Appendix 1

August 2022

Kent County Council Health Reform and Public Health Cabinet Committee
Re: Establishment of the Kent and Medway Integrated Care System

Purpose

1. This briefing provides the KCC Health Reform and Public Health Cabinet Committee with an update on developments of the Kent and Medway Integrated Care System following the Health and Care Act being passed by Parliament earlier this year.

2. This paper is for INFORMATION

National Policy Context and Background

3. In February 2021, the Department of Health and Social Care (DHSC) published legislative proposals in a White Paper that promoted service integration and the bringing together of health bodies and local government to coordinate care. The subsequent Health and Care Bill (the Act) received Royal Assent in April of this year and was formally implemented on 1 July.

4. In particular the Act confirmed the dissolution of Clinical Commissioning Groups (CCGs), and placed new Integrated Care Systems, of which Kent and Medway is one of 42 nationally, on to a statutory footing.

5. An **Integrated Care System** (ICS) is a partnership that brings together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas typically covering circa 1 to 2 million people. The four core purposes of an ICS are defined as:

   - 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

6. There are two mandated parts to every ICS:

   a. A new statutory NHS body called the **Integrated Care Board** (ICB), accountable for overseeing the commissioning, provision and expenditure of healthcare services in the ICS area; bringing the NHS together locally to improve population health and care.

   b. A new **Integrated Care Partnership** (ICP), jointly convened as a Committee of the ICB and upper tier local authorities within the ICS, with a broad alliance of local stakeholders. The ICP is responsible for developing and overseeing an Integrated

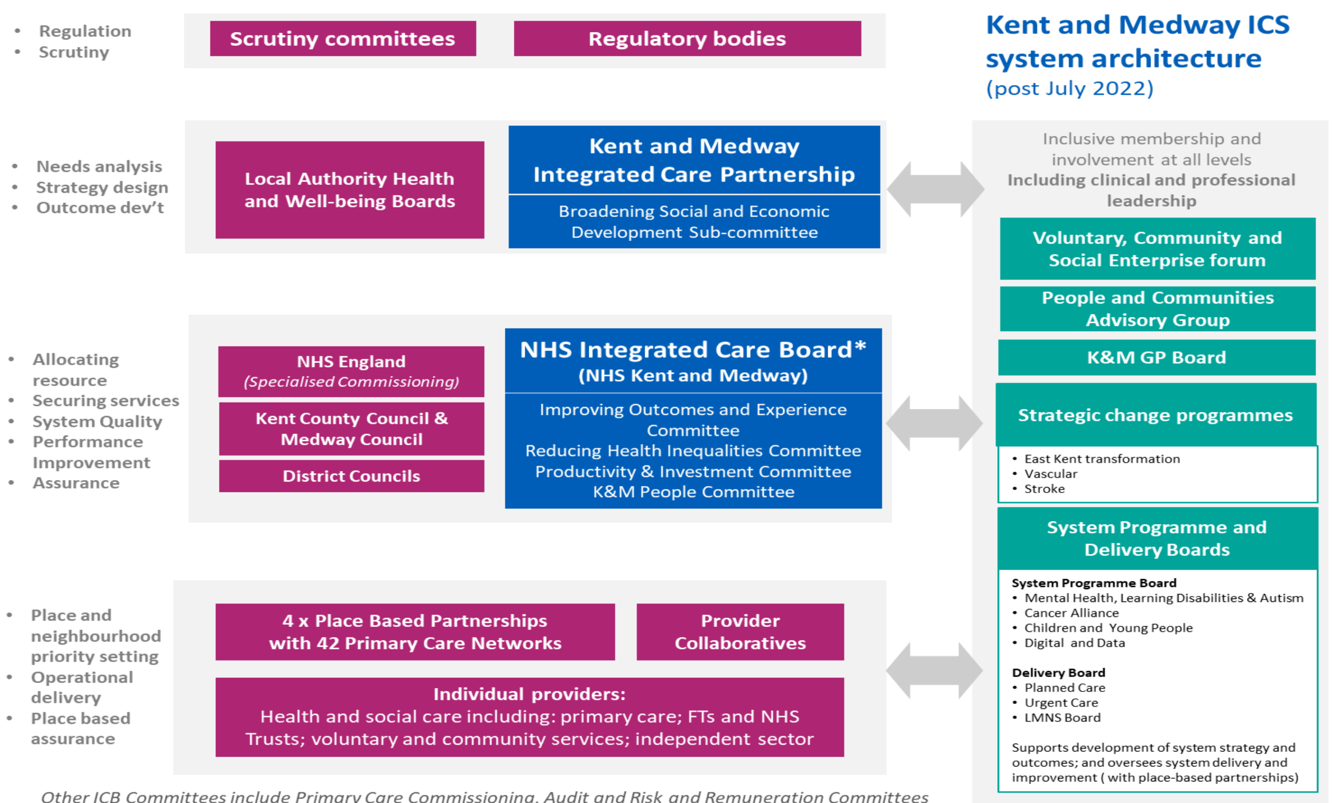
Care Strategy that will improve individual care, health and wellbeing for the total population. The Strategy is the primary document all related health and well-being strategies and plans should be developed from.

