## Health and Wellbeing Board

A meeting of this Committee will be held on:

**Date:** Tuesday, 10 September 2019  
**Time:** 3.00pm  
**Venue:** Meeting Room 9 - Level 3, Gun Wharf, Dock Road, Chatham ME4 4TR

<table>
<thead>
<tr>
<th>Membership</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ian Ayres</td>
<td>Managing Director for Dartford, Gravesham and Swanley, Medway, Swale and West Kent CCGs</td>
</tr>
<tr>
<td>Councillor David Brake (Chairman)</td>
<td>Portfolio Holder for Adults' Services</td>
</tr>
<tr>
<td>Councillor Howard Doe</td>
<td>Deputy Leader and Portfolio Holder for Housing and Community Services</td>
</tr>
<tr>
<td>Councillor Gary Etheridge</td>
<td></td>
</tr>
<tr>
<td>Dr Peter Green (Vice-Chairman)</td>
<td>Clinical Chair, NHS Medway Clinical Commissioning Group</td>
</tr>
<tr>
<td>Councillor Adrian Gulvin</td>
<td>Portfolio Holder for Resources</td>
</tr>
<tr>
<td>Eunice Lyons-Backhouse</td>
<td>Healthwatch Medway CIC Representative</td>
</tr>
<tr>
<td>Councillor Vince Maple</td>
<td>Leader of the Labour and Co-operative Group</td>
</tr>
<tr>
<td>Dr Antonia Moore</td>
<td>Elected Clinical Member, NHS Medway Clinical Commissioning Group</td>
</tr>
<tr>
<td>Councillor Martin Potter</td>
<td>Portfolio Holder for Education and Schools</td>
</tr>
<tr>
<td>Ian Sutherland</td>
<td>Director of People - Children and Adults Services</td>
</tr>
<tr>
<td>Councillor Stuart Tranter</td>
<td></td>
</tr>
<tr>
<td>James Williams</td>
<td>Director of Public Health</td>
</tr>
<tr>
<td>Vacancy - NHS England</td>
<td></td>
</tr>
</tbody>
</table>
Agenda

1 Apologies for absence

2 Record of meeting (Pages 5 - 16)

To approve the record of the meeting held on 2 July 2019.

3 Urgent matters by reason of special circumstances

The Chairman will announce any late items which do not appear on the main agenda but which he/she has agreed should be considered by reason of special circumstances to be specified in the report.

4 Declarations of Disclosable Pecuniary Interests and Other Significant Interests (Pages 17 - 18)

Members are invited to disclose any Disclosable Pecuniary Interests or Other Significant Interests in accordance with the Member Code of Conduct. Guidance on this is set out in agenda item 4.

5 Joint Health and Wellbeing Strategy Theme 1 Review (Pages 19 - 24)

This report asks the members of the Health and Wellbeing Board to consider how they and the organisations they represent can encourage and support the system to improve health and wellbeing with respect to the future state described for theme 1 of the Joint Health and Wellbeing Strategy: Giving every child a good start.

6 Medway Task Force (Pages 25 - 28)

The Medway Task Force is a multi-agency initiative agreed as part of the Kent Police and Crime Commissioner’s Violence Reduction Challenge. The aim of this initiative is to tackle and reduce violent crime by looking at causational factors and context. This briefing is to seek the support of the Health and Wellbeing Board.

7 Social Isolation Task Group: The Impact of Social Isolation in Medway - Progress Report (Pages 29 - 44)

In January 2019, the Social Isolation Task Group review entitled ‘The Impact of Social Isolation in Medway’ was agreed by Cabinet. Prior to publication, this report had been presented to and considered by, the Health and Adult Social Care Overview and Scrutiny Committee in December 2018 and the Health and Wellbeing Board in February 2019.

The Task Group report considered the impact of social isolation and loneliness in Medway. It made a number of recommendations for actions that the Council and other organisations could take to reduce social isolation locally. The attached progress report (Appendix 1) summarises progress against each of the review’s
recommendations.

