AGENDA

KENT HEALTH AND WELLBEING BOARD

Thursday, 16th September, 2021, at 1.00 pm Ask for: **Ann Hunter**

Council Chamber, Sessions House, County Hall, Maidstone (Please enter the building via the entrance in the Courtyard which will bring you to reception) Telephone **03000 416287**

Membership
Mrs C Bell (Chairman), Dr B Bowes, Sir Paul Carter, CBE, Mrs S Chandler, Dr A Duggal, Mr M Dunkley CBE, Mr R Goatham, Cllr F Gooch, Mr R W Gough, Cllr Mrs A Harrison, Cllr Mrs J Hollingsbee, Dr N Kumta, Mr R Smith and Mr W Williams

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

1. Election of Chair of the Kent Health and Wellbeing Board

2. Election of Vice-Chairman of the Kent Health and Wellbeing Board

3. Apologies and Substitutes

   To receive apologies for absence and notification of any substitutes

4. Declarations of Interest by Members in items on the agenda for this meeting

   To receive any declarations of Interest by Members in items on the agenda for the meeting

5. Minutes of the Meeting held on 17 September 2020 (Pages 1 - 2)

To receive and agree the minutes of the last meeting

6. The appointment of a representative to attend meetings of the Kent and Medway Primary Care Commissioning Group (Pages 3 - 34)

7. Proposal to Review and Reconfigure Kent Health and Wellbeing Board (Pages 35 - 40)

8. Date of Next Meeting- 1 February 2022

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Benjamin Watts
General Counsel
03000 416814

Wednesday, 8 September 2021

KENT COUNTY COUNCIL

KENT HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the Kent Health and Wellbeing Board held virtually on Thursday, 17 September 2020.

PRESENT: Mrs C Bell (Chairman), Cllr F Gooch, Cllr Mrs J Hollingsbee, Dr N Kumta, Mr A Scott-Clark, Dr R Stewart, Mr M Walker (Substitute for Mr M Dunkley CBE), P Graham (Substitute for Mr R Goatham) and Ms R Jones (Substitute for Mr W Williams)

ALSO PRESENT: Dr S MacDermott

IN ATTENDANCE: Ms K Cook (Policy and Relationships Adviser (Health)), Mr T Godfrey (Scrutiny Research Officer), Mrs K Goldsmith (Research Officer - Overview and Scrutiny) and Mr O Streatfield (Member Support Officer)

UNRESTRICTED ITEMS

355. Chairman's Welcome

(Item 1)

356. Apologies and Substitutes

(Item 2)

Apologies for absence were received from Mr Carter, Mrs Chandler, Dr Chaudhuri, Mr Dunkley, Mr Goatham, Mr Gough and Mr Williams. Mr Walker attended as substitute for Mr Dunkley, Ms Graham attended as a substitute for Mr Goatham, and Ms Jones attended as a substitute for Mr Williams.

357. Declarations of Interest by Members in items on the agenda for this meeting

(Item 3)

There were no declarations of interest.

358. Covid-19 Local Outbreak Control Plan

(Item 4)

(1) Mr Scott-Clark introduced the report which asked the Kent Health and Wellbeing Board to formally delegate the function of the Local Outbreak Engagement Board to the Kent and Medway Joint Health and Wellbeing Board.

(2) A Member welcomed the comprehensive document and acknowledged the amount of work put into it. However, she was concerned that the appendices seemed to be a Medway based document and failed to mention district and borough councils. Mr Scott-Clark assured the Member that it was a Kent and Medway document and he undertook to review the report and amend as

necessary. He recognised the importance of all types of local authority in making the plan work.

(3) Resolved that the function of Local Outbreak Engagement Board be delegated to the Kent and Medway Joint Health and Wellbeing Board.

From: Clair Bell, Cabinet Member for Adult Social Care and Public Health

To: Kent Health and Wellbeing Board – 16 September 2021

Subject: The appointment of a representative to attend meetings of the Kent and Medway Primary Care Commissioning Group

Classification: **Unrestricted**

Past Pathway of report: None

Future Pathway of report: Kent and Medway Joint Health and Wellbeing Board 16 September 2021

Electoral Division: All

Summary: This report asks the Kent Health and Wellbeing Board to consider recommending to the Kent and Medway Joint Health and Wellbeing Board the appointment of a representative to attend meetings of the Kent and Medway Primary Care Commissioning Group following a request from the Kent and Medway Clinical Commissioning Group (CCG).

Recommendation(s): The Kent Wellbeing Board is asked to agree:

1) that a member of the Kent and Medway Joint Health and Wellbeing Board be nominated to attend meetings of the Kent and Medway Primary Care Commissioning Group's Primary Care Commissioning Committee (PCCC) in accordance with paragraph 4 of the terms of reference of the PCCC;

2) that James Williams, Director of Public Health at Medway attends the PCCC's meetings as the representative of the KAMJHWB; and

3) that this appointment is reviewed in 12 months' time in line with the development of the Integrated Care Systems boards.

1. Introduction

1.1 A request has been received from the Kent and Medway Clinical Commissioning Group (CCG) asking that a representative of the Kent and Medway Joint Health and Wellbeing Board (KAMJHWB) be nominated to attend meetings of the Kent and Medway Primary Care Commissioning Committee (PCCC), in accordance with the PCCC's terms of reference (attached at appendix 1 to this report). Paragraph 4.1 of the terms of reference requires the PCCC to invite a representative of the health and wellbeing board to attend its meetings. Paragraph 4.5.5 indicates that the representative of the health and wellbeing board can comment but not vote on matters considered at meetings of the PCCC.

1.2 The CCG is seeking one representative from the KAMJHWB to attend meetings in a non-voting capacity. They are particularly keen for the representative to be involved in discussions relating to strategy and population health.

1.3 It has been suggested that having one representative would enable engagement without creating a greater burden by asking a representative from each local authority to attend monthly three-hour meetings of the PCCC.

1.4 James Williams, Director of Public Health at Medway, has indicated his willingness to attend these meetings subject to the agreement of Kent County Council.

1.5 The KAMJHWB has no delegated authority to make this appointment and such an appointment must be made by the Kent Health and Wellbeing Board and the Medway Health and Wellbeing Board respectively. The boards are therefore being asked to agree:

1) That a member of the Kent and Medway Joint Health and Wellbeing Board be nominated to attend meetings of the Kent and Medway Primary Care Commissioning Group's Primary Care Commissioning Committee (PCCC) in accordance with paragraph 4 of the terms of reference of the PCCC;

2) That James Williams, Director of Public Health at Medway, attends the PCCC's meetings as the representative of the KAMJHWB and

3) That this appointment is reviewed in 12 months' time in line with the development of the Integrated Care Systems boards.