7. Alongside the bringing together of key partners and stakeholders at a system level, a key premise of the White Paper and the Act is that much of the work to integrate care and improve population health and well-being should be driven by commissioners and providers of health and care collaborating over smaller 'place based' geographies within each ICS, where people live and directly access local services. These typically cover populations of 250,000 to 500,000. In Kent and Medway, four place-based **Health and Care Partnerships** (H&CPs) have been established to fulfil this role:

- Dartford, Gravesham and Swanley H&CP
- East Kent H&CP
- Medway and Swale H&CP
- West Kent H&CP

8. Completing the ICS 'jigsaw', within each H&CP, neighbourhood level **Primary Care Networks** continue to develop. These are groups of GP practices, serving populations averaging 30,000 registered patients, working together with community and social care partners through multi-disciplinary teams, to support individuals and families with health and well-being issues such as the management of long term conditions and preventing people from getting acutely ill. In Kent and Medway there are currently 40 such PCNs.

Figure 1 – Kent and Medway ICS



Other related policy context

9. In areport to County Council on 26th May by the Council Leader and the Cabinet Member for Adult Social Care & Public Health[1], it was noted that the Health and Care Act is part of the wider set of 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.
10. The report noted that the Integration White Paper is significant as it sets out plans to join up care at a H&CP level for:

- patients and service users
- staff across the health, care and other relevant sectors
- organisations delivering these services to the local population

11. The Integration White Paper will further shape how the Kent and Medway system will operate and it provides both opportunities and challenges for NHS and local authority partners, including:

   a. The expectation that all local areas should aim to manage services and have associated budgets by 2026. In Kent this could provide opportunities for the local authority to work in new ways with the H&CPs to build local pathways of care and encourage investment in community and preventative services.

   b. Places are expected to accelerate the pooling and alignment of NHS and social care budgets and to develop ambitious plans to increase the scope and proportion of health and care spend through 'place-based' (H&CP) arrangements.

   c. Whilst the Integration White Paper has clear ambitions regarding future joint resourcing arrangements at a local level, considerable work needs to be undertaken at a national and local level to determine how this might work 'on the ground'.

   d. That each place based area will have "a single person, accountable for shared outcomes" agreed by the relevant ICB and local authority(ies) and in place from April 2023. Kent and Medway partners plan to commence discussions on this during the autumn.

Kent and Medway ICS Developments, post 1 July 2022

12. The Health and Care Act was implemented nationally on 1 July 2022. Along with all other CCG's, Kent and Medway CCG was dissolved on 30th June and NHS Kent and Medway Integrated Care Board was established on 1st July 2022. The ICB has taken over the functions and duties of the former CCG, plus a number of new functions from NHS England, including the commissioning of local pharmacy, ophthalmic and dentistry services.

[1] *'Health and Care Partnership Working with the Kent and Medway Integrated Care System'* dated 26 May 2022, a report from Roger Gough, Leader of the Council and Clair Bell, Cabinet Member for Adult Social Care & Public Health

13. Overall, the transition from the CCG to the ICB was smooth, with no material issues resulting. During July and August the ICB and its committees, including the ICP Joint Committee, have had inaugural meetings and commenced forward planning for the coming period. A number of transitional priorities have also been agreed in advance of the ICS strategy being developed (see commentary later in this briefing).

