the Joint Committee to the ICB and Local Authorities for formal approval through their individual governance arrangements

5.3.2. Request any information necessary from partner members to enable effective review and on-going assurance regarding delivery of the Integrated Care Strategy and associated outcome measures. All information requests between the partner members and with the Joint Committee will be managed in accordance with the relevant legislation and any partner sharing agreements in place

5.3.3. Agree actions amongst ICP partner members to secure the required assurances regarding delivery of the Integrated Care Strategy and outcomes, in so far as partner member schemes of delegation allow this

6. Membership, Chair and Leadership Team

6.1. Membership of the Joint Committee will be made up of elected, non-executive and clinical and professional members as follows:

6.1.1. Leader of KCC

6.1.2. Leader of Medway Council

6.1.3. Chair of the Kent and Medway ICB

6.1.4. Two additional Local Authority elected executive members from KCC, who hold an appropriate portfolio responsibility related to Joint Committee

business

6.1.5. Two additional Local Authority elected executive members from Medway Council, who hold an appropriate portfolio responsibility related to Joint Committee business

6.1.6. One additional ICB Non-Executive Director

6.1.7. An ICB Partner Member who can bring the perspective of primary care

6.1.8. The Chairs of the four Kent and Medway Health and Care Partnerships

6.1.9. An elected District Council representative from within the geographies of each of the four Kent and Medway Health and Care Partnerships

6.2. Members are not permitted to have deputies to represent them.

6.3. The Chair of the Joint Committee shall be either the Leader of Kent County Council or Medway Council and will be elected at the first meeting of the Joint Committee to serve as Chair for a two year period. The Chair will rotate every two years between the Local Authority leaders.

6.4. The Joint Committee shall have the following standing non-voting attendees (these shall be known as Participants):

6.4.1. Medway Council Chief Executive

6.4.2. Kent County Council Head of Paid Service, or nominated representative

6.4.3. Kent and Medway ICB Chief Executive

6.4.4. Kent and Medway Directors of Public Health

6.4.5. Kent and Medway ICB Medical Director

6.4.6. A representative from each of Kent Healthwatch and Medway Heathwatch

6.4.7. A representative from the Kent and Medway Voluntary, Community and Social Enterprise Steering Group

6.4.8. Kent and Medway Local Authority directors of adult and children's social care

6.4.9. A representative from Kent Integrated Care Alliance

6.4.10. A representative from the Kent, Surrey and Sussex Academic Health and Science Network

6.4.11. A representative from the Local Medical Committee

6.5. The Chair may call additional individuals to attend meetings to inform discussion. Attendees may present at Joint Committee meetings and contribute to discussions as invited by the Chair but are not allowed to participate in any vote.

6.6. The Chair may invite or allow individuals to attend meetings held in private as observers. Observers may not present or contribute to any discussion unless invited

by the Chair and may not vote.

6.7. To support the Chair and recognising the collective model of accountability, a Leadership Team comprising the two Local Authority leaders and the Chair of the ICB will be established to agree the forward plan (in discussion with partner members), meeting agendas, and other items of business relating to the Joint Committee.

6.8. In the event that the Joint Committee Chair is not available to chair the meeting (due to absence or a conflict of interest), the other Local Authority leader will preside over the matter(s) to be discussed. Where neither leader is available to preside, the ICB Chair will preside over matters.

7. Meetings and Voting

7.1. Meetings of the Joint Committee will be open to the public. The public and other Observers may be excluded from the meeting, whether for the whole or part of the proceedings, where the Joint Committee determines that discussion in public would be prejudicial to the public interest or the interests of ICB or Local Authorities by reason of:

7.1.1. The confidential nature of the business to be transacted

7.1.2. The matter being commercially sensitive or confidential

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

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

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

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

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

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

7.3. When the Chair of the Joint Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as they shall specify. Where possible this will be agreed by the Leadership Team.

7.4. The aim of the Joint Committee will be to achieve consensus decision-making wherever possible. Where a formal vote is required each member of the Joint Committee shall have one vote. The Joint Committee shall reach decisions by a majority of members' present, subject always to the meeting being quorate. Where a majority vote is not achieved the proposal will not be passed. The Chair shall not

have a second or casting vote, where the vote is tied.

7.5. All Members, Participants and any other individuals involved in the discussions are required to declare any interest relating to any matter to be considered at each meeting, in accordance with the partner member's relevant policy on standards and managing conflict of interests. Where the partner member does not have such a policy or policies, the ICB's policy on business standards and managing conflicts of interest shall apply.

8. Quorum

8.1. A quorum shall be nine voting members:

8.1.1. One of whom shall come from each of the two Local Authorities and one from the ICB

8.1.2. One of whom shall be from the Leadership Team

8.1.3. A minimum of two of the four health and care partnership areas shall be represented by their respective chair or district council representative

8.2. Whilst not part of the quorum, the Joint Committee shall endeavour to always have a public health representative in attendance, unless a conflict of interest precludes this.