1.6 The Medway Health and Wellbeing Board considered and agreed this matter at its meeting on 2 September 2021.

2. Financial Implications

2.1 There are no financial implications arising from the implementation of the recommendation.

3. Legal implications

3.1 The legal and constitutional implications are set out in the paragraphs above.

4. Equalities implications

4.1 There are no equalities implications arising from this report.

5. Recommendations

5.1 The Kent Health and Wellbeing Board is asked to agree:

1) that a member of the Kent and Medway Joint Health and Wellbeing Board be nominated to attend meetings of the Kent and Medway Primary Care Commissioning Group's Primary Care Commissioning Committee) in accordance with paragraph 4 of the terms of reference of the PCCC;

2) that James Williams, Director of Public Health at Medway, attends the PCCC's meetings as the representative of the KAMJHWB and

3) that this appointment is reviewed in 12 months' time in line with the development of the Integrated Care Systems boards

6. Background Documents

None.

7. Contact details

Report Author:

Ann Hunter, Principal Democratic Services Officer

Telephone: 03000 416287

Email: ann.hunter@kent.gov.uk

Relevant Director:

Benjamin Watts, General Counsel

Telephone: 03000 416814

Email: Benjamin.watts@kent.gov.uk

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Kent and Medway Clinical Commissioning Group
Primary Care Commissioning Committee
Terms of Reference

1. Introduction

1.1 In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended) (the NHS Act), NHS England delegated the exercise of the functions specified in Clause 3 to NHS Kent and Medway Clinical Commissioning Group (CCG).

1.2 The CCG has established the Primary Care Commissioning Committee (the Committee). The Committee is established as a Committee of the Governing Body in accordance with Schedule 1A of the NHS Act. The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

1.3 The Committee will consider local commissioning needs within its decision making. This will ensure that Integrated Care Partnerships (ICPs) and Primary Care Networks are able to co-ordinate through general practices, community services and hospitals to meet the needs of local people requiring care.

1.4 These terms of reference set out the membership, the remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the Constitution.

2. Statutory Framework

2.1 NHS England has delegated to the CCG the authority to exercise the primary care commissioning functions set out in Annex A in accordance with section 13Z of the National Health Service (NHS) Act. (for information, Annex B provides the definition and interpretation of terms in the Delegation Agreement between the CCG and NHS England)

2.2 Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

2.3 Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it) it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

2.3.1 Management of conflicts of interest (section 14O)

2.3.2 Duty to promote the NHS Constitution (section 14P)

2.3.3 Duty to exercise its functions effectively, efficiently and economically (section 14Q)

2.3.4 Duty as to improvement in quality of services (section 14R)

2.3.5 Duty in relation to quality of primary medical services (section 14S)

2.3.6 Duties as to reducing inequalities (section 14T)

2.3.7 Duty to promote the involvement of each patient (section 14U)

2.3.8 Duty as to patient choice (section 14V)

2.3.9 Duty as to promoting integration (section 14Z1)

2.3.10 Public involvement and consultation (section 14Z2)

2.4 In respect of the delegated functions from NHS England the CCG will need to specifically exercise those functions set out below in accordance with the relevant provisions of section 13 of the NHS Act:

2.4.1 Duty to have regard to impact on services in certain areas (section 13O)

2.4.2 Duty as respects variation in provision of health services (section 13P)

2.5 Members of the Committee acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

3. Role of the Committee

3.1 The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care medical services in the CCG, under delegated authority from NHS England.

3.2 In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and the CCG, which will sit alongside the delegation and terms of reference.

3.3 The functions of the Committee are undertaken in the context of a desire to improve the sustainability of primary care and promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

3.4 The Committee will have due regard to any relevant quality and safety issues which may arise as agreed by Committee members.

3.5 The role of the Committee shall be to carry out the functions relating to the commissioning

of primary medical services under section 83 of the NHS Act. This includes the following:

3.5.1 GMS, PMS and APMS contracts (including procurement of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract)

3.5.2 Decisions in relation to Enhanced Services

3.5.3 Decisions in relation to Local Incentive Schemes

3.5.4 Decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices

3.5.5 Decisions about 'discretionary' payments

3.5.6 Decisions about commissioning urgent care (including home visits as required) for out of area registered patients

3.5.7 The approval of practice mergers

3.5.8 Planning primary medical care services in the area, including carrying out needs assessments

3.5.9 Undertaking reviews of primary medical care services in the area

3.5.10 Decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the Care Quality Commission (CQC) where the CQC has reported non-compliance with standards. For clarity, this excludes any decisions in relation to the performers list

3.5.11 Management of delegated funds in the area

3.5.12 Premises costs directions functions

3.5.13 Oversee the implementation of the Kent and Medway primary care strategy as it relates to the remit of the Committee

3.5.14 Coordinating a common approach to the commissioning of primary care services with other commissioners in the area where appropriate

3.5.15 Such other ancillary activities that are necessary in order to exercise the Delegated Functions

3.6 The Committee will also carry out the following activities:

3.6.1 Plan, including needs assessment, primary medical care services in the CCG's geographical area

3.6.2 Undertake reviews of primary medical care services in the CCG's geographical area

3.6.3 Co-ordinate a common approach to the commissioning of primary care services generally

3.6.4 Approve the policies and operating procedures that the Primary Care Operational Groups will adhere to when considering routine business items, for example requests for a boundary change to a GP practice; and

3.6.5 Manage the budget for commissioning of primary medical care services in the CCG's geographical area.

4. Membership

4.1 This Committee is constituted with a lay and executive majority, and includes a requirement to invite a Health and Well-Being Board and Healthwatch representative to attend (as per paragraph 97 onwards of the Managing Conflict of Interest: Revised Statutory Guidance for CCGs 2017).

4.2 The voting membership of the Committee is as follows:

4.2.1 Independent Lay Member for Primary Care

4.2.2 Lay Member for Patient and Public Engagement

4.2.3 The Accountable Officer or their nominated deputy

4.2.4 The Executive Director for Health Improvement or their nominated deputy

4.2.5 The Chief Finance Officer or their nominated deputy

4.2.6 The Chief Nurse or their nominated deputy

4.2.7 The Governing Body independent secondary care specialist

4.2.8 The Governing Body independent registered nurse

4.3 The Chair of the Committee shall be the Governing Body Lay Member for Primary Care

4.4 The Vice-Chair of the Committee shall be the Governing Body Lay Member for Patient and Public Engagement.

4.5 The Committee shall have the following standing attendees who may be invited to comment but shall not vote:

4.5.1 One GP member from each of the Primary Care Co-Commissioning Operational Groups

4.5.2 The Chairs of Primary Care Commissioning Operational Groups (PCOGs)

4.5.3 An NHS England Primary Care representative

4.5.4 A Local Medical Committee Representative

4.5.5 A Kent and Medway Joint Health and Wellbeing Board representative

4.5.6 A Representative on behalf of Kent Healthwatch and a representative on behalf of Medway Healthwatch

4.5.7 Head of Primary Care commissioning (one per each PCOG)

4.6 Officers of the CCG may nominate deputies to represent them in their absence and make decisions on their behalf. Non-voting members may nominate deputies to attend in their absence.

4.7 As Chair of the Audit Committee, the Independent Lay Member for Governance shall receive all papers for the Primary Care Commissioning Committee meetings and shall have the right to attend any meeting of the Committee, but shall not be a voting member.

4.8 Whilst not part of the quorum, Committee members should have access to appropriate clinical and operational expertise in order to inform their deliberations, subject to the CCG's policies on business standards and conflicts of interest requirements.

