Kent and Medway
Clinical Commissioning Groups

Merger Application

Summary Case For Change

Version: 1.0
September 2019

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Supporting documents to NHSE application

1 Executive summary

The eight Kent and Medway (K&M) clinical commissioning groups (CCGs) are pleased and excited to submit this application to become a single commissioner. We are looking forward to presenting and discussing our case for change with NHS England and NHS Improvement (NHSE/I) at the beginning of October 2019.

Our primary objective is to enable people living across Kent and Medway to have a great quality of life and high-quality care. While significant strides have been taken to collaborate as well as work more closely with our partners and providers to achieve this goal, **it is now a matter of urgency** that we build on and accelerate this joint working to address some of our key local challenges. Progressing this application, particularly clarifying the benefits we expect, has cemented our long term and collective view that we need to move forward with a merger at pace. **This will unlock short and long-term advantages, which will not be achieved without a change to the current arrangements.**

The benefits

1. Redirection of clinical and management resources closer to local front-line services and our patients

The proposed merger is a fundamental building block for a successful integrated care system (ICS), a necessary pre-cursor to innovative, vibrant and patient-centric primary care networks (PCNs) and integrated care providers (ICPs). The merger will allow us to bring together CCG clinical and managerial time to deal with the critical issues facing us now, and to redirect resource and effort to the PCNs and ICPs and therefore closer to the health and social care frontline. **Without a single commissioner in place, our ability to redirect resources, while addressing current pressures, will be hampered. It will take longer before our proposals for a fresh, shrewder approach to commissioning, provision and the new ICS result in tangible improvements.**

2. Development of a coherent service strategy and acceleration of an outcomes-based approach to commissioning and service delivery ultimately improving patients' health, wellbeing and experience of our services:

The K&M CCGs, partners and providers are committed to a new way of working and have been working towards an ICS for many months through the wider system transformation programme. As a cornerstone of the ICS, a single commissioner will:

- allow a more coherent commissioning strategy for K&M as a whole (including more specialised areas such as digital, workforce and estates)
- enable and oversee a consistent outcomes-based approach to commissioning across the system with our partners and providers moving away from bilateral, payment by results (PBR) contracts to financial and contractual frameworks that target population health improvement and maximise the potential for prevention
- provide oversight and insight across a larger area helping us identify and share best practice, deliver consistency in commissioning approach and expected outcomes, as well as help address inequity and inequality across K&M.

3. De-duplication and delivery of nationally mandated 20% CCG running costs reduction

- The establishment of a K&M-wide programme/workstreams has partly mitigated duplication of effort across eight CCGs and a complex local system. However, **the current myriad layers of commissioning management and governance can more than double our 'speed to market' and often dilute the bold and innovative proposals.** This hampers our ability to address our short and long-term constitutional and financial challenges. The K&M CCG savings requirement for 2020/21 is £4.7m, which is achievable if we merge.

Tackling the risks

Engagement on the merger with CCG constituents, staff, patients and partners has highlighted perceived risks to a single commissioning organisation. These have been addressed through, for example, the proposed organisational design or funding commitments. Our local conversations highlighted a recurring theme relating to the potential loss of the local, clinical voice engendered by our current CCGs. Aside from the establishment of PCNs, which will provide that vital 'ear to the ground' the following commitments have been agreed:

- **the new CCG will always be GP-led**, with a GP governing body majority including a GP from each current CCG until at least April 2022 and clinical representation/leadership where appropriate on all committees
- a full and robust **development programme for PCNs** enabling effective leadership within the emerging integrated care system.
- strong local patient and public representation from the CCG governing body down to individual PCNs e.g. **maintenance of patient and public lay members' effort and funding.**

Conversely, the risks of not moving to a single organisation at pace will be the potential inability to answer, at scale, our current major challenges. Examples include constitutional standards and financial sustainability, loss of momentum in development of the ICS, ICPs and PCNs, and a loss of confidence in us by staff and the public, following perceived failure to follow up on the merger engagement work carried out to date.

In short, an early merger will accelerate our vision and plans, simplify, significantly reduce inefficiency and unnecessary duplication of effort and reap benefits for our patients sooner rather than later. The merger is on our critical path to achieving better health and financial outcomes. It is the natural, next step for K&M and builds on the progress we have already made to date.

Glenn Douglas

Accountable Officer for the Kent and Medway Clinical Commissioning Groups

2 Introduction

The NHS Long Term Plan (LTP) sets an expectation that ICSs will be established across the country by April 2021. These will be based on existing sustainability and transformation partnership (STP) footprints. They will refocus commissioning and care provision on improving population health and wellbeing, address inequity and, where it is within our ability, health inequalities – the unacceptable differences in health and life expectancy for some communities compared to others.

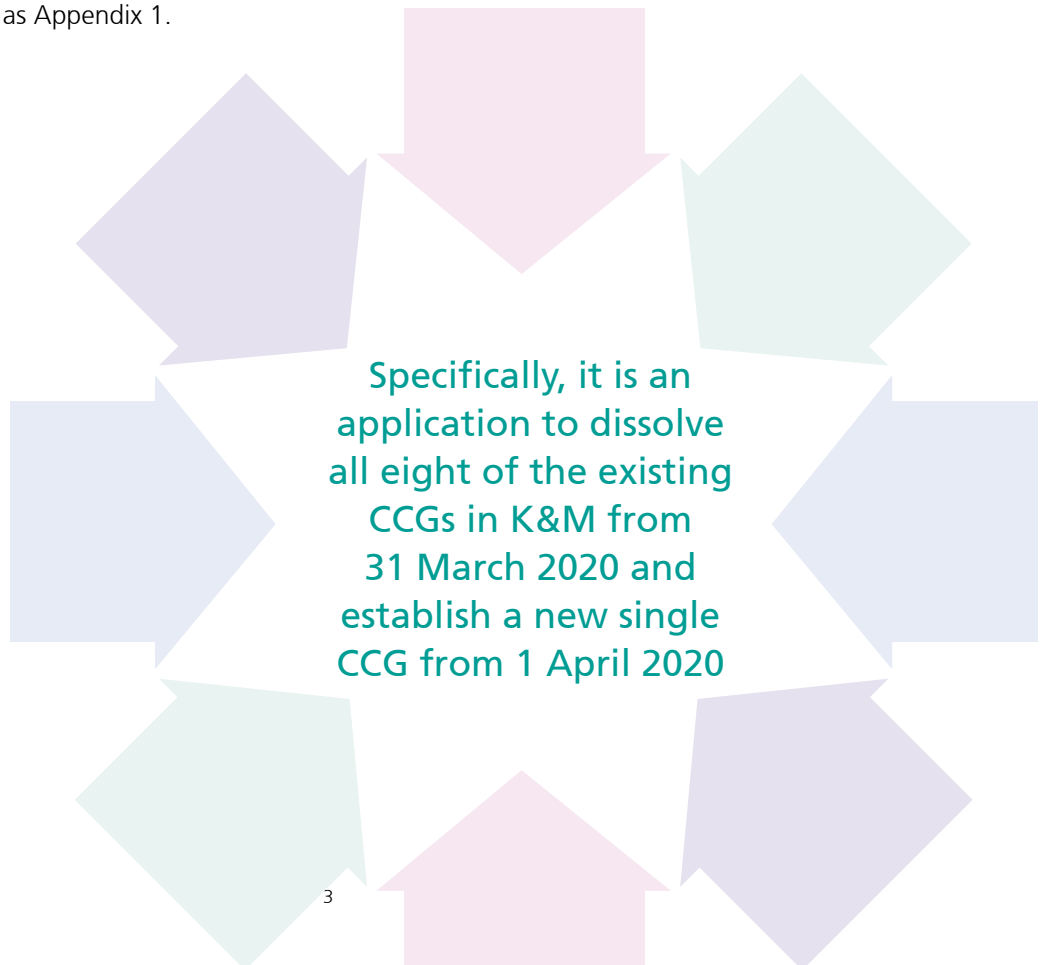
The LTP is clear that each ICS will need streamlined commissioning arrangements to enable a consistent set of decisions to be made at system level. CCGs will become leaner, more strategic organisations that support care providers through ICPs to partner with other local organisations to deliver population health, care transformation and implement the requirements of the LTP. They will also develop enhanced management capability for more specialist functions, such as estates, digital and workforce.

In K&M, we have been working towards the vision set out above for many months. We recognise that while K&M has many achievements to be proud of over recent years, there are a number of fundamental challenges (Section 4.2) we have not yet been able to tackle and which have impacted negatively on individual patient experience, care and wellbeing. Two of the primary reasons for this are the complexity and fragmentation of the current system and the inefficient duplication of effort. Partners across K&M agree that merger gives us the opportunity to act and address some of the challenges that have faced us for many years.