8.3. At the discretion of the Chair, members who are not physically present at a Joint Committee meeting but are present through tele-conference or other acceptable media, shall be deemed to be present and count towards the quorum as appropriate.

8.4. Members of the Joint Committee have a collective responsibility for the operation of the Joint Committee. They will participate in discussion, review evidence, and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

9. Dispute resolution

9.1. Where a dispute or concern arises, this should be brought to the attention of the Chair. The matter will be discussed by the Leadership Team, who will agree a course of action by consensus, having sought appropriate advice where required and having due regard to the principles of the ICP set out in paragraph 2. Where a consensus cannot be reached, the matter will be referred to the Joint Committee for discussion.

10. Frequency and Notice of Meetings

10.1. The Joint Committee shall meet at least quarterly .

10.2. Notice of any Joint Committee meeting must indicate:

10.2.1. Its proposed date and time, which must be at least five (5) clear working days after the date of the notice, except where a meeting to discuss an urgent issue is required (in which case as much notice as reasonably practicable in the circumstances should be given)

10.2.2. Where it is to take place

10.3. Notice of a Joint Committee meeting must be given to each member of the Joint Committee in writing. Failure to effectively serve notice on all members of the Joint Committee does not affect the validity of the meeting, or of any business conducted at it.

10.4. Where Joint Committee meetings are to be held in public the date, times and location of the meetings will be published in advance on the websites of KCC, Medway Council and the ICB. Other technological and communication media may also be used to maximise public awareness of the work of the ICP.

11. Policy and best practice

11.1. The Joint Committee is authorised by KCC, Medway Council and the ICB to instruct professional advisors and request the attendance of individuals and authorities from outside of the partner members with relevant experience and expertise if it considers this necessary for or expedient to the exercise its responsibilities.

11.2. The Joint Committee is authorised to obtain such information from partner members as is necessary and expedient to the fulfilment of its responsibilities and partner members will cooperate with any such reasonable request.

11.3. The Joint Committee is authorised to establish such sub-committees as the Joint Committee deems appropriate in order to assist the Joint Committee in discharging its responsibilities.

11.4. The Joint Committee will be conducted in accordance with the ICB policy on business standards, specifically:

11.4.1. There must be transparency and clear accountability of the Joint Committee.

11.4.2. The Joint Committee will hold a Register of Members Interests which will be presented to each meeting of the Joint Committee and available on the websites of the ICB and Local Authorities

11.4.3. Members must declare any interests and /or conflicts of interest at the start of the meeting. Where matters on conflicts of interest arise, the individual must withdraw from any discussion/voting until the matter(s) is concluded

11.5. The Joint Committee shall undertake a self-assessment of its effectiveness on an annual basis. This may be facilitated by independent advisors if the Joint Committee

considers this appropriate or necessary.

11.6. Members of the Joint Committee should aim to attend all scheduled meetings.

11.7. Joint Committee members, participants and other observers must maintain the highest standards of personal conduct and in this regard must comply with:

11.7.1. The laws of England

11.7.2. The Nolan Principles

11.7.3. Any additional regulations or codes of practice adopted by the Member's appointing body

12. Secretariat

12.1. The Leadership Team will agree the secretariat arrangements to the Joint Committee. The duties of the secretariat include but are not limited to:

12.1.1. Agreement of the agenda with the Chair together with the collation of connected papers;

12.1.2. Taking the minutes and keeping a record of matters arising and issues to be carried forward.

12.2. Before each Joint Committee meeting an agenda and papers will be sent to every Joint Committee member and where appropriate published on the the websites of KCC, Medway Council and the ICB, excluding any confidential information, no less than five (5) clear working days in advance of the meeting.

12.3. If a Joint Committee member wishes to include an item on the agenda, they must notify the Chair via the Joint Committee's Secretary no later than twenty (20) clear working days prior to the meeting. In exceptional circumstances for urgent items this will be reduced to ten (10) clear working days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Chair.

12.4. A copy of the minutes of Joint Committee meetings will be presented to KCC, Medway Council and the ICB. These will be presented in the most appropriate way as determined by these organisations.

13. Confidentiality

13.1. Joint Committee meetings may in whole or in part be held in private as detailed at paragraph 7. Any papers relating to a private meeting will not be available for inspection by the press or the public. For any meeting or any part of a meeting held in private all attendees must treat the contents of the meeting, any discussion and decisions, and any relevant papers as confidential.

13.2. Decisions of the Joint Committee will be published by the Joint Committee except where these have been made in a private meeting. Where decisions have been

made in private a summary of the decision will be made public without any confidential information being disclosed.

14. Review of Terms of Reference

14.1. The terms of reference of the Joint Committee will be approved by the Local Authorities and the ICB and shall be reviewed by the parties annually.

Approved: xxxxx

Version Control:

Version No	Amendment	Amendment Owner	Date of Amendment