8 Development of Single Kent and Medway Clinical Commissioning Group (Pages 45 - 116)

This report provides a high level summary of the work to date in developing an integrated care system across Kent and Medway and in particular the development of a single CCG and the Medway and Swale Integrated Care Partnership (ICP). This report will be accompanied by a presentation on the health and care system transformation and a presentation on the ICP.

The Health and Adult Social Care Overview and Scrutiny Committee considered an update on the development of a single Kent and Medway Clinical Commissioning Group on 20 August 2019. The Comments of this Committee are set out in section 3 of the report. The Health and Wellbeing Board is asked to note and comment on the proposals.

9 Food Justice (Pages 117 - 124)

At a meeting of Medway Council on 25 April 2019, the Council requested a detailed report from Public Health team to the Medway Health and Wellbeing Board. This report determines the extent (if any) of food poverty within Medway and what action could be taken to facilitate the concept of food justice within Medway.

The report sets out the related local data to indicate the levels of food poverty across Medway. It also highlights key elements of local action and possible options that could be progressed to address the issue of food poverty.

10 Better Care Fund (Pages 125 - 158)

This report presents Medway’s Better Care Fund plan for 2019/20 for the Board’s support.

11 Work Programme (Pages 159 - 164)

The report advises the Health and Wellbeing Board of the forward work programme for discussion in the light of latest priorities, issues and circumstances. It gives the Board an opportunity to shape and direct the Board’s activities.

For further information please contact Jade Milnes, Democratic Services Officer on Telephone: 01634 332008 or Email: democratic.services@medway.gov.uk

Date: 2 September 2019
**Reporting on the meeting:** Members of the press and public are entitled to report on this meeting except where the public are excluded, as permitted by law. Reporting includes filming and recording of the proceedings and use of the internet and social media such as tweeting and blogging to report the proceedings. Guidance for people wishing to exercise this right is available on the Council’s website and in the public seating area at the meeting.

It is helpful if people wishing to film the proceedings could contact the Council’s media team in advance on 01634 332736 or by email to pressoffice@medway.gov.uk. Please sit in the front row or other designated area if you wish to report on the meeting. If you are attending and do not wish to be filmed or recorded please sit at the back of the public seating area.

Medway Council  
Meeting of Health and Wellbeing Board  
Tuesday, 2 July 2019  
4.06pm to 5.45pm  

Record of the meeting  
Subject to approval as an accurate record at the next meeting of this committee

Present:  
Councillor David Brake, Portfolio Holder for Adults’ Services (Chairman)  
Ann Domeney, Deputy Director, Children and Adults Services  
Councillor Gary Etheridge  
Councillor Adrian Gulvin, Portfolio Holder for Resources  
Eunice Lyons-Backhouse, Healthwatch Medway CIC Representative  
Ian Sutherland, Director of People - Children and Adults Services  
Councillor Stuart Tranter  
James Williams, Director of Public Health

Substitutes:  
Stuart Jeffery, Deputy Managing Director, NHS Medway Clinical Commissioning Group (Substitute for Ian Ayres)

In Attendance:  
Sharon Akuma, Legal Services  
Glynis Alexander, Director of Communications, Medway NHS Foundation Trust  
Clare Ebberson, Consultant in Public Health  
Jade Milnes, Democratic Services Officer  
Martin Riley, Managing Director, Medway Community Healthcare

114 Election of Chairman  
Councillor David Brake was elected as Chairman for the forthcoming year.

115 Election of Vice-Chairman  
Dr Peter Green was elected as Vice-Chairman for the forthcoming year.

116 Chairman's Announcements  
The Chairman informed the Board that a notice of resignation had been received from Sally Allum, the named substitute for NHS England on the Board. He also informed the Board that Dr Mike Parks, Medical Secretary for the Kent Local Medical Committee (LMC) had retired and confirmed that Dr Caroline Rickard would now represent the LMC as invited attendee to the Board.
Board wished Dr Mike Parks a very happy retirement and thanked him for his longstanding efforts on the Board.