This application is a fundamental building block in establishing an ICS across K&M. Specifically, it is an application to dissolve all eight of the existing CCGs in K&M and establish a new single CCG from 1 April 2020. **The new organisation will be called the NHS Kent and Medway Clinical Commissioning Group and will cover the full geographical area of the existing eight CCGs.**

This application is being made in accordance with national guidance and each of the eight CCGs' constitutions. It has been approved by each of the CCG governing bodies and their GP memberships (TBC).

The application has been developed in accordance with the Equality Act 2010 and specifically the requirements of the Public Sector Equality Duty. A copy of the **combined (equality) impact assessment** (CIA) is attached as Appendix 1.



3 Background

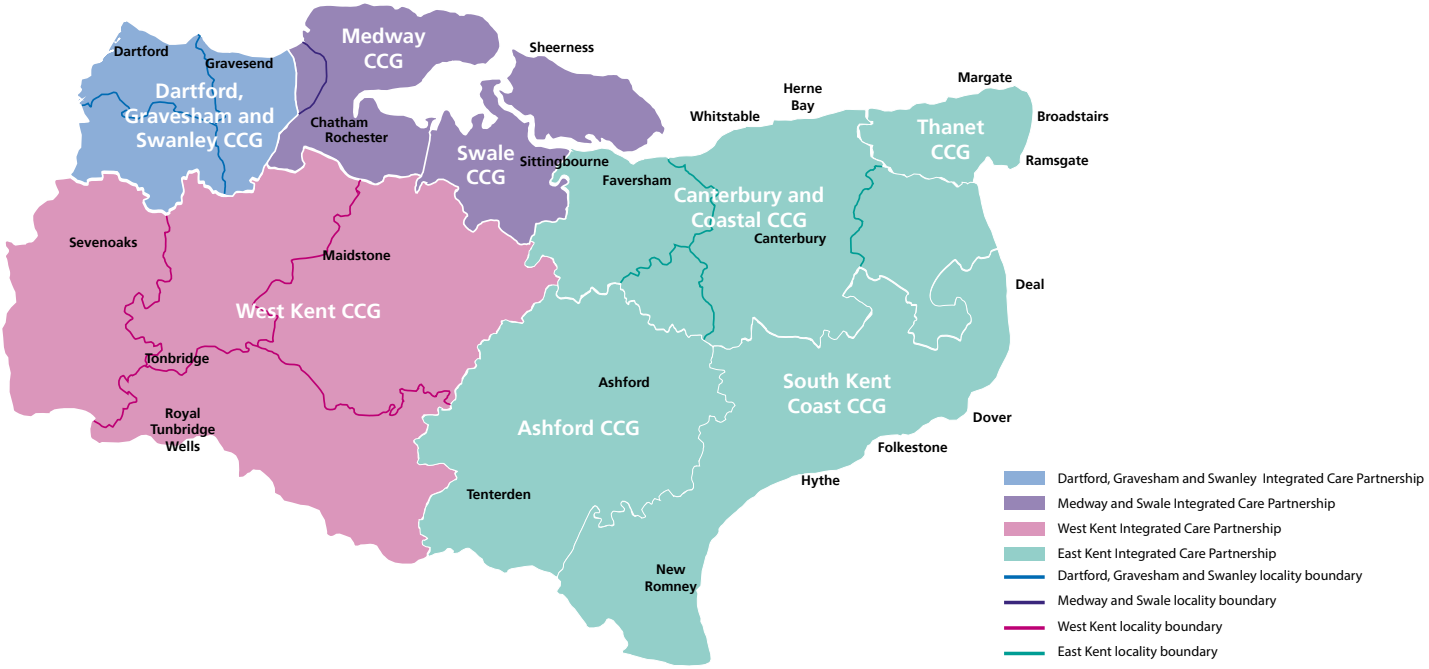
High-level information regarding the eight K&M CCGs is provided below:

	Population	Practices	Total CCG budget 2019/20 £m's
Ashford CCG	135,242	11	£179.5
Canterbury and Coastal CCG	210,353	14	£320.0
Dartford, Gravesham and Swanley CCG	274,881	28	£386.2
Medway CCG	302,150	45	£441.7
South Kent Coast CCG	221,148	28	£338.3
Swale CCG	115,565	16	£175.5
Thanet CCG	167,172	14	£245.8
West Kent CCG	460,000	55	£682.0
Total	**1,886,511**	**211**	**£2,778**

* Total budget includes primary care commissioning budget and CCG management cost budget.

Total health and social care spend including specialised services across K&M is approximately £4bn per annum.

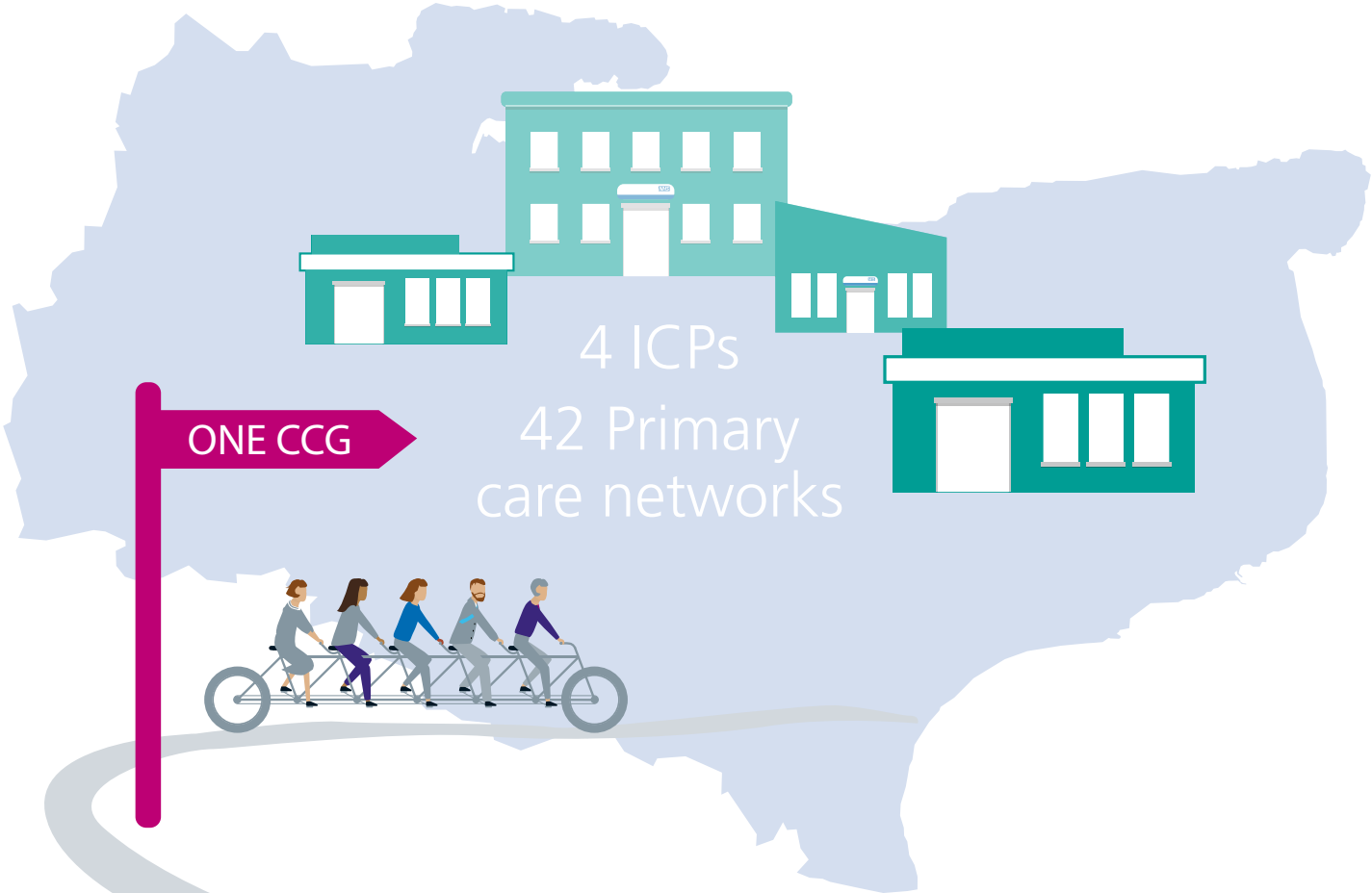
The eight CCGs combined cover the coterminous areas of Kent County Council (KCC) and Medway Unitary Authority. Kent includes the city of Canterbury in the east and the large market (county) town of Maidstone in the west. The large conurbation of Medway in the north includes the main towns of Chatham and Gillingham. Thanet in the east is one of most deprived areas in England.



This large geographical area (1,368 square miles) includes many towns and villages and rural areas, particularly in the south and east of the county; and more urban and light industrial towns in the north and the west. The county has a very long coastline and is a major transitory route for the continent through the port of Dover and Channel Tunnel in Folkestone. The number of people living in Kent and Medway is approximately 1.8 million, which is expected to grow to 2.1 million in 2031.