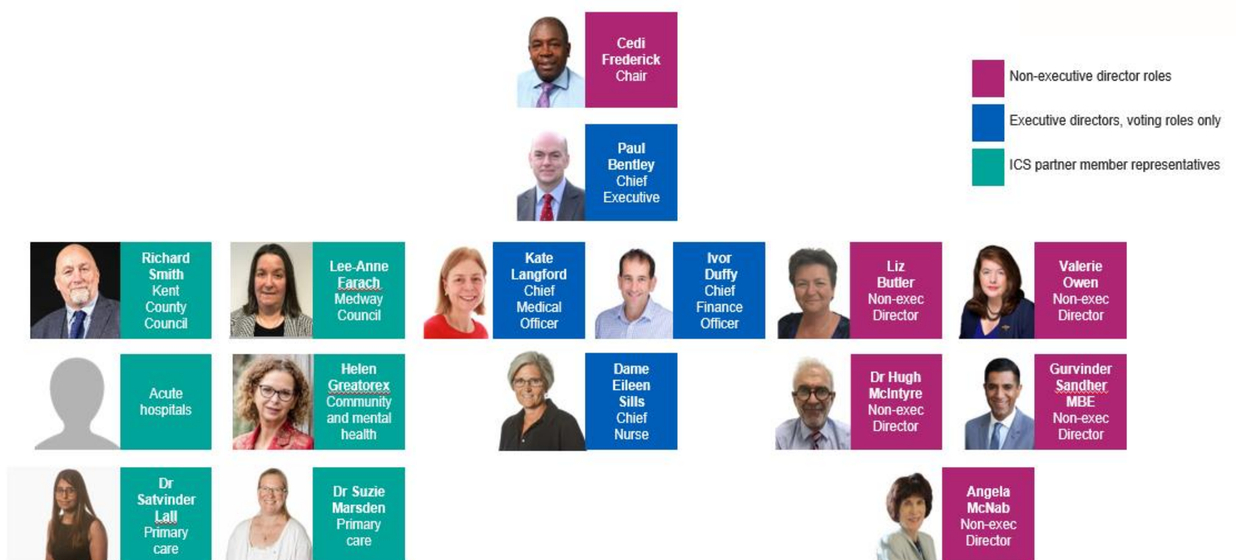
Kent and Medway ICB

14. Importantly, the new ICB is not the same as the organisations that preceded it. Through the Act, the ICB has greater authority and is expected to act as a system leader for NHS partners. The ICB has greater delegated authority to oversee assurance and performance of providers and H&CPs, and has new specific duties on behalf of the NHS at a system level, such as ensuring delivery of financial balance and developing a jointly agreed NHS five-year forward plan.

15. The ICB Board and its committees also have much broader memberships with representation from the voluntary and community sector, upper and lower tier councils, public health, providers of health and social care and other representatives from key sectors. A Kent and Medway people and communities forum is being established, and members of the community will be invited to be part of this alongside a growing Citizens Network (The ICB is working closely with KCC with regard to our voluntary, community and citizens engagement arrangements). This broader involvement of partners in the influencing and making of decisions is a stepped change only possible through the Act. This should facilitate a greater emphasis on improving health and well-being outcomes, alongside the continuing need ensure high quality, effective and compassionate care for people when they need it.

16. The ICB Board held its inaugural meeting in public at the beginning of July and will meet formally in public every other month thereafter.

Figure 2 – Kent and Medway ICB Board



17. Whilst some of the ICB committees are 'corporate' and focus on internal governance, a number are deliberately outwardly system focused, recognising the different approach and system leadership responsibilities of the ICB. These include:

   a. Kent and Medway **Integrated Care Partnership:** As previously noted, this is a Joint Committee of the ICB, Kent County Council and Medway Council and is responsible for the development and oversight of an Integrated Care Strategy for the total population. Further information on the ICP is provided further below.

   b. ICB **Inequalities, Prevention and Population Health Committee**: Whilst this is a formal Committee of the ICB it is also a sub-group of the ICP. Part of the Committee's remit is to support the ICP with developing the health and care aspects of the Integrated Care Strategy and associated outcome measures. This Committee is also responsible for overseeing development of the interrelated NHS five year joint forward plan that will sit alongside the ICS Strategy.

   c. The ICB **Improving Outcomes and Experience Committee** seeks assurance that the ICB is delivering its functions in a way that secures continuous improvement in the quality, safety and performance of commissioned health and care services; and provides direction at an ICS level on quality and performance assurance and oversight.