117 Apologies for absence

Apologies for absence were received from Board Members, Councillors Doe, Maple and Potter and the NHS Medway Clinical Commissioning Group representatives Ian Ayres, Dr Peter Green (Vice-Chairman) and Dr Antonia Moore.

Apologies for absence were also received from invited attendees James Devine (Chief Executive, Medway NHS Foundation Trust), Helen Greatorex (Chief Executive, Kent and Medway NHS and Social Care Partnership Trust) and Dr Caroline Rickard (Medical Secretary, Kent Local Medical Committee).

118 Record of meeting

The record of the meeting held on 16 April 2019 was agreed and signed by the Chairman as correct.

119 Urgent matters by reason of special circumstances

There were none.

120 Declarations of Disclosable Pecuniary Interests and Other Significant Interests

Disclosable pecuniary interests

In relation to agenda item 8 (Suicide Prevention Update) Ian Sutherland, the Director of People – Children’s and Adults Services explained that he had a Disclosable Pecuniary Interest (DPI) in relation to the national charity Samaritans as his wife was the Chief Executive of this organisation. He explained that having taken advice, it was considered that although the Samaritans was referenced within the report, the DPI was not closely aligned to the business within the agenda item and therefore on this occasion it did not give rise to the need to take any further action.

Other significant interests (OSIs)

There were none.

Other interests

There were none.
121 Medway, North and West Kent CCGs Operating Plan 2019/2020

Discussion:

The Deputy Managing Director, NHS Medway Clinical Commissioning Group (CCG) acknowledged that there were a significant number of acronyms and technical terms included within the Operating Plan ‘the Plan’ and undertook to consider this when producing future Plans.

It was explained that as well as Medway, the Plan also covered the areas of Dartford, Swale and West Kent. There were three core areas within the Plan which were particularly relevant to Medway, including:

1. **System changes**: The Plan provided information on the introduction of Primary Care Networks (PCNs). There were 7 PCNs emerging in Medway which covered populations of between 30,000 to 50,000 people. These PCNs were similar to Local Care Hubs established under the Local Care Model except Strood had been split to reflect probable developments on the Peninsula. The PCNs were aligned to existing Healthy Living Centres.

   With respect to the Healthy Living Centres, it was explained that 4 had already been established and another 3 were needed. The Plan also reflected the work being undertaken with partners and providers across Medway and Swale to develop the Integrated Care Partnership (ICP) which covered this footprint.

2. **Outpatient transformation**: In line with the Medway Model, the Plan anticipated that some services would be relocated to enable them to be provided at community level, closer to the home of patients. The Plan aimed to improve care pathways and increase the number of ways patients could access clinical advice and clinicians.

3. **Progressing Local Care**: The Plan also set out proposals to: embed extended access to GPs, increasing the number of appointments available to patients; embed care home support; and complete integrated local reviews.

Other areas detailed within the Plan included: developing the 111 Service to ensure clinicians such as GPs and mental health nurses were available to consult with patients calling the service; reducing waiting times for planned care; and strengthening mental health provision which included increasing physical health checks for patients with serious mental illness and learning disabilities.

A Board Member commented that as this was an annual plan, it was out of context with other NHS Plans such as the Long Term Plan, the Five Year Plan and the Sustainability and Transformation Plan. It was suggested that the Operating Plan should include narrative on how it interacts with the priorities of other NHS Plans and include timescales for implementation, budget, workforce requirements etc. Without this context it was difficult for Members to fully understand the Operating Plan.
In response to this and questions regarding the complexity of the Plan, it was explained that the Long Term Plan was published in January 2019 and was the basis for the Operating Plan. The Plan was constructed to meet the requirements and priorities mandated by NHS England, which was the target audience. A shorter, more user friendly, public facing version was being created. A Member asked that going forward the Health and Wellbeing Board and relevant Overview and Scrutiny Committee receive an informative presentation on the Plan ahead of it being discussed at the Board/Committee.