4.9 GP members shall not vote on any matter considered by the Committee. However, GP members shall participate in Committee discussions, subject to the CCG's policies on business standards and conflicts of interest requirements.

4.10 The Committee may call additional individuals to attend meetings on a case by case basis to inform discussion. The Committee may also invite or allow additional individuals to attend meetings on a regular basis. Attendees and additional members may present at Committee meetings and contribute to discussions, but are not allowed to participate in any vote.

4.11 The Committee may invite or allow people to attend meetings as observers. Observers may not present or contribute to any Committee discussion unless invited by the Chair of the Committee, and may not vote.

5. Meetings and Voting

5.1 Meetings of the Committee will be open to the public unless the Chair resolves that the public be excluded from the meeting, whether for the whole or part of the proceedings on the grounds that publicity would be prejudicial to the public interest or the interests of the CCG by reason of the confidential nature of the business to be transacted or for other

special reasons stated in the resolution and arising from the nature of the business to be transacted or the proceedings.

5.2 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.

5.3 Non-voting members, observers and the public may be excluded from all or part of a meeting at the Chair's absolute discretion whenever the business to be considered would be prejudicial to the public interest by reason of:

5.3.1 The confidential nature of the business to be transacted

5.3.2 The matter being commercially sensitive or confidential

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

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

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

5.3.6 Other special reasons stated in the resolution and arising from the nature of that business or of the proceedings

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

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

5.4 The Committee will operate in accordance with the CCG's Standing Orders. When the Chair of the 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.

5.5 The aim of the Committee will be to achieve consensus decision-making wherever possible with the show of hands. Each member of the Committee shall have one vote. The Committee shall reach decisions by a majority of members' present, subject always to the meeting being quorate. The Chair shall have a second and deciding vote, where the vote is tied.

5.6 If an urgent decision is needed prior to the next scheduled meeting and or it is not considered possible to call a full meeting, the Committee Chair may decide to convene a virtual meeting. The arrangements for such meeting will be determined by the Chair in discussion with the Executive Director of Corporate Affairs, but will normally include the invitation of all voting and non-voting members. Where possible the details of the meeting will be publicised in advance of the meeting unless the meeting is confidential or of such an urgent nature that it would not reasonably be possible to do so. In all other

respects the meeting will be managed in accordance with these Terms of Reference, as if it were a planned meeting of the Committee, including the minute taking and decision making. Any decision made virtually will be noted at the next available and appropriate meeting of the Committee.

5.7 All members (voting and non-voting) and any other participant in the discussions are required to declare any interest relating to any matter to be considered at each meeting, in accordance with the CCG's Constitution and the CCG's policies on business standards and managing conflicts of interest. At the sole discretion of the Chair, individuals who have declared an interest may be allowed to participate in the discussion but will not participate in any vote and may be requested to leave the meeting for any or all of the items in question.

6. Quorum

6.1 A quorum shall be four voting members, two of whom shall be independent or lay members, one shall be a CCG officer and one shall be a clinician. The clinician members of the committee are the Independent Nurse member of Governing Body, the Independent Secondary Care Doctor member of Governing Body and the Chief Nurse. For the avoidance of doubt, any other voting member of the committee who may also be clinically qualified, will not count as a clinician for the purposes of this committee or its quorum. Deputies are invited to attend in the place of the regular members as required.

6.2 Deputies approved by the Chair count toward quorum requirements

6.3 Whilst not part of the quorum, the Committee shall endeavour to always have a GP representative or a representative from the LMC in attendance, unless conflicts of interest precludes this.

6.4 At the discretion of the Chair, members who are not physically present at a 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. In this, the Chair will consider an appropriate balance between demands on committee members (for instance during any period of major incident management) and the sizeable geography of the CCG, whilst ensuring ease of access to the meetings proceedings for members of the press and public.

6.5 If any representative is conflicted on a particular item of business they will not count towards the quorum for that item of business. If this renders a meeting or part of a meeting non quorate, a non-conflicted person may be temporarily appointed or co-opted to satisfy the quorum requirements, subject to the agreement of the Chair.

6.6 If a group of members are temporarily excluded due to a conflict of interest, and this results in a failure to meet the requirements of paragraph 6.1, with the agreement of the chair the requirement for that category of member to be present may be relaxed.

6.7 Members of the Committee have a collective responsibility for the operation of the

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.

7. Frequency and Notice of Meetings

7.1 The Committee shall meet monthly unless circumstances necessitate the need to meet more frequently as agreed by the Committee. Meeting venues will where possible rotate across Kent and Medway in accordance with the local agenda items.

7.2 Notice of any Committee meeting must indicate:

7.2.1 Its proposed date and time, which must be at least seven (7) 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)

7.2.2 Where it is to take place

7.2.3 An agenda of the items to be discussed at the meeting and any supporting papers

7.2.4 If it is anticipated that members of the Committee participating in the meeting will not be in the same place, how it is proposed that they should communicate with each other during the meeting

7.3 Notice of a Committee meeting must be given to each member of the Committee in writing.

7.4 Failure to effectively serve notice on all members of the Committee does not affect the validity of the meeting, or of any business conducted at it.

7.5 Where Committee meetings are to be held in public the date, times and location of the meetings will be published in advance on the CCG's website.

Where appropriate meetings held in public will be divided into two sessions:

7.6.1 Part 1a – first session to discuss Kent and Medway system agenda items

7.6.2 Part 1b – second session with a local focus on specific geographical area

7.6.3 The Chair will ensure that critical items of business from any part of the county are not delayed should the item apply to an area that is not the specific local focus for any given meeting.

8. Secretary

8.1 The Executive Director of Corporate Affairs or their nominated representative shall be the Secretary to the Committee and will ensure the provision of administrative support and advice. The duties of the Secretary include but are not limited to:

8.1.1 agreement of the agenda with the chair of the Committee and attendees together with the collation of connected papers;

8.1.2 taking the minutes and keeping a record of matters arising and issues to be carried forward.

9. Agendas and Circulation of Papers

9.1 Before each Committee meeting an agenda and papers will be sent to every Committee member and where appropriate published on the CCG website no less than five (5) Business Days in advance of the meeting.

9.2 If a Committee member wishes to include an item on the agenda they must notify the Chair via the Committee's Secretary no later than ten (10) Business Days prior to the meeting. In exceptional circumstances for urgent items this will be reduced to five (5) Business Days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Chair.

10. Minutes and Reporting

10.1 Minutes of the Committee shall be prepared by the Committee's Secretariat and submitted for agreement at the following Committee meeting.

10.2 A copy of the minutes and or a summary of Committee meetings will be presented the CCG Governing Body as appropriate. The approved minutes will also be made available to NHS England on request.

11. Conflicts of Interest

11.1 Conflicts of Interest shall be dealt with in accordance with the CCG policy on business standards and managing conflicts of interest.

11.2 The Committee shall have a Register of Business Interests that will be presented as a standing item on the Committee's agenda.

11.3 In accordance with 5.3, at the absolute discretion of the Chair, non-voting members may be excluded from all or any part of a meeting where the business to be considered would be prejudicial to the public interest. This includes issues of confidentiality and commercial sensitivity that may require GP members to be excluded as a result of any potential or actual conflict of interest.