   d. The **Productivity and Investment Committee** provides assurance that the ICB and the NHS system can meet all statutory and mandatory financial obligations, alongside effective financial frameworks and operating models. The Committee also ensures resources are being targeted as efficiently and effectively as possible to address the greatest need and tackle inequalities.

   e. **Kent and Medway People Committee**: This Committee will have its inaugural meeting in September and will provide assurance to the ICB Board regarding delivery of local, regional, and national workforce priorities, plus assurances around delivery of the five year NHS workforce strategy and associated programmes.

18. The majority of ICB Executive posts have now been appointed to, albeit some individuals have yet to fully start in post. Those that remain outstanding are currently being filled by interim directors. Composition of the ICB Executive at the time of reporting is in figure 3.

Chief Executive	Paul Bentley
Chief Medical Officer	Kate Langford
Chief Nurse	Dame Eileen Sills
Chief Finance Officer	Ivor Duffy
Chief People Officer	Rebecca Bradd
Chief Strategy Officer	Vincent Badu (wef Nov 22)
Chief Delivery Officer	Lee Martin (interim)
Chief Digital Officer	Morfydd Williams (interim) Martin Carpenter (wef Jan 23)
Chief of Staff	Natalie Davies
Executive Director of Corporate Governance	Mike Gilbert
Executive Director of Communications and Engagement	Matthew Tee (interim)

The Kent and Medway Integrated Care Partnership (ICP)

19. As previously noted, the overarching remit of the ICP Joint Committee is to oversee development and implementation of an ICS Strategy for the total population. The ICP is also expected to highlight where coordination is needed on health and care issues and to challenge partners to deliver the actions 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

20. ICPs are encouraged to form relationships with a wide range of stakeholders appropriate to the places they cover, by either inviting them to be members of the ICP or engaging with them in other ways. This is because only 20% of good health is considered to come from clinical interventions. The other 80% is associated with health-related behaviours, socioeconomic factors, and environmental factors. As such, without the involvement of the district and borough councils, the voluntary and community sectors, housing, education, environment and other key partners, a huge opportunity is likely to be missed to improve the health and wellbeing of our population. The Kent and Medway ICP and the groups that feed in to it have this membership cohort, and as part of the ICS strategy development, many more community organisations and people will be able to feed in to this.

Figure 3 – Robert Johnson model on key attributes that effect 'good health status'

21. The ICP Joint Committee meets in public and is chaired by KCC and Medway council leaders on a rotational basis, 2 years at a time, with the leader who is not the chair acting as vice-chair. Roger Gough is the inaugural chair of the Committee. The two council leaders, along with the ICB Chair, have also established a triumvirate leadership group setting the vision and forward agenda for the ICP.

Transitional Priorities and Development of an ICS Strategy

22. The DHSC requires an initial Integrated Care Strategy to be published by each ICS by December 2022, in order to inform the NHS Five Year Forward View by March 2023. The KCC Strategy, Policy Relationships and Corporate Assurance Department of August 2022[2], helpfully summarises the national requirements for the ICS Strategy.

23. Given the breadth of what an ICS strategy is expected to include, plus recognising that the Strategy needs to be developed in partnership with a broad range of stakeholders, the strategy required for December is an 'initial' strategy. Further work will be required during the early months of 2023 alongside completion of the two related local authority strategies to ensure they join up with each other, and, importantly, have the support of all stakeholders and the wider Kent and Medway community.

24. As a result, and to ensure there is not a void during the intervening period, the ICB has agreed a set of transitional priorities for the current year, with a focus on the most immediate and pressing issues.