Board Members expressed concern in relation to the pace at which the Healthy Living Centres were being delivered, in addition to access to future hubs, particularly in rural areas. In response, the Deputy Managing Director, NHS Medway CCG advised that work was ongoing with the Council to find a suitable location and with NHS England and the Treasury to obtain the funding required to deliver the three outstanding Centres. It was added that rural needs around access had been assessed and the CCG was keen to locate a Healthy Living Centre on the Peninsula. Discussions in this regard had been undertaken in line with the new Local Plan. Referencing his experience on Medway’s Planning Committee, a Board Member said that there was an opportunity for the CCG to take more advantage of S106 process and seek contributions from upcoming developments.

A Member raised a concern that the Plan encouraged the use of Personal Health Budgets (PHBs) but then also discouraged self-referrals. In response, the Board was advised that the expansion of PHBs was borne from a drive to ensure that patients had more control over the treatment and care they received, increasing the choice and availability of services for patients. On the other hand, work had also been undertaken to consolidate secondary care pathways. Through utilising the private sector, this had reduced waiting lists for Medway. It was noted that one provider has recently been lost and it was recognised that there was a need to ensure the Medway Hospital retained its elective portfolio and was increasingly a choice for patients going forward.

It was recognised that there was a national shortage of doctors, nurses and professionals across the wider health service. Feedback from GPs in Medway indicated that some practices had struggled to recruit doctors. However, there had been 100% sign up by GPs to work in clinics to support the extended access programme which delivered an extra 900 appointments. On this basis, in some regards Medway was doing well, although more needed to be done.

In response to questions concerning attracting health professionals to live and work in Medway, it was expected that establishing the new Medical School and developing new housing would be an attraction. The Director of Communications, Medway NHS Foundation Trust (MFT) advised that the research offer at MFT had also been a draw for clinicians and the Managing Director, Medway Community Healthcare (MCH) explained that MCH had worked with local schools and colleges to encourage young people to consider a health profession as an option. It was also explained that in moving toward
ICPs, there would be a focus on delivering care in different way, especially in light of a reduced workforce pool.

There was an emphasis on promoting Medway as a place and having a more holistic approach to promoting Medway. It was recognised that providers, commissioners and the Council needed to promote a shared narrative. The Director of Communications, MFT, explained that the Council’s place branding had been promoted. It was recognised that many doctors lived in the areas surrounding Medway but chose to work in the area. In order to encourage health professionals to move to Medway, as a Director of Medway Development Company Limited (MDC), a Board Member encouraged the CCG to explore opportunities with MDC for key worker housing in upcoming Council developments. A Board Member hoped that proceeds from the sale of St Bartholomew’s Hospital, Rochester, by NHS Property Services would be utilised in Medway to provide additional medical facilities and encourage people to move to the area. The Deputy Managing Director, NHS Medway CCG confirmed discussions were ongoing with MHS Property Services. A Board Member indicated that the property had been sold.

Whilst welcoming proposals for urgent and crisis care set out on page 114 of the Plan, a Board Member expressed serious concerns in relation to the lack of a section 136 facility in Medway, noting that the nearest facilities were located in Maidstone or Dartford. It was explained that the Kent Police and Crime Commissioner had taken responsibility for strategic planning around this area of work.

With respect to the national target to reduce suicides by 10%, a Board Member commented that the target should be zero and suggested that the Plan had been poorly worded in this regard. The CCG representative agreed with the sentiment and undertook to consider this when producing future plans.