12. Confidentiality

12.1 Members of the Committee shall respect the confidentiality requirements set out in the CCG's Standing Orders, relevant corporate policies and these Terms of Reference unless separate confidentiality requirements are set out for the Committee in which event these shall be observed.

12.2 Committee meetings may in whole or in part be held in private. Any papers relating to these agenda items will be excluded from the public domain. 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.

12.3 Decisions of the Committee will be published by the Committee except where matters under consideration or when decisions have been made in private and so excluded from the public domain in accordance with Clause 5 above.

13. Conduct of the Committee

13.1 The Committee shall undertake a self-assessment of its effectiveness on at least an annual basis. This may be facilitated by independent advisors if the Committee considers this appropriate or necessary.

13.2 Members of the Committee should aim to attend all scheduled meetings, but must attend at least 75% of scheduled meetings in any financial year.

13.3 Having due regard to clause 14.1, the Chair will reserve the right to refer a matter to the Governing Body should an item or issue arise where it is judged that the view of the Governing Body would secure essential good corporate governance and decision making.

13.4 Committee members, members and/or invited observers must maintain the highest standards of personal conduct and in this regard must comply with:

13.1.1 The laws of England and Wales

13.1.2 The spirit and requirements of the NHS Constitution

13.1.3 The Nolan Principles

13.1.4 The standards of behaviour set out in the CCG's Constitution and supporting documents and policies, as they would be reasonably expected to know

13.1.5 Any additional regulations or codes of practice relevant to the Committee

14. Sub-Committees

14.1 The Committee may not delegate to a Committee or Sub-committee any functions or

statutory responsibilities delegated to it by NHS England. The Committee may, however, appoint Sub-committees and/or working groups to advise and assist it in carrying out its functions.

14.2 The Committee may appoint tasks to such Sub-committees, working groups or individual members as it shall see fit, provided that any such appointment is consistent with NHS England regulations and the CCG's Constitution and associated documents and policies, including but not limited to Standing Orders, the Overarching Scheme of Reservation and Delegation and the Scheme of Delegated Financial Limits. Any such appointment shall be appropriately recorded by the Committee.

14.3 One or more Primary Care Operational Groups (PCOGs) may be established as a Sub-Committee of the Committee. The PCOG(s) will:

14.4.1 Provide a strategic forum to develop commissioning plans and commissioning opportunities for the development and delivery of high quality local primary care services

14.4.2 Oversee and co-ordinate the operational delegated arrangements, supporting the delivery of the delegated responsibilities relating to the commissioning of primary care medical services under section 83 of the NHS Act, and

14.4.3 Assure the day to day business associated with the commissioning and contracting of primary care medical services in line with delegated arrangements, and delivery of the delegated functions in line with the statutory framework.

14.4 Separate terms of reference will be compiled to cover the scope of the PCOG(s) and will be approved by the PCCC.

14.5 Officers of the Primary Care Commissioning Committee, who have the appropriate level of delegated authority, may be able to approve PCOG recommendations outside of the Committee meeting so long as they comply at the time with any requirements of the Committee and any relevant operational policies in place. These decisions will subsequently be acknowledged at the next available Committee meeting.

15. Review of Terms of Reference

15.1 The terms of reference of the Committee will be approved by Governing Body and shall be reviewed by the Governing Body at least annually.

Approved: August 2020

Version Control:

Version No	Amendment	Amendment Owner	Date of Amendment
1.0	Original Draft	Company Secretary	Dec 2019
1.01	Final Draft – Post GP Members and NHSE	Company Secretary	Feb 20
2.0	Approved Governing Body		02 April 2020
2.1	Content updated; 6.0, 7.6 Approved by Governing Body on 30 April 2020	Company Secretary	30 April 2020
2.3	Change in director titles	Exec Director of Corporate Affairs	August 2020

Annex A to Appendix 8 to
NHS Kent and Medway Clinical Commissioning Group Constitution

Delegated Functions

The following narrative forms Schedule 2 to the Delegation Agreement between NHS England and the Kent and Medway Clinical Commissioning Group pertaining to the delegation of primary care medical services to the CCG.

"Schedule 2

Delegated Functions

Part 1: Delegated Functions: Specific Obligations

1. Introduction

1.1. This Part 1 of Schedule 2 *(Delegated Functions)* sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Medical Services Contract Management

2.1. The CCG must:

2.1.1. manage the Primary Medical Services Contracts on behalf of NHS England and perform all of NHS England's obligations under each of the Primary Medical Services Contracts in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England;

2.1.2. actively manage the performance of the counter-party to the Primary Medical Services Contracts in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches and serve notice;

2.1.3. ensure that it obtains value for money under the Primary Medical Services Contracts on behalf of NHS England and avoids making any double payments under any Primary Medical Services Contracts;

2.1.4. comply with all current and future relevant national Guidance regarding PMS reviews and the management of practices receiving Minimum Practice Income Guarantee (MPIG) (including without limitation the *Framework for Personal Medical Services (PMS) Contracts Review* guidance published by NHS England in September 2014 (http://www.england.nhs.uk/wp-content/uploads/2014/09/pms- review-guidance-sept14.pdf));

2.1.5. notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the CCG of its obligations to perform any of NHS England's obligations under the Primary Medical Services Contracts;

2.1.6. keep a record of all of the Primary Medical Services Contracts that the CCG manages on behalf of NHS England setting out the following details in relation to each Primary Medical Services Contract:

2.1.6.1. name of counter-party;

2.1.6.2. location of provision of services; and

2.1.6.3. amounts payable under the contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.2. For the avoidance of doubt, all Primary Medical Services Contracts will be in the name of NHS England.

2.3. The CCG must comply with any Guidance in relation to the issuing and signing of Primary Medical Services Contracts in the name of NHS England.

2.4. Without prejudice to clause 13 *(Financial Provisions and Liability)* or paragraph 2.1 above, the CCG must actively manage each of the relevant Primary Medical Services Contracts including by:

2.4.1. managing the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance;

2.4.2. assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.4.3. managing variations to the relevant Primary Medical Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.4.4. agreeing information and reporting requirements and managing information breaches (which will include use of the HSCIC IG Toolkit SIRI system);

2.4.5. agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.4.6. conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.4.7. complying with and implementing any relevant Guidance issued from time to time.

Enhanced Services

2.5. The CCG must manage the design and commissioning of Enhanced Services,

including re-commissioning these services annually where appropriate.

2.6. The CCG must ensure that it complies with any Guidance in relation to the design and commissioning of Enhanced Services.

2.7. When commissioning newly designed Enhanced Services, the CCG must:

2.7.1. consider the needs of the local population in the Area;
2.7.2. support Data Controllers in providing 'fair processing' information as required by the DPA;
2.7.3. develop the necessary specifications and templates for the Enhanced Services, as required to meet the needs of the local population in the Area;
2.7.4. when developing the necessary specifications and templates for the Enhanced Services, ensure that value for money will be obtained;
2.7.5. consult with Local Medical Committees, each relevant Health and Wellbeing Board and other stakeholders in accordance with the duty of public involvement and consultation under section 14Z2 of the NHS Act;
2.7.6. obtain the appropriate read codes, to be maintained by the HSCIC;
2.7.7. liaise with system providers and representative bodies to ensure that the system in relation to the Enhanced Services will be functional and secure; and
2.7.8. support GPs in entering into data processing agreements with data processors in the terms required by the DPA.