Many of the organisations that make up the K&M health and (integrated) care system are detailed in the Kent and Medway partners document, Appendix 2.

Section 4



The Kent and Medway context

4 Case for change: the K&M context

Section 4 provides **further context** for our local case for change. It includes a high-level view of the current health and wellbeing of our population, our track record as a nascent ICS, key challenges and our current, collective financial position.

4.1 Our population – the needs of local people

The needs of local people drive local requirements for health and social care. The appended K&M case for change 2018 (Appendix 3), published by the Clinical and Professional Board includes details of the key population health issues facing the area, which will continue to inform our ICS priorities and work plan. The key headlines are:

Population growth

From 2011 to 2031, planned housing developments are expected to bring an additional 414,000 people to K&M in circa 190,000 new homes.

Living longer, but with additional health needs

The number of older people is growing quickly and older people tend to use health and social care services more than other age groups. Growth in the number of over 65s is over four times greater than those under 65; an ageing population means increasing demand for health and social care, for example, there are currently around 12,000 people living with dementia in K&M.

Inequalities

There are widespread health inequalities across K&M with a large difference in average life expectancy across wards. For example, men residing in the most deprived areas live on average eight years less than those living in the least deprived.

Preventable long-term conditions

Over half a million people, including 19,000 children under the age of 16, live with one or more significant long-term health conditions, many of which are preventable. Furthermore, many of these people have multiple long-term health conditions; and on average total spend on a person with a long-term condition is six times more than on someone who is healthy.

Mental health

The prevalence of mental health disorders in K&M is generally in line with the rest of England, but mental health problems disproportionately affect people living in the most deprived areas. Approximately, one in 10 children aged between five and 16 years has a diagnosable mental health problem. Self-harm can be a useful mental health indicator and in K&M, self-harm rates have risen steadily since 2007. In Kent, there were around 5,900 admissions to hospital last year for self-harm and in Medway, there were nearly 600.

Children and young people

The health and wellbeing of children is a significant determinant of physical and emotional wellbeing all the way through to adulthood. The current issues facing children and young people include an average of 20% being obese or overweight, rising to nearly 30% in some areas; inadequate vaccination coverage; and just under half of all looked after children being at higher risk of developing a mental health disorder. Clinical standards for paediatric and maternity services are also not being met.

4.2 Our track record and challenges

K&M has much to be proud of. The vast majority of its population receives good care and treatment. There are many services that provide high-quality care, day after day and will continue to do so. Indeed, since the establishment of CCGs in 2013, the NHS and social care in K&M have had a number of successes making changes to local services and improving patient outcomes:

- **Out of hospital care.** Over the past couple of years, there has been a wide-spread introduction of GP-led multidisciplinary teams across K&M, working both proactively to manage the health of people with multiple health conditions, and reactively to treat them at home when they suddenly deteriorate. More services are being provided out of hospital such as multi-disciplinary teams in Medway, Canterbury and Ashford, diabetes care in west Kent, cataract clinics in Herne Bay and urgent home visiting service in south Kent. The key now is to 'industrialise' these schemes where they are making a real difference to secure better care outcomes.
- **Acute stroke services.** More than 3,000 people are treated for a stroke in K&M each year. Although hospital staff provide the best service they can, our local hospitals do not consistently meet the national standards for clinical quality because of their configuration. Following a huge amount of work over the past two years including a public consultation, the CCGs recently approved plans for the provision of three acute and hyper acute stroke units across K&M.
- **Reductions in smoking prevalence.** In the first six months of 2017, K&M recorded the highest success rates for people quitting smoking for the whole of England: 65% of smokers who attended drop in clinics in Kent, and 58% of smokers who used telephone support services in Medway, managed to stop smoking In Kent, only 15.2% of the adult population now smokes and in Medway the proportion of smokers is 19%.
- **Sustained reduction in teenage pregnancy.** The conception rate among under 18s has been steadily declining in K&M. This is as a result of years of multi-agency collaboration to ensure third sector organisations, school nurses and clinicians work together to deliver services tailored to young people.
- **Diabetes prevention programme.** The NHS Diabetes Prevention Programme (NDPP) is the first attempt to prevent Type 2 diabetes at a national scale anywhere in the world. Medway CCG and Medway Council's Public Health Team were one of the seven demonstrator sites to pilot this work. The learning from the pilots, including the adoption of a primary care case finding tool developed in Medway, has been used to inform the wider roll out across England. The NDPP has now been successfully rolled out across Kent.
- **Eating disorder services.** Services have now been redesigned to ensure there is no longer an access limit to those below a certain body mass index or an artificial divide between children's and adult services. The focus is instead strongly on the early intervention for all ages, which in turn improves individual patient outcomes and wellbeing and in the longer term reduces costs to the NHS.

However, while we have a lot to be proud of, there remain a number of fundamental challenges where the health and care system in K&M needs further focus and work:

Public health, prevention and inconsistency

- Only 2% of health and social care funding in K&M is spent on public health interventions to reduce the risk of avoidable disease and disability
- Around one in five primary school children are overweight or obese
- There are stark health inequalities across K&M. Around 1,600 early deaths each year could have been avoided with the right help and support early. This is a particular issue for people who live in deprived areas and/or who have a severe mental illness.
- Inequity of service provision. Services commissioned and provided across K&M vary by CCG.

Some of this is appropriate as the needs of the local populations differ. However, there are also inconsistencies in service provision which we need to address as a nascent ICS. While a single K&M CCG will not prescribe how local services are delivered, it will stipulate consistent and equitable minimum expected care and well-being outcomes across the system.

Capacity and capability

- Significant workforce issues. In Kent and Medway, we are behind the national average in terms of workforce growth. Our workforce supply has decreased for most workforce groups, with 6,820 full time equivalent vacancies, as depicted in the table below:

In Kent and Medway we employ more than **83,800 people across more than 350 health and social care roles.**

Workforce full-time equivalent (FTE)	
	March 2018 (FTE)
Social care	42,500
Clinical commissioners	530
Primary Care	3,630
Ambulance	3,080
Mental Health	3,670
Community	4,810
Acute	18,750
Vacancies	6,820

- Some services for seriously ill people in K&M find it hard to run round-the-clock and meet expected standards of care: all stroke patients who are medically suitable should get clot-busting drugs within 60 minutes of arriving at hospital. None of the hospitals in our area currently achieves this for all patients.

Complexity

The current commissioning system is far too complex and bureaucratic.

K&M example 1: Acute stroke services review

Initial papers and proposals were required to go through a number of individual CCG committees and other meetings. At one point, nearly 50 formal committee meetings over a six-month period were planned. The subsequent establishment of a joint committee for stroke services reduced the bureaucracy in this instance, but such solutions can only go so far given the current complexity of our system.

Standards and outcomes

- People with mental ill health have poor outcomes: the average life expectancy for people with severe mental illness is 15 to 20 years less than the average for other adults as their physical health needs are less likely to be met.
- Cancer care regularly does not meet national standards: for instance waiting times for diagnostic tests, to see a specialist and for treatment.
- Every day around one in three people in a hospital bed could get the health and social care support they need out of hospital, if the right services were available.
- Services and outcomes for people with long-term conditions are poor: as many as four in 10 emergency hospital admissions could be avoided if the right care was available outside hospital.

Finance

- We are not able to live within our means: it is estimated that by the end of this financial year (2019/20) the NHS in K&M will have overspent its planned budgets by £153m. This is excluding the benefit of non-recurrent support from the commissioner support fund and provider support fund, which reduces this overspend to circa £54m. Services could be run more productively: around £190m of savings could be made if services were run as efficiently as top performing areas in England.

Supplementary track record information

In September 2017, NHS Dartford, Gravesham and Swanley CCG was placed under directions by NHS England as a result of not meeting statutory financial duties with associated concerns regarding the capacity and capability of the senior leadership team. The CCG was released of these interventions in March 2018, having assured NHSE/I of the required improvements in both areas.

In May 2019, NHS Ashford CCG, NHS Canterbury and Coastal CCG, NHS South Kent Coast CCG and NHS Thanet CCG were placed under directions by NHS England as a result of not achieving their statutory financial duties. Again, this was supplemented with concerns regarding leadership capacity. The CCGs are implementing an agreed joint financial recovery and management plan and they hope to be lifted from directions before the end of the current financial year. It is anticipated the current programme of work, as well as the benefits of a single CCG, (detailed in section 5.3 and appendix 8) including simplification, accelerated decision making, implementation of an outcomes-based/ population health approach to commissioning will significantly mitigate the original, underlying causes for the east Kent directions.

All eight CCGs in K&M have delegated responsibility from NHS England for the commissioning of primary medical care services. The CCGs plan for this to be transferred to the new K&M CCG with effect from April 2020.