**Decision:**

The Health and Wellbeing Board:

a) noted the comments of the Health and Adult Social Care Overview and Scrutiny Committee set out at section 3 of the report;

b) commented, as set out within the minute, on the Plan set out in this report and Appendix 1; and

c) requested that a presentation be given to the Health and Wellbeing Board and relevant Overview and Scrutiny Committee on such plans ahead of discussion at the relevant meeting(s).
122 Suicide Prevention Update

Discussion:

It was recognised that suicide was a tragic event that could have a devastating impact for family and friends of the person and on the community as whole. In Medway, as nationally, men, particularly middle aged men, were at a greater risk of suicide than women. In the year before a suicide, a third of people had contact with secondary mental health services, a third had contact with their GP and a third had no contact with health services. This suggested that there was a need to look at community interventions as well interventions relating directly to health services. In 2018, new funding was secured from the NHS for the suicide prevention across the Kent and Medway Sustainability and Transformation Partnership (STP). Kent and Medway was one of eight areas nationally to have been awarded additional funding for the programme.

This was an evidenced based programme which through the Suicide Prevention Steering Group engaged with a wide range of partners, including transport and education providers, the voluntary sector and had representation from families who had been bereaved by suicide. The programme delivered over the last year had consisted of nine strands of work set out in detail in Table 2 of the report. Four areas were highlighted in particular, as follows:

1. The ‘Release the Pressure’ social media campaign. This campaign had been extended significantly over the last year to reach more men and encourage them to seek help. The campaign signposted them to a 24 hour / 7 day a week helpline staffed by trained counsellors. 4,500 calls from Medway residents had been made to the helpline during the previous year.

2. The ‘Saving Lives Innovation Fund’ was launched which provided grants to community organisations to undertake innovative projects to prevent suicides. 29 such projects had been undertaken in the year, with over 1,000 people benefitting from these. An example project was a mentoring programme to support men going through family breakdown.

3. Suicide prevention training for professionals and the public. One programme had trained over 100 adults. E-learning had also been launched.

4. The Kent and Medway NHS and Social Care Partnership Trust (KMPT) had also developed a Zero Suicide Plan.

Each suicide prevention workstream was assessed for impact, for example data on the number of calls to the helpline had been collected. The programme had also been externally evaluated, although this data was not yet available. Qualitative data was set out at paragraph 3.6 of the report. Feedback from the national team responsible for funding the programme suggested that work in Medway was well advanced compared to the other seven areas awarded funding.
Funding had also been secured for 2019/20 to further develop the programme. Table 3 of the report outlined the plans for the forthcoming year. This included a new workstream on system leadership which would focus on reviewing care pathways. The Kent and Medway Suicide Prevention Strategy would also be refreshed for 2020.

A Board Member said tackling suicide had to be holistic and could not be achieved by one individual or organisation on their own. Young people in education settings faced particular challenges and it was explained that a lot of work had been undertaken to support students in crisis. This included a ‘Suicide Safer Universities’ project, in which universities had introduced policies and training for staff to help support students, established tea and talk sessions and undertaken awareness raising about where to seek help. This was targeted around particular pressures students were likely to have, for example exam and relationship pressures.

A Board Member commended the suicide prevention projects for children and young people. He explained that in Medway, the Rivermead Trust coordinated a programme which provided an educational bridge for children and young people who had been in a mental health unit for a period of time to return to education locally. He asked that the Suicide Prevention Programme undertook targeted work for children and young people who had been in Tier 4 Child and Adolescent Mental Health Services (CAMHS) including working with the programme mentioned and within pupil referral units.

In response to a question concerning future funding for this programme, the Public Health Consultant said that the Suicide Prevention Steering Group met quarterly and would continue to do so post funding in 2019/20. In addition, the Suicide Prevention Strategy would be refreshed over the forthcoming year. The work set out in the Strategy would also continue beyond funding obtained for 2019/20. The 2019/20 funding was granted specifically to deliver the new workstream, however the Steering Group would be reviewing the sustainability of the programme, for example by seeking to embed programmes where possible and developing e-learning.

A Board Member asked whether officers had contacted the police to obtain data on the number of individuals they had contact with who had experienced a mental health issue but were not known to other organisations. The Public Health Consultant explained that the partnership worked closely with the police, sharing information and obtaining data from the coroner with respect to suicides.