Design of Local Incentive Schemes

2.8. The CCG may design and offer Local Incentive Schemes for GP practices, sensitive to the needs of their particular communities, in addition to or as an alternative to the national framework (including as an alternative to QOF or directed Enhanced Services), provided that such schemes are voluntary and the CCG continues to offer the national schemes.

2.9. There is no formal approvals process that the CCG must follow to develop a Local Incentive Scheme, although any proposed new Local Incentive Scheme:

2.9.1. is subject to consultation with the Local Medical Committee;
2.9.2. must be able to demonstrate improved outcomes, reduced inequalities and value for money; and
2.9.3. must reflect the changes agreed as part of the national PMS reviews.

2.10. The ongoing assurance of any new Local Incentive Schemes will form part of the CCG's assurance process under the CCG Assurance Framework.

2.11. Any new Local Incentive Scheme must be implemented without prejudice to the right of GP practices operating under a GMS Contract to obtain their entitlements which are negotiated and set nationally.

2.12. NHS England will continue to set national standing rules, to be reviewed

annually, and the CCG must comply with these rules which shall for the purposes of this Agreement be Guidance.

Making Decisions on Discretionary Payments

2.13. The CCG must manage and make decisions in relation to the discretionary payments to be made to GP practices in a consistent, open and transparent way.

2.14. The CCG must exercise its discretion to determine the level of payment to GP practices of discretionary payments, in accordance with the Statement of Financial Entitlements Directions.

Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients

2.15. The CCG must manage the design and commissioning of urgent care services (including home visits as required) for its patients registered out of area (including re-commissioning these services annually where appropriate).

2.16. The CCG must ensure that it complies with any Guidance in relation to the design and commissioning of these services.

3. Planning the Provider Landscape

3.1. The CCG must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to:

3.1.1. establishing new GP practices in the Area;
3.1.2. managing GP practices providing inadequate standards of patient care;
3.1.3. the procurement of new Primary Medical Services Contracts (in accordance with any procurement protocol issued by NHS England from time to time);
3.1.4. closure of practices and branch surgeries;
3.1.5. dispersing the lists of GP practices;
3.1.6. agreeing variations to the boundaries of GP practices; and
3.1.7. coordinating and carrying out the process of list cleansing in relation to GP practices, according to any policy or Guidance issued by NHS England from time to time.

3.2. In relation to any new Primary Medical Services Contract to be entered into, the CCG must, without prejudice to any obligation in Schedule 2, Part 2, paragraph 3 *(Procurement and New Contracts)* and Schedule 2, Part 1, paragraph 2.3:

3.2.1. consider and use the form of Primary Medical Services Contract that will ensure compliance with NHS England's obligations under Law including the Public Contracts Regulations 2015/102 and the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 taking into account the persons to whom such Primary Medical Services Contracts may be awarded;

3.2.2. provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

3.2.3. for the avoidance of doubt, Schedule 5 *(Financial Provisions and Decision Making Limits)* deals with the sign off requirements for Primary Medical Services Contracts.

4. Approving GP Practice Mergers and Closures

4.1. The CCG is responsible for approving GP practice mergers and GP practice closures in the Area.

4.2. The CCG must undertake all necessary consultation when taking any decision in relation to GP practice mergers or GP practice closures in the Area, including those set out under section 14Z2 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the Local Medical Committee.

4.3. Prior to making any decision in accordance with this paragraph 4 *(Approving GP Practice Mergers and Closures)*, the CCG must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on the GP practice's registered population and that of surrounding practices. The CCG must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the GP contractor as to how any closure or merger will be managed.

4.4. In making any decisions pursuant to paragraph 4 *(Approving GP Practice Mergers and Closures)*, the CCG shall also take account of its obligations as set out in Schedule 2, part 2, paragraph 3 *(Procurement and New Contracts)*, where applicable.

5. Information Sharing with NHS England in relation to the Delegated Functions

5.1. This paragraph 5 *(Information Sharing with NHS England)* is without prejudice to clause 9.4 or any other provision in this Agreement. The CCG must provide NHS England with:

5.1.1. such information relating to individual GP practices in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the performances of GP practices;

5.1.2. such data/data sets as required by NHS England to ensure population of the primary medical services dashboard;

5.1.3. any other data/data sets as required by NHS England; and

5.1.4. the CCG shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

5.2. The CCG must use the NHS England approved primary medical services dashboard, as updated from time to time, for the collection and dissemination of information relating to GP practices.

5.3. The CCG must (where appropriate) use the NHS England approved GP exception reporting service (as notified to the CCGs by NHS England from time to time).

5.4. The CCG must provide any other information, and in any such form, as NHS England considers necessary and relevant.

5.5. NHS England reserves the right to set national standing rules (which may be considered Guidance for the purpose of this Agreement), as needed, to be reviewed annually. NHS England will work with CCGs to agree rules for, without limitation, areas such as the collection of data for national data sets and IT intra-operability. Such national standing rules set from time to time shall be deemed to be part of this Agreement.

6. Making Decisions in relation to Management of Poorly Performing GP Practices

6.1. The CCG must make decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list).

6.2. In accordance with paragraph 6.1 above, the CCG must:

6.2.1. ensure regular and effective collaboration with the CQC to ensure that information on general practice is shared and discussed in an appropriate and timely manner;
6.2.2. ensure that any risks identified are managed and escalated where necessary;
6.2.3. respond to CQC assessments of GP practices where improvement is required;
6.2.4. where a GP practice is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and
6.2.5. take appropriate contractual action in response to CQC findings.

7. Premises Costs Directions Functions

7.1. The CCG must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

7.2. In particular, but without limiting the generality of paragraph 7.1, the CCG shall make decisions concerning:

7.2.1. applications for new payments under the Premises Costs Directions (whether such payments are to be made by way of grants or in respect of recurring premises costs); and

7.2.2. revisions to existing payments being made under the Premises Costs Directions.

7.3. The CCG must comply with any decision-making limits set out in Schedule 5 *(Financial Provisions and Decision Making Limits)* when taking decisions in relation to the Premises Costs Directions Functions.

7.4. The CCG will comply with any guidance issued by the Secretary of State or NHS England in relation to the Premises Costs Directions, including the Principles of Best Practice, and any other Guidance in relation to the Premises Costs Directions.

7.5. The CCG must work cooperatively with other CCGs to manage premises and strategic estates planning.

7.6. The CCG must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.

Part 2 – Delegated Functions: General Obligations

1. Introduction

1.1. This Part 2 of Schedule 2 *(Delegated Functions)* sets out general provisions regarding the carrying out of the Delegated Functions.