4.3 Joint working to date

Despite the complexity of the local system we have a good track record of working together both as CCGs and at a K&M system level, although this needs to go much further to **enable accelerated decision making** and deliver better outcomes for our population. From a collaborative perspective we believe that we have gone as far as we can under existing arrangements and the establishment of a single CCG is the key catalyst required to **simplify, deliver a transformational change and build a strong K&M ICS**. The following demonstrates the joint working arrangements **currently** in place:

CCG joint working

Six of the eight CCGs in K&M have had joint executive teams since 2013 and from 2016 governing bodies and other committees have been meeting-in-common. In addition, independent and lay members of CCG governing bodies have increasingly shared roles across two or more CCGs. The establishment of the K&M STP and associated programme of work has accelerated this joint working:

- In autumn 2017, the first K&M CCG's joint committee, for stroke services, was established to develop the future arrangements for acute and hyper acute stroke services
- In spring 2018:
    - a single accountable officer (AO) was appointed to the eight K&M CCGs. The post holder is also the STP CEO
    - the senior management structure of the CCGs was also revised to cover two geographical footprint areas: east Kent (encompassing four CCGs); and Medway, north and west Kent (encompassing the other four CCGs). A managing director was appointed to each footprint area, reporting directly to the AO, and deputy managing directors were appointed to individual CCG and pan-footprint portfolio areas
    - functional teams, such as quality and safety, finance etc, started working more formally together within the footprint areas.
- In autumn 2018, a second joint committee was established with responsibility for other commissioning services that require a pan-county response to service development and delivery. This was because a number of critical challenges were not being effectively addressed. The committee is currently responsible for cancer and children's services with plans to add mental health. A further east Kent CCGs joint committee was also established with responsibility for specific east Kent commissioning issues, particularly relating to the proposed reconfiguration of local acute hospital services.
- Since January 2019, the K&M CCG remuneration committees have been meeting 'in-common' to ensure consistent decision making across the organisations. The CCG audit committees are also considering this.

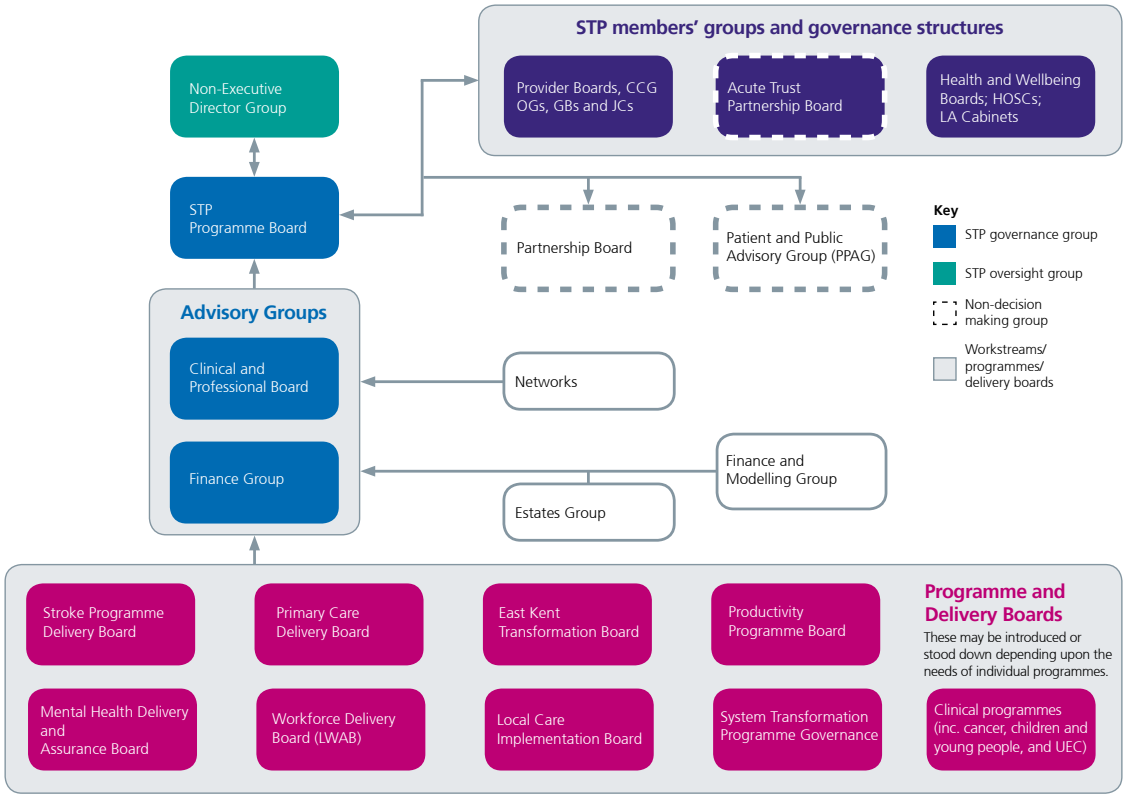
K&M example 2: joint working

While the above joint working arrangements have progressed there have also been areas where joint working has been more difficult to sustain. For example, prior to the establishment of CCGs in 2013, K&M primary care trusts (PCTs) had a single contracting team and various collaborative contracting agreements in place. While a number of these agreements continued after 2013, they have become more disparate as a result of differing contractual approaches, more recently linked to increasing individual financial pressures in each CCG. **A merged CCG presents an opportunity to bring consistency and efficiency to our market management, procurement and contracting approaches, which in turn will support accelerated improvement of financial standards.**

System transformation

At a system level, the K&M STP programme board has been in place since 2016. It has membership from the main providers and commissioners of care across the area including local authorities. The remit of the STP has been to develop and oversee shared plans for improving system-wide quality, health outcomes and efficiency.

The current governance structure for the K&M STP is depicted below:



In parallel with publication of the NHS LTP, a system transformation programme (formerly known in K&M as the system leadership programme) is now fully in place. This reports to the STP Programme Board and the statutory organisations through a system transformation executive board. The programme initiation document (PID) in Appendix 4 provides the background and governance framework in which the programme operates.

The merger will be the next natural step for K&M building on the joint working arrangements put in place to date.

4.4 Our financial position

The K&M CCGs face a significant financial challenge. The accumulated deficit position as at the end of 2018/19 is a net £87.5m (comprising six deficit CCGs £108.5m and two surplus CCGs £21m). In 2019/20, the CCGs collectively have a deficit control total of £4.7m but this position is after receipt of planned commissioner sustainability funds (CSF) totalling £34.2m. Without CSF, the position is a deficit of £38.9m. The total quality, innovation, productivity and prevention (QIPP) requirement for K&M CCGs in 2019/20 is £89.4m.

As already described, four of our eight CCGs are subject to 'directions', which require the preparation of a robust and credible financial recovery plan.

The control total for all NHS providers in 2019/20 is a deficit of £49.3m, after deployment of the provider sustainability fund (PSF), financial recovery fund (FRF) and marginal rate emergency threshold (MRET). Without these funds, the position of NHS providers across K&M is a deficit of £113.7m. Therefore, in total the wider K&M system is tasked with delivery of a control total deficit in 2019/20 of £54m. Achieving this will require considerable focus and energy, and for the system to develop new approaches of working together that lead to optimisation of care pathways and less waste within the system. The achievement of the control total in 2019/20 is an essential platform for the proposed single CCG allowing it to operate within the new landscape of the ICS, and ICPs from April 2021.

The table below shows, by CCG and in total for Kent and Medway, the accumulated surplus/deficit over the last three years and the planned forecast out turn (FOT) for 2019/20.

Kent and Medway CCGs	Pre 2017/18	2017/18	2018/19	2018/19	2019/20	2019/20	2019/20	2019/20
	Accumulated Surplus/ deficit	Surplus/ deficit	Surplus/ deficit	Accumulated Surplus/ deficit	Planned FOT Surplus/ deficit	Planned FOT CSF support	Planned FOT Surplus/ deficit	Planned FOT CSF support
	£m	£m	£m	£m	£m	£m	£m	£m
NHS Ashford CCG	-2.1	-12.2	-15.1	-29.4	-15.8	11.1	-4.7	-34.1
NHS Canterbury & Coastal CCG	5.5	-9.5	-17.7	-21.7	-10.1	10.1	0	-21.7
NHS Dartford, Gravesham and Swanley CCG	-13	-9.1	-9.9	-32	-5	5	0	-32
NHS Medway CCG	7.1	0.7	0	7.8	0	0	0	7.8
NHS South Kent Coast CCG	5.5	-7.3	-15.2	-17	-9.5	9.5	0	-17
NHS Swale CCG	-2	-3	0	-5	0	0	0	-5
NHS Thanet CCG	3.8	0	-6.6	-2.8	-3.2	3.2	0	-2.8
NHS West Kent CCG	11.5	1.7	0	13.2	0	0	0	13.2
Total Kent and Medway Commissioner	**16.3**	**-38.7**	**-64.5**	**-86.9**	**-43.6**	**38.9**	**-4.7**	**-91.6**

Section 5

Our ambition

Quality of care, quality of life

5 Case for Change: Our ambition 'Quality of life, quality of care'

As highlighted in the previous sections, the K&M system continues to face a number of strategic, operational and financial challenges. Responding to these local challenges requires a whole system transformation of how we commission and deliver services. The future model needs to be financially sustainable, demonstrate operational effectiveness through improved outcomes, deliver high quality and safe care and importantly, be responsive to the physical and mental health and care needs of the population of K&M. To deliver sustainable and responsive services **we need a simplified and consistent K&M system for which the cornerstone will be a single K&M CCG.**

Our appended STP PID (Appendix 4) and the associated project and workstreams explain the next phase of our journey while the following sub-sections summarise how we will commission differently, structure ourselves to deliver positive change and what we expect the benefits of the change to be. **The development of a K&M commissioning and population health strategy and accelerated delivery of the outcomes in our draft LTP are predicated on the basis of CCG merger in April 2020 and effective establishment of the wider ICS by April 2021.**

5.1 Our commissioning strategy

Where are we now?