A Board Member asked how it had been established that a third of people who commit suicide were not known to health services. The Public Health Consultant explained that this proportion was derived from robust audit data which reviewed the records of individuals who had completed suicide.

With respect to a question concerning the measurement of outcomes from the 4,500 individuals who had called the helpline promoted by the ‘Release the Pressure’ campaign, the Public Health Consultant explained that where
appropriate, individuals would be asked about their wellbeing at the beginning and the end of the call. This information would be recorded to determine whether their wellbeing had improved.

A Board Member asked whether difficulties in accessing GP appointments contributed to individuals reaching crisis without seeking further help from health services. The Public Health Consultant advised that evidence suggested that where people had not had any contact with health services this was because of the stigma surrounding help seeking. Asked whether stigma had reduced as a result of campaigns to increase help seeking, the Board was advised that attitudes to mental health were changing but further progress was needed. It was recognised that the other initiatives to reduce stigma associated with mental health should be promoted.

With reference to mental health in the workplace, the Board was advised that the Council had signed up to the Time to Change Pledge. The Managing Director, Medway Community Healthcare (MCH) added that providers within the emerging Integrated Care Partnership (ICP) had committed to join the Zero Suicide Alliance. In addition, at the next Transformation Board, members would receive a presentation on the Zero Suicide Plan developed by KMPT.

Asked what support was provided to the voluntary sector to in turn support their clients who might be at risk, the Public Health Consultant explained that suicide prevention training could be accessed by these organisations. Different training programme focussed on supporting adults and children and young people and included face to face training sessions as well as e-learning, so there would be an option to suit each organisation and meet the need of the client base. Organisations forming the voluntary sector were also welcome to attend the Suicide Prevention Steering Group. An undertaking was given to ensure the Medway Voluntary Action Group was on the mailing list for the Steering Group.

Decision:

The Health and Wellbeing Board:

a) noted the comments of the Health and Adult Social Care Overview and Scrutiny Committee set out at section 5 of the report;

b) noted the update on the suicide prevention programme; and

c) requested that officers contact the police to obtain data on the number of individuals they have had contact with who have experienced a mental health issue but are not known to other organisations and share this with Board Members.
Health and Wellbeing Board Approach to Communications and Engagement

Discussion:

This report provided a summary of the existing communications and engagement activities relating to the Health and Wellbeing Board, including those relating to the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS). These were set out in detail at paragraphs 3.6 to 3.10 of the report. Having evaluated existing arrangements and following liaison with communications representatives from Medway Council and Medway NHS Clinical Commissioning Group (as two of the key partners on the Health and Wellbeing Board), the Consultant in Public Health proposed areas of further action as set out in paragraphs 3.12 to 3.18 of the report. The proposed recommendations would increase awareness of the Board and further develop the Board’s understanding of and engagement with local people on health and wellbeing topics.

Board Members expressed support for the proposals set out within the report and welcomed this as a starting point. A number of further suggestions were made, including:

- publishing information on the Health and Wellbeing Board, including contact points and its work programme within the ‘Medway Matters’ magazine at least twice a year. It was noted that this could be shared with local schools and universities to include within their own publications.

- seeking information on health and wellbeing topics from key target groups by for example consulting with organisations such as the Medway Parents and Carers Forum who represent the views of parents of children with disabilities and Medway’s Children and Young People Council who represent the views of young people in care and care leavers; and

- with respect to the upcoming formation of Integrated Care Partnerships (ICPs), developing a single engagement plan across providers to work in parallel with the proposals within the report.

In response to the latter point, the Director of Communications, Medway NHS Foundation Trust explained that there were already good communication networks among providers and these would be built in to the ICP going forward.