2. Planning and reviews

2.1. The CCG is responsible for planning the commissioning of primary medical services.

2.2. The role of the CCG includes:

2.2.1. carrying out primary medical health needs assessments (to be developed by the CCG) to help determine the needs of the local population in the Area;

2.2.2. recommending and implementing changes to meet any unmet primary medical services needs; and

2.2.3. undertaking regular reviews of the primary medical health needs of the local population in the Area.

3. Procurement and New Contracts

3.1. The CCG will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS

England from time to time.

3.2. In discharging its responsibilities set out in clause 6 *(Performance of the Delegated Functions)* of this Agreement and paragraph 1 of this Schedule 2 *(Delegated Functions)*, the CCG must comply at all times with Law including its obligations set out in the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 and any other relevant statutory provisions. The CCG must have regard to any relevant guidance, particularly Monitor's guidance *Substantive guidance on the Procurement, Patient Choice and Competition Regulations*

(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283505/SubstantiveGuidanceDec2013_0.pdf).

3.3. Where the CCG wishes to develop and offer a locally designed contract, it must ensure that it has consulted with its Local Medical Committee in relation to the proposal and that it can demonstrate that the scheme will:

3.3.1. improve outcomes;
3.3.2. reduce inequalities; and
3.3.3. provide value for money.

4. Integrated working

4.1. The CCG must take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Professional Networks, local authorities, Healthwatch, acute and community providers, the Local Medical Committee, Public Health England and other stakeholders.

4.2. The CCG must work with NHS England and other CCGs to co-ordinate a common approach to the commissioning of primary medical services generally.

4.3. The CCG and NHS England will work together to coordinate the exercise of their respective performance management functions.

5. Resourcing

5.1. NHS England may, at its discretion provide support or staff to the CCG. NHS England may, when exercising such discretion, take into account, any relevant factors (including without limitation the size of the CCG, the number of Primary Medical Services Contracts held and the need for the Local NHS England Team to continue to deliver the Reserved Functions)."

NHS Kent and Medway Clinical Commissioning Group Constitution

Definitions and Interpretation

The following narrative forms Schedule 1 to the Delegation Agreement between NHS England and the Kent and Medway Clinical Commissioning Group pertaining to the delegation of primary care medical services to the CCG. This provides the definitions used in Schedule 2 to the Delegation Agreement.

"Schedule 1

Definitions and Interpretation

In this Agreement, the following words and phrases will bear the following meanings:

Agreement	means this agreement between NHS England and the CCG comprising the Particulars, the Terms and Conditions and the Schedules;
Agreement Representatives	means the CCG Representative and the NHS England Representative as set out in the Particulars;
APMS Contract	means an agreement made in accordance with section 92 of the NHS Act;
Assigned Staff	means those NHS England staff as agreed between NHS England and the CCG from time to time;
Caldicott Principles	means the patient confidentiality principles set out in the report of the Caldicott Committee (December 1997 as amended by the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*) and now included in the NHS Confidentiality Code of Practice, as may be amended from time to time;
Capital	shall have the meaning set out in the Capital Investment Guidance or such other replacement Guidance as issued by NHS England from time to time;
Capital Expenditure Functions	means those functions of NHS England in relation to the use and expenditure of Capital funds (but excluding the Premises Costs Directions Functions);

Capital Investment Guidance	means any Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to: - the expenditure of Capital, or investment in property, infrastructure or information and technology; or - the revenue consequences for commissioners or third parties making such investment;
CCG Assurance Framework	means the assurance framework that applies to CCGs pursuant to the NHS Act;
Claims	means, for or in relation to the Primary Medical Services Contracts (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;
Claim Losses	means all Losses arising in relation to any Claim;
Complaints Regulations	means the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009/309;
Contractual Notice	means a contractual notice issued by NHS England to the CCG or all CCGs (as the case may be) from time to time and relating to the manner in which the Delegated Functions should be exercised by the CCG, in accordance with clause 24.3;
CQC	means the Care Quality Commission;
Data Controller	shall have the same meaning as set out in the GDPR;
Data Processor	shall have the same meaning as set out in the GDPR;
Data Subject	shall have the same meaning as set out in the GDPR;
Delegated Functions	means the functions delegated by NHS England to the CCG under the Delegation and as set out in detail in this Agreement;
Delegated Funds	shall have the meaning in clause 13.1;

Enhanced Services	means the nationally defined enhanced services, as set out in the Primary Medical Services (Directed Enhanced Services) Directions 2014 or as amended from time to time, and any other enhanced services schemes locally developed by the CCG in the exercise of its Delegated Functions (and excluding, for the avoidance of doubt, any enhanced services arranged or provided pursuant to the Section 7A Functions);
Escalation Rights	means the escalation rights as defined in clause 16 *(Escalation Rights)*;
Financial Year	shall bear the same meaning as in section 275 of the NHS Act;
GDPR	means the General Data Protection Regulation
GMS Contract	means a general medical services contract made under section 84(1) of the NHS Act;
Good Practice	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
Guidance	means any protocol, policy, guidance or manual (issued by NHS England whether under this Agreement or otherwise) and/or any policy or guidance relating to the exercise of the Delegated Functions issued by NHS England from time to time, in accordance with clause 24.4;
HSCA	means the Health and Social Care Act 2012;
HSCIC	means the Health and Social Care Information Centre;
Information Law	the GDPR, the Data Protection Act 2018, regulations and guidance made under section 13S and section 251 of the NHS Act; guidance made or given under sections 263 and 265 of the HSCA; the Freedom of Information Act 2000; the common law duty of confidentiality; the Human Rights Act 1998 and all other applicable laws and regulations relating to processing of Personal Data and privacy;

Law	means any applicable law, statute, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including, for the avoidance of doubt, the Premises Costs Directions, the Statement of Financial Entitlements Directions and the Primary Medical Services (Directed Enhanced Services) Directions 2014 as amended from time to time);
Local Incentive Schemes	means an incentive scheme developed by the CCG in the exercise of its Delegated Functions including (without limitation) as an alternative to QOF;
Local Terms	means the terms set out in Schedule 7 *(Local Terms)*;
Losses	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges;
National Variation	an addition, deletion or amendment to the provisions of this Agreement mandated by NHS England (whether in respect of the CCG or all or some of other Clinical Commissioning Groups) including any addition, deletion or amendment to reflect changes to the Delegation, changes in Law, changes in policy and notified to the CCG in accordance with clause 22 *(Variations)*;
National Variation Proposal	a written proposal for a National Variation, which complies with the requirements of clause 22.7;
Need to Know	has the meaning set out in paragraph 6.2 of Schedule 4 *(Further Information Sharing Provisions)*;
NHS Act	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 or other legislation from time to time);
NHS England	means the National Health Service Commissioning Board established by section 1H of the NHS Act, also known as NHS England;
Non-Personal Data	means data which is not Personal Data;
Operational Days	a day other than a Saturday, Sunday or bank holiday in England;
Particulars	means the Particulars of this Agreement as set out in clause 1 *(Particulars)*;