Vision, strategy and STP work programme

K&M's clinical vision and strategy, **'Quality of life, quality of care',** sets out our ambition for the population of K&M to have a great quality of life through high-quality care; for them to be as healthy, fit (physically and mentally) and independent as possible; participating in their local economies and communities and able to access the right help and support when they need it. It sets out how we intend to develop and foster **a vibrant voluntary sector and a strong sense of community** in our towns and villages, where people feel connected and we support one another across the generations; and where we are in control of our health and happiness, feeling good and functioning well.

In addition to the clinical vision and strategy, senior doctors, nurses and care professionals from across the K&M system developed the aforementioned **clinical case for change** (Appendix 3) that sets out our key challenges and outlined the actions that need to be taken in the coming years. Aligned with the NHS LTP, the document included four key themes, which are being driven through current STP programme workstreams:

- Care transformation: **preventing ill health, intervening earlier and bringing excellent care closer to home.**
- Productivity: **maximising efficiencies** in shared services, procurement and prescribing.
- **Enablers:** investing in buildings, digital infrastructure and the workforce needed to deliver high-performing health and social care services.
- **System leadership:** developing commissioner and provider structures, which will deliver the greatest impact i.e. single system commissioner, integrated care partnerships and primary care networks.

Population health

K&M is one of the most advanced areas in the country in linking longitudinal patient and social care user data across health and care settings, through the Kent Integrated Dataset (the 'KID'). This gives us an opportunity to understand the health of the K&M population, including an ability to segment and stratify our population to identify "at risk" cohorts and assess the impact of proposed strategies. While we have developed leading edge approaches around the capture and linking of data we have historically failed to fully optimise this insight to drive improvements in the health of the entire K&M population. This has been largely due to a lack of consistency of approach, coupled with a system that has not been focused on population health management.

A K&M population health review has also been drafted recently, structured around the NHS LTP, that confirms key population health needs and gives recommendations across priority areas for improvement (Appendix 5).

Defining how we commission/provide services

Detailed work has already started to determine future commissioning/provider roles and responsibilities. Working with the emerging ICPs we have reviewed all current commissioning functions and considered where these are likely to fit in the new ICS. This work also includes where the commissioning support functions e.g. finance, quality and safety, HR are likely to sit in the initial phases post-CCG merger. Details are provided in the high level summary and detailed future functions worksheets (Appendices 6a and 6b).

In addition to this, we have developed an interim system operating framework (Appendix 7). This is a working discussion document entitled 'One Team' which is the term K&M are applying to our joined up working arrangements. It reflects the need to focus on the system and sub-systems rather than individual organisations, drawing expertise together from across organisations to address the key challenges, and realise opportunities for patients. The One Team approach is considered in how our functions, systems and workforce are developed and deployed.

Where do we want to be?

The work described above and the autumnal K&M response to the NHS LTP will provide strong input to a bold new K&M integrated care commissioning and population health strategy which will form the bedrock of work of the new ICS. The strategy will be co-developed with a wide range of stakeholders across our local ICS and will support both delivery of the LTP and the benefits identified to date in the merger benefits realisation plan. The K&M strategy will include our approach to the challenges set out in section 4.2 including how we intend to deploy our new integrated care system to:

- root out and eradicate (as far as we can) inequality and inequity across the K&M system
- tackle some of the individual CCG assurance rating issues and poor delivery of constitutional standards
- tackle our estates, digital and workforce challenges.

The intent is to complete the strategy in early 2020. However, we know that two key elements will be our approach to:

1. Population health management/data

Building on the KID and the population health review we need to develop our capability to maximise use of tools/data and the intelligence they provide, to support the development of population health management and establish ICP/PCN delivery plans.

We recognise that access to data and toolkits is not enough to deliver population health management. As outlined in the benefits realisation plan (Appendix 8) the development and critical mass of the a single CCG will enable us to focus on, prioritise and emphasise a consistent framework for population health management, supported by the tools and expertise to support the take-up and use of these. The K&M CCG will have a dedicated clinical lead and a lead director on its governing body with primary responsibility for population health and population health management. The lead director will act as the system senior responsible officer for this portfolio which will build on the work of the Kent and Medway Strategic Health Analytics Board and the recent Kent and Medway population health case for change, completed by the two public health teams.

2. Managing the 'K&M pound'

A further key component of the commissioning strategy will be moving towards a more sustainable financial footing. The working draft medium term financial plan (MTFP) (Appendices 9a and 9b) is expected to be finalised alongside the local response to the LTP in November 2019. Delivery of the MTFP is based on managing spend through a range of programmes:

- CCG merger and the benefits described in the benefits realisation plan
- the integration of provision, and the integration of commissioning and provision, through the development of the K&M ICS
- continued delivery of a range of provider and commissioner efficiencies, enabled through our integration plans
- the levelling up of clinical variation across the system using RightCare, GIRFT, etc. and other analysis
- supply side reconfiguration (e.g. the east Kent reconfiguration programme, the review of K&M stroke services and the consolidation of emergency vascular surgery).

How do we get there?

The subsequent sections in this document describe in detail how we intend to move forward with the new approach/strategy, including our operating framework, workforce strategy and benefits realisation. To get ourselves ready we have started re-aligning staff and functions across K&M, recognising that all CCG staff will initially transfer to the K&M CCG in April 2020:

- primary care and medicines optimisation teams will retain a local customer care/commissioning focus based on GP neighbourhood areas
- other commissioning functions and staff will start to be more aligned to place/system-based areas of responsibility during winter 2019/20, with a view to the majority working on an ICP/PCN footprint basis and ultimately being employed by these partnerships when they are mature enough to hold respective contracts (circa April 2021)
- supporting functions including finance, corporate services, communications and engagement, quality and safety, etc. will be consolidated into K&M wide teams where appropriate on a staged basis from October 2019 in preparation for CCG merger (HR, C&E and Corporate Services will be the first to consolidate). During 2020/21 further work will be undertaken to determine the structure of back-office functions pan-K&M as the new landscape emerges (and the old CCGs are closed down, with annual accounts, reports, etc.).

In parallel we:

- will continue to work on the wider system transformation programme, to develop high performing, effective delivery functions over the next two years using our existing talent pool, building on areas of strength. As new joint functions evolve (such as population health) we will then address identified gaps in skills and expertise
- will further develop our emerging K&M digital, estates and workforce strategies
- are starting to weave in the current STP programme/resources into a single CCG/future ICS programme of work.

A further key component of the commissioning strategy will be moving towards a more sustainable financial footing.

Developing outcomes-based contracts

The population health management approach outlined in the 'Where do we want to be?' section will be underpinned by a change in the way we commission. We will move from a contracting model based on inputs and activity volumes to an outcomes based framework, that incentivises and rewards based on improvements in the health of the population, at-risk cohorts and individuals. The revised ICP contract, as released by NHS England, provides the contractual vehicle for a K&M outcomes-based contract. We see the outcomes within this contract being derived from a number of sources:

- at a national level as established through the LTP (delivered through a framework established by the single K&M CCG, working with ICPs, PCNs and other partners)
- at a K&M level established through the single CCG
- at a local level through the PCNs and ICPs.

The development of this framework is a critical piece of work, which is closely aligned to the K&M response to the NHS LTP. Linking to the 'future functions' work above and central guidance, this will ensure partners from across the system work within an agreed and consistent framework when determining what and how services will be commissioned and delivered.

While much of the above would need to need to happen with or without merger approval, a successful application will help build on the energy and momentum to deliver change at pace. It will also help foster a collaborative culture between commissioners, providers and partners which in turn will allow integration to happen sooner and faster.

5.2 Our proposed operating framework

Based on this collaborative culture, the K&M operational framework represents a significant shift from historic transactional relationships to embracing clinically led, intelligence driven and outcomes-based integrated partnerships.