Decision:

The Health and Wellbeing Board agreed to:

a) nominate a named communications lead for the Health and Wellbeing Board and request the lead to explore ways of promoting the role of the Board to the public, e.g. using partners’ websites and e-bulletins;

This record is available on our website – www.medway.gov.uk
b) add an update on the “Involving Medway” programme to the Board’s Work Programme;

c) add an update on the work of the Patient Experience and Public and Patient Engagement (PEPPE) group to the Board’s Work Programme;

d) consider if there are any health and wellbeing topics which the Board would like to ask the PEPPE group to consider engaging with the public about;

e) delegate authority to the Director of Public Health in consultation with the Chairman of the Health and Wellbeing Board to review patient experience case studies developed by the PEPPE and include them in the JSNA as appropriate;

f) request that the citizens’ panel is used to gather information about health and wellbeing topics, and receive an update on this and the results of the health and wellbeing survey when it is complete in 2019/20;

g) request that community groups and partnership organisations are used to gather information about health and wellbeing topics from key target groups; and

h) share information on the Health and Wellbeing Board with Medway’s schools and colleges.

124 Work Programme

Discussion:

The Democratic Services Officer introduced the work programme report and drew the Board’s attention to the recommended amendments to the work programme set out at paragraphs 2.2 to 2.5.1 of the report. These amendments had been reflected in the work programme set out at Appendix 1 of the report.

It was explained that following the pre-agenda meeting, officers had proposed a scope for the research in relation to food justice, set out at paragraph 2.5.2 of the report and had recommended that the report be presented to the Board at their meeting on 10 September 2019.

Having reviewed the items listed on the work programme with dates to be determined, a Member expressed a view that the reports regarding the evaluation of the Suicide Prevention Programme and the update on the outcome of the section 136 ‘deep dive’ should be prioritised. The Democratic Services Officer undertook to review with officers how soon these reports could be brought forward and schedule them accordingly.

The Board considered the start time of their meetings and it was proposed that start time be brought forward to 3pm.

This record is available on our website – www.medway.gov.uk
Decision:

The Health and Wellbeing Board:

a) noted the comments and actions regarding prioritisation set out within the minute and agreed the work programme attached at Appendix 1 to the report, subject to adding the Reference from Full Council – Food Justice report to the agenda for 10 September 2019.

b) agreed the scope of the Reference from Full Council – Food Justice report set out paragraphs 2.5.2 of the report; and

c) agreed to bring forward the start time for Health and Wellbeing Board meetings to 3pm, subject to the clinical representatives of NHS Medway Clinical Commissioning Group (CCG) being able to attend.

Chairman

Date:

Jade Milnes, Democratic Services Officer

Telephone: 01634 332008
Email: democratic.services@medway.gov.uk
This page is intentionally left blank
Declarations of Disclosable Pecuniary Interests and Other Significant Interests

a) Disclosure at meetings

If you know you have a Disclosable Pecuniary Interest (DPI) or Other Significant Interest (OSI) (see below for definitions) in a matter to be considered at a meeting, you must disclose, at the start of the meeting or when the interest becomes apparent, the existence and nature of the interest.

Even if a DPI has already been registered you must still disclose it at the meeting.

Where you disclose an interest at a meeting which is not entered on the Council’s register of interests, or the subject of a pending notification, you must notify the Monitoring Officer in writing of that interest within 28 days from the date of disclosure at the meeting.

b) Participation in Meetings

Where you have a DPI or OSI in a matter to be considered at a meeting you must, unless a dispensation has been granted:

I. **not** take part in any discussion of the matter
II. **not** take part in any vote on the matter
III. **leave** the meeting room (including the public gallery).

c) Bias and Pre-Determination

You must also be aware of and act within the rules on predetermination and bias. Avoidance of bias or predetermination is a principle of natural justice. Even if you do not have a DPI or OSI you may cause a decision to be invalid if you participate while predetermined or biased.

You should not participate in decisions where you are actually biased or give the appearance of being biased. The test is whether a fair minded and informed observer, having considered the facts, would conclude that there was a possibility that you as the decision maker are biased.