Party/Parties	means a party or both parties to this Agreement;
Personal Data	shall have the same meaning as set out in the General Data Protection Regulation and shall include references to Special Category Personal Data where appropriate;
Personal Data Agreement	means the agreement governing Information Law issues completed further to Schedule 4 *(Further Information Sharing Provisions)*;
Personnel	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
PMS Contract	means an arrangement or contract for the provision of primary medical services made under section 83(2) of the NHS Act (including any arrangements which are made in reliance on a combination of that section and other powers to arrange for primary medical services);
Premises Agreements	means tenancies, leases and other arrangements in relation to the occupation of land for the delivery of services under the Primary Medical Services Contracts;
Premises Costs Directions	means the National Health Service (General Medical Services Premises Costs) Directions 2013, as amended;
Premises Costs Directions Functions	means NHS England's functions in relation to the Premises Costs Directions;
Primary Medical Care Infrastructure Guidance	means any Guidance issued by NHS England from time to time in relation to the procurement, development and management of primary medical care infrastructure and which may include principles of best practice;

Primary Medical Services Contracts	means: - PMS Contracts; - GMS Contracts; and - APMS Contracts, in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements but excluding any Premises Agreements;
Prime Minister's Challenge Fund	means the Prime Minister's challenge fund announced in October 2013 to help improve access to general practice and stimulate innovative ways of providing primary care services;
Principles of Best Practice	means the Guidance in relation to property and investment which is to be published either before or after the date of this Agreement;
QOF	means the quality and outcomes framework;
Relevant Information	means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "To Share or Not to Share?");
Reserved Functions	means the functions relating to the commissioning of primary medical services which are reserved to NHS England (and are therefore not delegated to the CCG under the Delegation) and as set out in detail in clause 8.2 and Schedule 3 *(Reserved Functions)* of this Agreement;
Secretary of State	means the Secretary of State for Health from time to time;
Section 7A Functions	means those functions of NHS England exercised pursuant to section 7A of the NHS Act relating to primary medical services;
Section 7A Funds	shall have the meaning in clause 13.18.1;
Special Category Personal Data	shall have the same meaning as in GDPR;

Specified Purpose	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the CCG's Delegated Functions and NHS England's Reserved Functions as specified in paragraph 2.1 of Schedule 4 *(Further Information Sharing Provisions)* to this Agreement;
Statement of Financial Entitlements Directions	means the General Medical Services Statement of Financial Entitlements Directions 2013, as amended or updated from time to time;
Statutory Guidance	means any applicable health and social care guidance, guidelines, direction or determination, framework, standard or requirement to which the CCG and/or NHS England have a duty to have regard, to the extent that the same are published and publicly available or the existence or contents of them have been notified to the CCG by NHS England from time to time;
Survival Clauses	means clauses 10 *(Information Sharing and Information Governance),* 13 *(Financial Provisions and Liability),* 14 *(Claims and Litigation)* 17 *(Termination),* 18 *(Staffing),* 19 *(Disputes)* and 20 *(Freedom of Information)*, together with such other provisions as are required to interpret these clauses (including the Schedules to this Agreement); and
Transfer Regulations	means the Transfer of Undertakings (Protection of Employment) Regulations 2006, as amended."

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From: Clair Bell, Cabinet Member for Adult Social Care and Health and Public Health and Chairman of the Kent Health and Wellbeing Board

David Whittle, Director Strategy, Policy, Relationships and Corporate Assurance

To: Kent Health and Wellbeing Board – 16th September 2021

Subject: Proposal to Review and Reconfigure Kent Health and Wellbeing Board

Classification: Unrestricted

Summary:
This paper sets out the implications of the Health and Social Care Bill 2021 on Health and Wellbeing Board arrangements and seeks approval for the Kent Health and Wellbeing Board

a) To review its current operating arrangements and terms of reference including membership and frequency of meetings in response to these requirements.

b) To agree that the Kent and Medway Joint Health and Wellbeing Board transitions into the Integrated Care Partnership Board as of 1st April 2022

1. Introduction

1.1 Major changes are taking place in the way health and care is organised in England as the emphasis of national policy continues to shift towards preventing illness and promoting collaboration within local health and care systems. Integrated Care Partnerships, of which Kent and Medway is one, are being established in all areas of the country to drive changes that are intended to lead to better, more joined-up care for people and improvements in the health of the population.

1.2 The Health and Social Care Bill was published on July 5th, 2021, setting out the upper tier structures and functions of an Integrated Care Partnership and introduces new language to describe the emerging organisation and governance of the system, which may still be subject to change as the Bill passes through Parliament:

a) The Integrated Care System will be known as the Integrated Care Partnership.
b) There is a requirement for a new strategic partnership forum to be established called, in this document the Integrated Care Partnership Board. This is the collective meeting of all local partners including NHS organisations, local authorities, and other key stakeholders.

c) Requirement for CCGs to be dissolved and the establishment of an Integrated Care Board (ICB) as the statutory NHS organisation from 1 April 2022. Its remit is to plan and commission health services in an area and fulfil any further responsibilities delegated by NHS England.

1.3 As well as confirming in law the structural arrangements that have been developing since 2016, with the establishment of Sustainability and Transformation Partnerships, the Bill sets out the four core purposes of an Integrated Care Partnership which are:

- Improving outcomes (population health and care)
- Tackling inequalities in outcomes and access
- Enhancing productivity and value for money
- Supporting broader social economic development

1.4 This purpose of this paper is to set out the implications of the structural and governance changes proposed in the Bill on Health and Wellbeing Board arrangements. It describes how the requirement to develop an Integrated Care Partnership Board will duplicate the role and purpose of the Kent and Medway Joint Health and Wellbeing Board. The paper suggests that the work of the Joint Board will be continued through the Integrated Care Partnership Board and that the Joint Board has served its purpose.

1.5 Changes to the Kent and Medway Joint Health and Wellbeing Board will impact on Kent's Health and Wellbeing Board arrangements. Local Health and Wellbeing Boards have an important role to play in the emerging Integrated Care Partnership arrangements. This paper therefore also seeks approval for the Kent Health and Wellbeing Board to review its current terms of reference including membership, and frequency of meetings in response to these requirements.

2. Background

2.1 The Kent and Medway Joint Health and Wellbeing Board was established in 2018. It was constituted as an Advisory Sub Board of both Kent and Medway's Health and Wellbeing Boards as provided for in the Health and Social Care Act 2012. Its purpose has been to secure a collaborative approach between the Kent and Medway Health and Wellbeing Boards as the health and care system developed as a single partnership across the County.

2.2 In the three years it has been operating the Joint Health and Wellbeing Board has provided a strong democratic voice in the discussions of the future design and delivery of health and social care services. Most recently the Board has been focussing on population health and health inequalities and the impact of Covid-19 on the health and wellbeing of the population, suggesting an overlap with the core purposes of the Integrated Care Partnership.

2.3 When the Kent and Medway Joint Health and Wellbeing Board was established The Kent Board decided to reduce its meetings to once a year, or as required, to fulfil any statutory requirements. This was to focus resources

on the Joint Board and the opportunities and benefits of wider partnership working as one system. Therefore, the Kent Board has only met three times in the past three years. During those three years there has been significant changes in the structure and personnel of the NHS leaving the current membership of the Kent Health and Wellbeing Board out of date and based on old CCG structures

2.4 There have also been changes in the intervening 3 years with internal KCC structures and governance arrangements, for example the 0-25 Health and Wellbeing Board has developed into an Integrated Children's Delivery Board and a number of joint system wide boards have emerged, such as the learning disability and autism improvement board and the mental health alliance. Alongside this the four place based partnerships, (formerly known as 4 Integrated Care Partnerships) across Kent and Medway are in place, but it is unclear whether or how they will relate to the Health and Wellbeing Board.