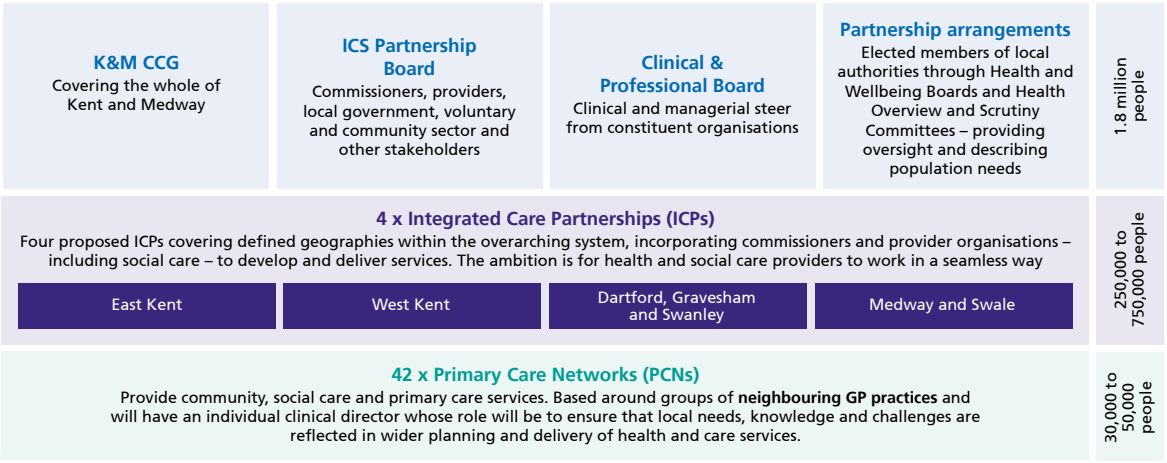
The emerging ICS

As mentioned in the previous commissioning strategy section a working draft discussion document 'One Team: the operating model for K&M' has been developed and agreed by the STP programme board detailing the transitional operating framework for K&M. It is a dynamic document that will evolve over the coming months but already gives a clear steer on the proposed relationship and remit of the ICS partnership board, the K&M clinical and professional board, the K&M joint health and wellbeing board, and the CCG.

In advance of any change in legislation and as the STP starts to transition to the ICS, system specific programmes of work will transfer their hosting arrangements to the new CCG or alternative statutory body(ies) as appropriate. The ICS partnership board will take over from the STP programme board and over the next 18 to 24 months membership of the ICS partnership board will move towards the new landscape with more focus on ICP, PCN and CCG partnerships. At an ICS level, there will be an independent chair of the ICS partnership board, in line with the NHS LTP. The K&M CCG will provide business support to the ICS partnership board and the CCG AO will be the lead senior officer working with the independent chair.

A K&M patient and public engagement (PPE) group will be established as part of the ICS infrastructure (replacing the existing group) and will link in with the respective PPE forums in the various organisations and partnerships – **a PPE 'golden thread'.**

The high level structure of the ICS is depicted below:



The K&M CCG

Recognising the need to **maintain an effective grip on operational delivery alongside organisational and transformational change,** the CCG operating framework has been developed on the basis of **minimising disruption during transition to a single CCG** in April 2020 and thereafter, to a fully functioning ICS in 2021/22.

A transitional senior management team for the eight CCGs has been in place since April 2018. This will be further bolstered over the autumn. With the impending retirement of the current AO, the appointment of a permanent AO is currently underway. Subject to successful recruitment, it is expected that the new incumbent will be in post early in 2020. The appointment of a permanent Chief Finance Officer (CFO) is planned to take place alongside the AO recruitment process, albeit six to eight weeks behind, to allow the new AO to be on the appointment panel. Permanent appointment to the other executive director and senior manager posts will take place once the AO is in post, hence the transitional senior management structure is planned to remain in place up to June 2020. This will enable a smooth transfer from eight organisations to one. The appointment of the CCG Chair and GP governing body members will start following approval of the merger application. The proposed K&M CCG constitution is in development, but the main components relating to the governance framework have been agreed. Details are provided in Appendix 10.

The senior leadership team of the new CCG will take key system leadership roles within the ICS, led by the newly appointed AO, working with the CCG clinical chair and independent ICS chair. These arrangements will build on the transitional arrangements as noted above with some additional roles identified from the commissioning and system functions review recently undertaken. **Appendix 11 outlines the transitional leadership organisational structure that will be in place across the CCG and wider system programme areas until at least June 2020**, which will give the new AO time to review existing and future requirements.

Section 5.6 (Merger Plan) details how we will effect the merger through a robust PMO approach while maintaining business as usual.

5.3 Realising our potential – benefits realisation

As we have progressed the benefits realisation analysis it has cemented our long held and collective view that we need to move forward with a merger at pace. Assumptions made locally about the opportunities of merger now have associated and measurable time and effort estimates. These estimates now provide us with the opportunity cost of not merging, not least of which will be the inability to fully release investment into our ambitious ICS. **A CCG merger will unlock short and long term advantages which will not be achieved at pace without a change to the current arrangements.**

The benefits

1. Redirection of clinical and management resources closer to local front-line services and our patients

The proposed merger is a fundamental building block for a successful ICS (ICS), a necessary pre-cursor to innovative, vibrant and patient-centric primary care networks (PCNs) and integrated care partnerships (ICPs). The merger will allow us to bring together CCG clinical and managerial time to deal with the critical issues facing us now, as well as redirect resource and effort to the PCNs and ICPs and therefore closer to the health and social care frontline **Without a single commissioner in place, our ability to redirect resources, while addressing current pressures, will be hampered and it will be longer before proposals for a fresh, shrewder approach to commissioning, provision and the new ICS result in tangible improvements.**

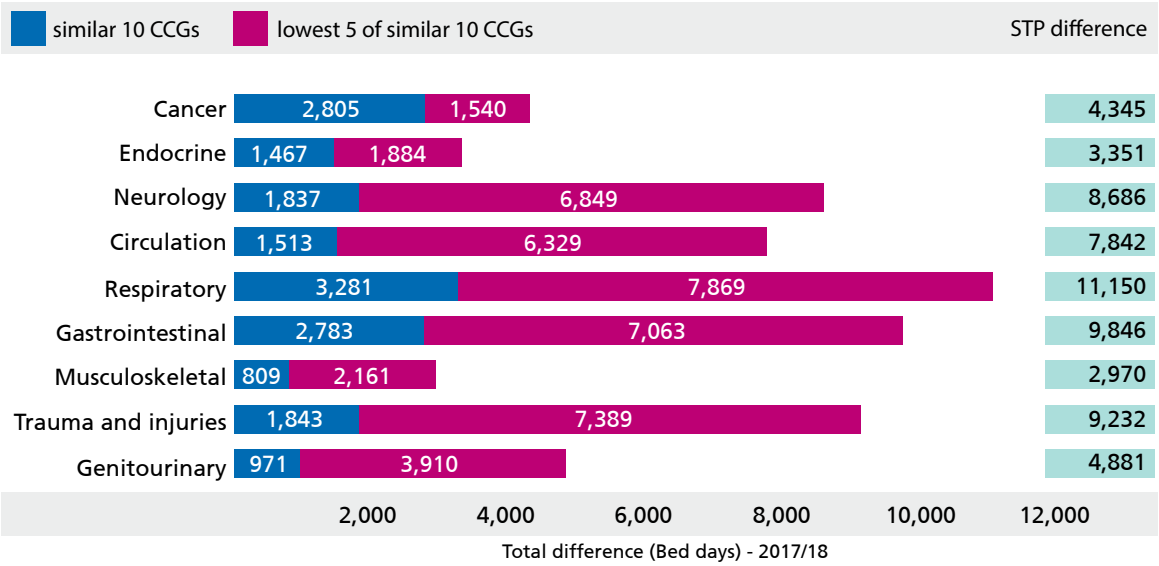
2. Development of a coherent service strategy and acceleration of an outcomes-based approach to commissioning and service delivery ultimately improving patient's health, wellbeing and experience of our services:

The K&M CCGs, partners and providers are committed to a new way of working and have been working towards an ICS for many months through the wider system transformation programme. As a cornerstone of the ICS, a single commissioner will:

- allow a more coherent commissioning strategy for K&M as a whole (including more specialised areas such as digital, workforce and estates)
- enable and oversee a consistent outcomes-based approach to commissioning across the system with our partners and providers moving away from bilateral, payment by results (PBR) based contracts to financial and contractual frameworks that target population health improvement and maximise the potential for prevention
- provide oversight and insight across a larger area helping us identify and share best practice, deliver consistency in commissioning approach and expected outcomes and help address inequity and inequality across K&M.

Information gleaned from sources such as NHS RightCare (see shared K&M CCG opportunities diagram below) provides us with a potential focus for unwarranted clinical and financial variation.