Transitional Priorities	
1	Leading **operational recovery** as a result of the pandemic with a focus on elective care, urgent and emergency care, cancer and diagnostics: Too many people are waiting too long to have elective treatment, so we need to reduce the length of time people are waiting.
2	Leading, with our trusts, the **improvement of east Kent and Medway hospital** services: System partners need to work ceaselessly to support and move these most challenged NHS providers in Kent and Medway out of their current poor NHSE ratings and to effectively deliver their recovery programmes, towards a sustainable and high quality footing.
3	Implementation of the **Kent and Medway GP development** plan and development of a wider primary care strategy: It is still too difficult to get an appointment to see your primary care team, including your GP. This is the front door to the health system, and we must do all we can to support our general practices, including use of technology.
4	Working with local authority and other partners to **build and grow our social care sector**: We have a significant number of people in hospital do not need to be there and who would be better served elsewhere; we need to build sustainable domiciliary and care capacity in the system and find better solutions to support these people.
5	Establishing a **high-performing integrated care board (ICB)** and transitioning well from the CCG: We need to actively manage the transition of the new ICB with different priorities, accountabilities and ways of working.
6	Development of our **ICS Strategy and the NHS Joint Forward Plan** (JFP) including our shared ambition and deliverables: Our strategy and JFP, as an ICS and ICB, must enable people to be the very best they can be. We need clear ambitions, deliverables and ways of working that will reduce inequalities and improve population health and well-being.
7	Leading the wider **development of our ICS:** developing our places, our provider collaboratives and how all partners work together to be a high performing ICS: There is a new architecture, we have four geographically based health and care partnerships, and we will have provider collaboratives; we will do things that have not been done before but must be done.

[2] Briefing Note – New DHSC guidance for Integrated Care Systems, 29 July 2022,

Health and Care Partnerships and Primary Care Networks

25. The four H&CPs, and the PCNs that work within them, will become the engine room for planning and delivering more joined up integrated care and tackling local health inequalities and population health over time. H&CPs have been given the freedom to develop over the past couple of years at their own pace. The pandemic forged immediate and innovative ways of joint working and collaboration that have endured. This has shaped the basis for how they and the PCNs work going forwards. All H&CPs have representation from local authority and other sector stakeholders, and the recent KCC adult social care consultation on place-based operating will inevitably strengthen this.

26. Importantly, whilst the ICB has only been established for a number of weeks, a key priority already being progressed is the development of a consistent framework and approach from which these partnerships can work within and further mature at pace in order to take on local delegated functions and responsibilities as soon as they are able.

KCC collaboration and local delivery

27. This paper has focused on the development of the ICS, in particular from July 2022. However, this builds on the strong and increasing relationship between the NHS and KCC that has been in place for a number of years. Again, as reported by The Leader at the meeting of the Council in May[3], 'building on the opportunities provided through the structures of the emerging ICS and the challenges that brought us together through the pandemic, strengthens what we are already doing, for example:

    a. Adult Social Services is working in collaboration with the NHS to support the flow from hospitals into the community. A joint commissioning management group is being re-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.

    b. 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.

    c. 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.'

[3] 'Health and Care Partnership Working with the Kent and Medway Integrated Care System' dated 26 May 2022, a report from Roger Gough, Leader of the Council and Clair Bell, Cabinet Member for Adult Social Care & Public Health

Conclusion

28. Development of the Kent and Medway ICS and the associated establishment of new organisations and partnerships has been a significant and complex programme of work, undertaken over many months and years. Implementation of the Health and Care Act on 1 July 2022 was a major milestone. However, we are only in the early stages of implementation and this new way of working, and it is too soon to take away any material judgements.

29. Notwithstanding this, health and care system partners continue to face considerable and growing joint challenges, all within a seemingly more pressured social and economic environment. The only way of effectively addressing this has to be through closer collaboration, joint decision making, combining resources, harnessing innovation, and where appropriate, integrating our services. Also, decisions around the planning and delivery of health, care and well-being services need to be made as close to the patient/citizen as possible, whilst recognising this needs to be within a clear and consistent system framework; all of which demands and assures high quality, effective and efficient service delivery wherever it is provided.

30. We also need to move away from focusing the majority of our combined efforts on tackling immediate operational service and political pressures, to developing an appropriately resourced infrastructure that also gives equal if not greater focus on preventing ill-health, reducing inequalities and improving well-being. These programmes will inevitably take much longer to achieve the required outcomes, but we need to prioritise their commencement now. Whilst not perfect, the Health and Care Act and the arrangements we have put in place locally to deliver the spirit of the Act should enable us to achieve these ambitions more effectively than we have been able to do before.

Recommendation:
1. The Health Reform and Public Health Cabinet Committee is asked to **NOTE** and **CONSIDER** the content of this briefing

Mike Gilbert
Executive Director of Corporate Governance
NHS Kent and Medway ICB