3. National and Local Changes that will Impact on Health and Wellbeing Boards

3.1 An Integrated Care Partnership Board is described as the collective of all local partners including NHS organisations, local authorities, and other key stakeholders. It will be responsible for agreeing an integrated care strategy for improving health and well-being across the totality of the population it serves, built from local assessments of needs and focusing on reducing inequalities and addressing the consequences of the pandemic for communities.

3.2 The Partnership will be established in the form of a Board. Its terms of reference will be determined locally and any decision making responsibilities (if any) outside of developing the integrated care strategy will be delegated by partner organisations. The recently released NHS design framework describes the Integrated Care Partnership Board component membership and states that it should include local authority and Integrated Care Board NHS representation plus representatives as agreed from health and wellbeing boards; other statutory organisations such as Districts; voluntary, community and social enterprise (VCSE) sector partners; social care providers; and organisations with a relevant wider interest such as employers, housing and education providers. The membership may change as the priorities of the partnership evolve.

3.3 As can be seen there is significant similarity between the proposed remit of the Integrated Care Partnership Board and the Kent and Medway Joint Health and Wellbeing Board. It is suggested that to maintain both will lead to considerable overlap and duplication of role and purpose. The core membership of both will be the same, as are the stated purposes- to support integration, population health management and address Health Inequalities. Therefore, to rationalise our governance across the Partnership it is proposed that the Kent and Medway Joint Health and Wellbeing Board transitions into the Integrated Care Partnership Board as of 1st April 2022.

4. Context for Proposed Review of Kent Health and Wellbeing Board

4.1 Changes to the Kent and Medway Joint Health and Wellbeing Board will require a refocus on the role, purpose and membership of the Kent Health and Wellbeing Board which has been in abatement since 2018. This is necessary to ensure that the statutory duties relating to the Health and Wellbeing Board are discharged.

4.2 Members will recall the Health and Wellbeing Board Statutory functions:

1. Ensuring production of:
    a. Joint Strategic Needs Assessment.
    b. Local Joint Health and Wellbeing Strategy.
    c. Pharmaceutical Needs Assessment.

2. Reviewing commissioning plans in light of Local Joint Health and Wellbeing strategy.
3. Promotion of integrated working.

4.3 Health and Wellbeing Boards also have a role in the new system wide arrangements. The Integrated Care Boards that will replace the Clinical Commissioning Groups have been given duties to relate to the Health and Wellbeing Board. It will be important for the Partnership to create a golden thread that runs between all the required strategies and plans to create a coherent picture for residents and staff. The Partnership needs to be clear about the expectations on the System as a whole to improve the health and wellbeing of the population and how each organisation will contribute individually to achieving those priorities. The Kent Health and Wellbeing Board will play a significant role in shaping these plans. It is worth describing the strategies and plans from across the System that the Kent Health and Wellbeing Board must be consulted on:

- **A joint local health and wellbeing strategy** setting out how the assessed needs in relation to the responsible local authority's area are to be met by the partners. Note there will be 2 Health and Wellbeing Board strategies that the Integrated Care Partnership will need to have regard to- one for Medway Council and one for KCC. KCC's strategy needs updating but it is recommended that the new strategy is based on the Health Inequalities Action plan currently in development.

- **Integrated Care Strategy**- An Integrated Care Partnership Board must prepare a strategy (an "integrated care strategy") setting out how the assessed health and care needs in relation to its area are to be met by the partners.

- **5 Year Forward plan with annual review** -Integrated Care Board Joint 5 year forward plan with annual review (will be statutory, must set out how it relates to the Health and Wellbeing Strategy and must share and consult with Health and Wellbeing Board.

- **Annual Report:** An integrated care board must, in each financial year, prepare an annual report on how it has discharged its functions in the previous financial year and in undertaking its review must consult each relevant Health and Wellbeing Board.

- **Annual Performance Assessment:** NHS England must conduct a performance assessment of each integrated care board in respect of each financial year. In conducting a performance assessment, NHS England must consult each relevant Health and Wellbeing Board as to its views on any steps that the board has taken to implement any joint local health and wellbeing strategy to which the board was required to have regard.

- **Joint capital resource use plan** for integrated care board and its partners (Health and Wellbeing Board Must have a copy).

- **Local Plans in development**:

    - System Wide Health Inequalities action plan (local priority in development as part of the work of the Kent and Medway Joint Health and Wellbeing Board)
    - KCC ASCH Strategy (local- in development)
    - System Wide Learning Disability and Autism Strategy.

4.4 Given this proposed programme of work and to discharge its functions within the current national and local policy context it is recommended that the Kent Board is reinstated to at least 4 meetings per year and is reviewed to ensure its terms of reference and membership are fit for purpose.

4.5 Current Statutory Membership stands as follows and would need updating as at the time of establishment there were eight CCGs across Kent. Now there will be one Integrated Care Partnership, one Integrated Care Board and four local place based commissioning areas. At present, the Kent Board allows Chairs and Accountable Officers of CCGs to be Members. It also has three Cabinet Members alongside the Leader and has three Borough/District representatives. Statutory members are listed below, other members are at local discretion.

- Leader of the Council or their representative.
- Director of adult social services.
- Director of children's services.
- Director of public health.
- Local Healthwatch representative.
- Representative of each relevant clinical commissioning group.

4.6 There is still some uncertainty and lack of clarity as the Integrated Care Partnership Board emerges. Therefore, any review of the Kent Health and Wellbeing Board will need to consider the following:

- Its relationship to the Integrated Care Partnership and requirements set out in the Bill. More guidance will be forthcoming through the Winter.
- Membership.
- Scope.
- The relationship with organisations currently not on the Board, notably NHS providers and representatives from the place based partnerships. (Formerly Integrated Care Partnerships)
- Resourcing/support for the Board including performance overview and policy support.
- Internal changes within KCC-particularly ensuring children and young people 0-25 agendas return to the Board's work programme.
- Not straying into scrutiny function (HOSC exists for this task and is a statutory Board of KCC).

5. Financial, legal and risk management implications

5.1 There will be a cost and resource allocation associated with re-establishing the Kent Health and Wellbeing Board in terms of administrative, performance and policy support. The Board itself will not have a budget.

5.2 There are no risks arising from the proposal.

6. Recommendations

6.1 The Health and Wellbeing Board is asked to agree:

a) That the Kent Health and Wellbeing Board is subject to a review of its terms of reference and membership, taking into account the requirements of the Health and Social Care Bill 2021 and its future relationship to the emerging Integrated Care Partnership

b) That the Kent and Medway Joint Health and Wellbeing Board transitions into the Integrated Care Partnership Board as of 1st April 2022.

REPORT AUTHOR:
Karen Cook
Policy and Relationships Adviser (Health)
Email: Karen.cook@kent.gov.uk
Tel: 03000 415281