If the CCGs in this STP performed at the average of their:



3. De-duplication, accelerating improvement and delivery of nationally mandated 20% running costs reduction

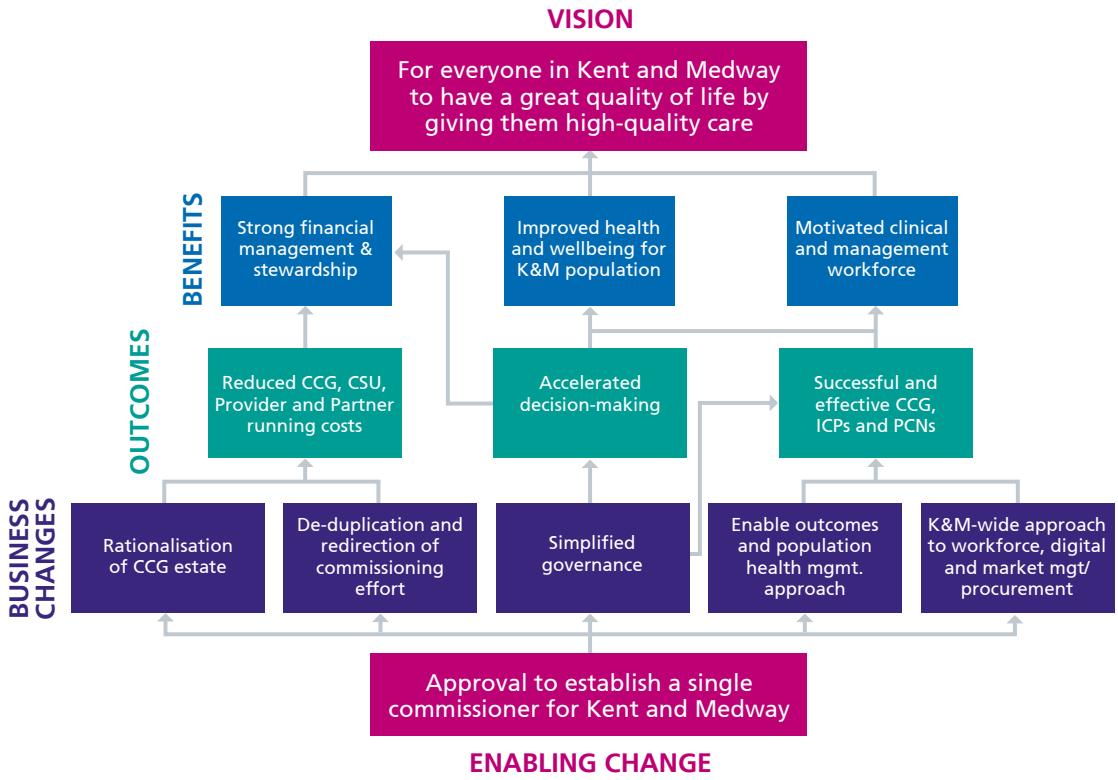
While the establishment of a K&M-wide programme, workstreams and joint committees has partly mitigated duplication and helped speed up decision making, **the current myriad layers of commissioning management and governance across eight organisations stifles decision making and can more than double our 'speed to market'. This in turn often dilutes the bold and innovative proposals** which are required to help address our short and long term constitutional and financial challenges: across K&M various national standards are continually not being achieved. We need to address this alongside making running cost savings in 20/21 of **£4.7m. Merger of the CCGs will facilitate:**

- consistent, targeted and accelerated decision making to improve poor performance and patient outcomes, such as cancer, diagnostic and mental health standards
- significant reduction in the level of duplication of tasks/resource across CCGs
- greater efficiency across the system enabling achievement of running cost savings and delivering accelerated wider financial gain.

The benefits realisation plan and mapping

All of the single system commissioner benefits are identified in the benefits realisation plan (Appendix 8). These are split into two main categories, direct benefits from the CCG merger and those subsequently enabled through a single commissioning organisation. It should also be noted at this stage of merger development, that the benefits of a single commissioner are **high-level estimates** and that as such ranges have been included. As we progress our organisational development and re-focus our STP and projects to deliver these identified benefits, more detailed work and analysis will allow for estimates with a higher degree of confidence and probability.

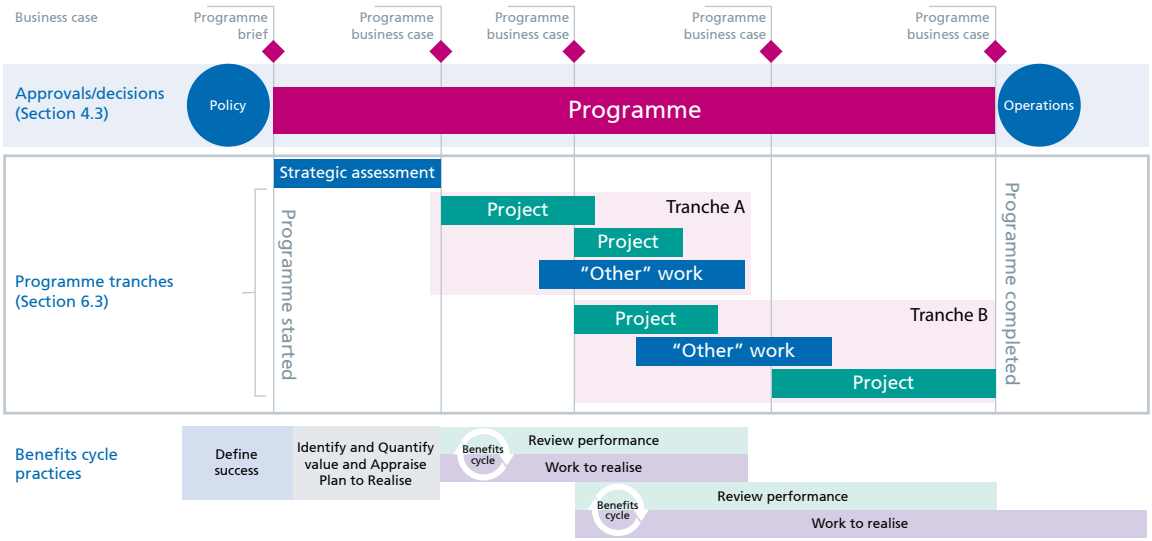
A view of how we map the approval for a single K&M CCG to benefits and our vision is shown below:



Finally, while realisation of the benefits do not come without challenges, which we have mitigated either through funding commitments or agreed OD/HR principles, **we believe these benefits far outweigh the risks.**

Measuring and tracking benefits

The benefits of merging the eight CCGs and the future transformation of the commissioning and provider landscape will be monitored and tracked by a programme management office (PMO) function, hosted within the newly merged CCG but shared across the ICPs and PCNs. It will deploy an approach similar to the government functional standard depicted below:



The PMO team will work with PCNs and ICPs to ensure that intended and stated benefits are realised within the given time period. Where they are not being realised in the timescales given, this will be escalated to the CCG, PCN and ICP leadership for resolution. The PMO will not only track the benefits of merger but the outcomes expected from the ICS as a whole. While there will undoubtedly be 'transactional' elements to track and monitor, the PMO team will have an emphasis on tracking transformational outcomes, giving system assurance in line with the culture of the ICS as a whole.

5.4 Our workforce

Our workforce will be crucial to delivering our vision and transformation is urgently needed to address the quality, service and capacity challenges scrosss health and social care.

To deliver our ambition and address the critical workforce challenges **we will develop a Kent and Medway Academy for Health and Social Care** working collectively across commissioners, providers and partners to:

- promote Kent and Medway as a great place to work
- maximise supply of health and social care workforce
- create lifelong careers in health and social care
- develop our system leaders and encourage culture change
- improve workforce wellbeing, inclusion and workload to increase retention.

We have established a STP workforce action board as part of the STP governance, made up of representatives from K&M partners. As well as supporting other STP workstreams, the workforce action board has specific workforce supporting governance groups including a primary care workforce group, a social care workforce group, and HR directors group, directors of nursing group and union group. Establishment of a single commissioner will allow for a more coherent and consistent commissioning strategy guiding and accelerating the work of the action board as well as the sub groups.

Further details on our approach to workforce challenges including the Kent and Medway Academy for Health and Social Care and how we plan to manage the transition period to a merged organisation and beyond are contained in the following appended documents with an excerpt provided below.

ID	Document name	Content
1	**Kent and Medway system workforce transformation strategy** (Appendix 12)	Sets out our ambition, strategies and plans for working together across health and care to prioritise and address our workforce challenges.
2	**NHS Kent and Medway CCG workforce and OD transition plan** (Appendix 13)	Sets out our high level plan for the work that needs to be undertaken over the next 18 months and a detailed CCG merger implementation plan.

5.5 Communications and engagement

Communications and engagement (C&E) during the past two years has been fundamental to shaping the future of our local system. We have continuously improved our ICS and merger CCG plans through extensive, clinically-led discussions with our stakeholders.

Engagement about system transformation started in January 2018, with the emphasis moving to a single CCG during 2019. Clinical chairs engaged through formal and informal face-to-face meetings, a webinar, written briefings, letters and emails. Between June and September 2019, they, with the support of senior managers, provided a series of written briefings and frequently asked questions to all stakeholders, plus face-to-face briefings to our two health overview and scrutiny committees, the Kent and Medway Health and Wellbeing Board, district and county councilors, and MPs. We also ran two surveys, which were promoted to all audiences.

The following documents set out the plan and outcomes of our extensive communications and engagement C&E activities:

ID	Document name	Content
1	**Communications and engagement plan** (Appendix 14)	Sets out our approach to informing, involving and listening to the wide range of different stakeholders we engaged as part of our merger application preparation and what we plan to do as part of the merger project
2	**'You said, we did' report** (Appendix 15)	Sets out how we responded to and incorporated merger engagement feedback into our ICS and proposed merger approach and plans.

Below is an example of how we have approached ICS and merger C&E during 2018/19:

K&M example 3: patient and public involvement

To develop recommendations for patient and public involvement in the new system, our C&E team worked with the Patient and Public Advisory Group, which has patient representatives from each of the existing CCGs including people who have protected characteristics, as well as CCG lay members, and the chief officer of Healthwatch Kent and Healthwatch Medway who is on many of our key committees. They held a series of workshops and co-produced an integrated approach to patient engagement with people able to get involved at PCN, ICP, CCG level and to form a 'bank' of experts to support all health and care providers.

The extensive communications and engagement undertaken highlighted the current complexity of our current local system. People strongly supported simplification with a single commissioner to free up time and resource for rapid changes to improve care.

5.6 Our merger plan

Pre-application (up to 30 September)

- May/Jun: PID approval, merger work-streams and ICP working group established.
- Jun/Jul: ICS 'One Team' model circulated to stakeholders.
- Jun/Jul: 1st stage 'Future Functions work' complete.
- Jan 2018 to Aug: Public engagement and survey proposals.
- Jul to Sep: Stakeholder, GP & Gov Body events.
- Jul to Sep: Governance framework (pre-constitution).
- Aug: Benefits Realisation and medium term financial planning.
- Aug/Sep: HR&OD and C&E strategies/planning.
- Sep: Agree CSU/support arrangements.
- **Sep: 8 x GP member votes and 8 x GB approval.**
- w/c 9 Sep: SCGOG/SG review.
- 27 Sep: Submission of LTP.
- **30 Sep: Application to NHS England and NHS Improvement.**

October to December 2019

- **3rd Oct: Regional Panel.**
- Oct: Centralise HR and C&E.
- Oct to Dec: Recruit AO/CFO.
- Oct to Dec: Develop ICP/ICS framework.
- **Nov: NHS England and NHS Improvement Merger Approval.**
- **Nov: Final LTP and MTFP submission.**
- Nov: Confirm merger with SBS (re ledger) and NHS Digital (re OSC code).
- Nov/Dec: Election of CCG Chair and GP GB members. Also appointment of other GB members and leads.
- Nov/Dec: Commence other CCG/ STP HR processes.
- Nov: CCG Constitution drafted.
- Confirm delegated commissioning transfer requirements.
- Dec: Stage 2 'Future Functions work' complete.
- Nov/Dec: Review/confirm CCG estate options for HQ.

January to March 2020

- Jan 20: Procure new auditors.
- Jan 20: Appoint ICS Independent Chair.
- Jan: Complete TUPE list of CCG staff.
- Jan: Constitution, SFIs and Standing Orders approved.
- Jan/Feb: CCG website and comms and engagement mechanisms.
- Jan: Inform regulatory bodies e.g. ICD, contract holders and stakeholders of merger.
- Jan to Mar: Prepare all Q&S assurance measures – safeguarding, CQC, etc.
- Jan: Confirm/prepare asset transfer arrangements.
- Jan: Confirm CCG HQ and prepare signage.
- Review CCG, STP and system PMO arrangements.
- 31 Mar: Complete HR TUPE transfer.

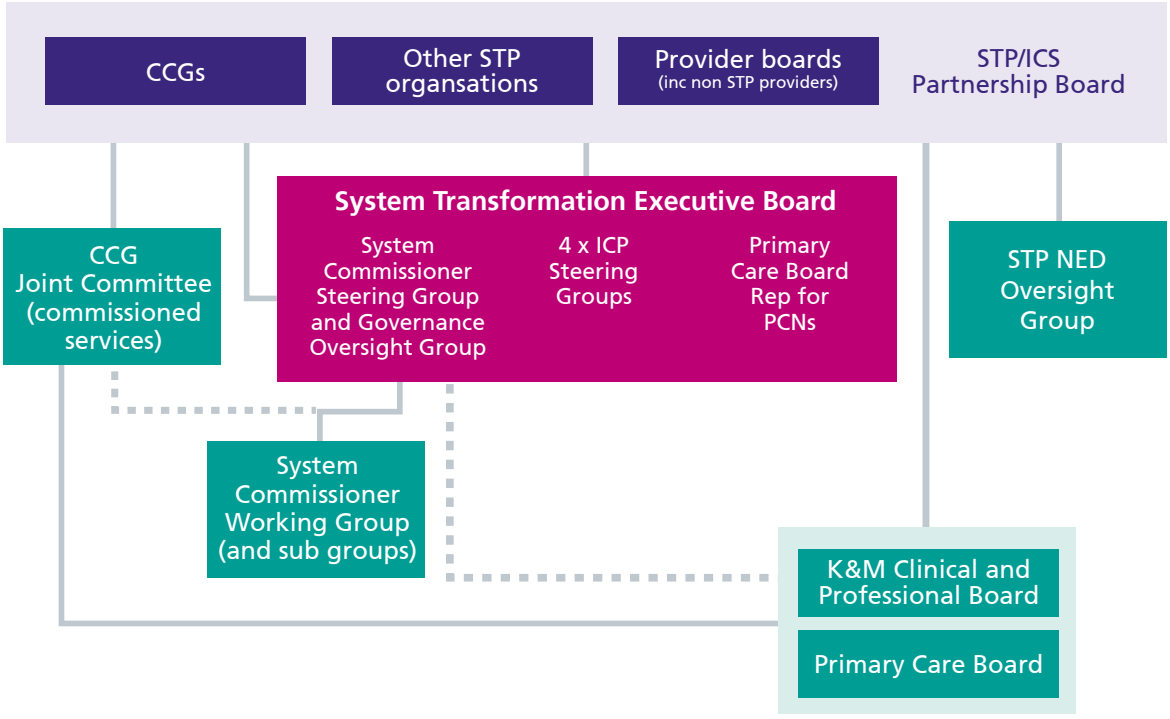
Post Merger April 2020

- **1 April: K&M CCG Operational.**
- 1 Apr: transfer e-mail accounts.
- 1 Apr: asset transfer.
- May/Jun: Year end Accounts and Annual Report.
- April: K&M Commissioning and Population Health Strategy completed.
- Spring: Revise system PMO arrangements towards new landscape.
- Spring/summer: 3rd final stage of future functions work complete.
- Close down CCG financial accounts.

The high level, merger 'Plan on a Page' is provided above. A copy of the detailed merger work programme including the individual merger workstreams is included as Appendix 16.

Delivery framework

The STP PID at Appendix 4 outlines the overarching governance arrangements for the whole system transformation, including the CCG merger (system commissioner) programme. The governance framework for the system transformation and system commissioner programmes is depicted below:



CCG Merger: Project Resourcing

The System Commissioner Steering Group (SCSG) – made up of the eight CCG Clinical Chairs, AO, MDs and PPE representative – has responsibility on behalf of the eight CCG governing bodies for oversight of the merger programme. Local authority and public health directors are also representatives on the group.

A System Commissioner Governance Oversight Group (SCGOG) provides advice and support to the SCSG on all aspects of governance. SCGOG members are the CCG independent lay members for audit.

A dedicated PMO team, led by the Director of System Transformation and the lead CCG Clinical Chair, has day-to-day responsibility for coordinating the programme on behalf of the SCSG. This reports in to an internal Executive Group made up of the AO, Managing Directors, CCG Clinical Lead, Director of System Transformation and lead Chief Finance Officer, which meet on a fortnightly basis (will start to meet weekly from November 2019).

Nine merger workstreams have been established to deliver the merger programme, each of which has a lead director(s) and HR lead – see Appendix 20. These feed in to a working group which holds the overarching merger work programme and risk register. The nine workstreams are: business intelligence, contracting and performance; commissioning and primary care commissioning; communications and engagement; corporate services and governance; digital; finance; HR, workforce and OD; and quality, safety and safeguarding. The structure we have put in place ensures there is focus on BAU and transformation as we embark on the significant changes ahead of us.

A copy of the corporate risk register for the system transformation programme detailing all the major risks of merger and the mitigating actions is attached as Appendix 17.