There is a distinction between predetermination, which rules out participation in decision-making and predisposition, which does not. It is acceptable for you as a Member to be predisposed towards a particular policy or viewpoint and that does not

...continued
prevent you from taking part in decision-making. However, if you take a stance which indicates that you have finally closed your mind on a matter and that nothing that you hear at Committee will alter your position then you will have moved on to becoming predetermined and, in that case, you should not participate.

**Definitions**

**Disclosable Pecuniary Interests** - are those interests set out in Schedule One to the Code of Conduct. You will have a DPI in a matter being considered at a meeting where the DPI is closely aligned to the business of the agenda item and where the interest is:

(a) your interest or

(b) an interest of your spouse or civil partner, a person with whom you are living as husband and wife, or a person with whom you are living as if you were civil partners and provided you are aware that the other person has the interest.

**Other Significant Interests** – you will have an OSI where your interest is closely aligned to the business of the Council agenda item and where the business affects the financial position or well being of the following to a greater extent than most inhabitants of the area affected by the decision:

I. you;

II. a member of your family or friends or any person with whom you have a close association;

III. any person or body from whom you have accepted or received any gifts or hospitality as specified in Schedule Two of the Code;

IV. any outside body or group specified in Schedule Two of the Code of which you are a member or in a position of general control or management (as relevant).

And where a member of the public with knowledge of the relevant facts would reasonably think that your interest is so significant that it would be likely to prejudice your judgement of the public interest.
Summary

This report asks the members of the Health and Wellbeing Board to consider how they and the organisations they represent can encourage and support the system to improve health and wellbeing with respect to the future state described for theme 1 of the Joint Health and Wellbeing Strategy: Giving every child a good start.

1. Budget and Policy Framework

1.1 The Health and Social Care Act 2012 places a statutory duty on upper tier Local Authorities and NHS Clinical Commissioning Groups (CCGs), to develop a Joint Health and Wellbeing Strategy (JHWS). The priorities within a JHWS are derived from a range of sources. The primary source of evidence is generally the area’s Joint Strategic Needs Assessment (JSNA). Additional information to assist in the development of JHWS priorities comes from a range of partners and key stakeholders and the specific views of local people. National guidance does not specify how long a JHWS should stay in force. It is up to the Local Authority and CCG to determine the period to be covered by a JHWS.

1.2 On 6 November 2018, the Health and Wellbeing Board considered and approved the final Joint Health and Wellbeing Strategy 2018-2023 for presentation to Cabinet. The Cabinet subsequently approved the Strategy on 20 November 2018 (decision no. 134/2018 refers).

1.3 The Health and Wellbeing Board, as established under the Health and Social Care Act 2012, aims to build strong and effective partnerships to improve the commissioning and delivery of services across NHS and local government and promotes integrated working between health and social care commissioners. The Statutory functions of the Health and Wellbeing Board are set out in Section 195 of the Health and Social Care Act 2012 and are reflected in the Terms of Reference for the Board set out in Chapter 3, Part 2 of the Council’s Constitution (Responsibility for Council Functions).
1.4 The Council, the NHS and Healthwatch, as representatives on the Health and Wellbeing Board, work together to improve population health and wellbeing and reduce health inequalities.

1.5 Section 195 of the Health and Social Care Act 2012 describes the duty to encourage integrated working thus:

(1) A Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.

(2) A Health and Wellbeing Board must, in particular, provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services.

(3) A Health and Wellbeing Board may encourage persons who arrange for the provision of any health-related services in its area to work closely with the Health and Wellbeing Board.

(4) A Health and Wellbeing Board may encourage persons who arrange for the provision of any health or social care services in its area and persons who arrange for the provision of any health-related services in its area to work closely together.

1.6 (5) Any reference in paragraph 1.5 of this report to the area of a Health and Wellbeing Board is a reference to the area of the local authority that established it.

1.6.1 “the health service” has the same meaning as in the National Health Service Act 2006;

1.6.2 “health services” means services that are provided as part of the health service in England;

1.6.3 “health-related services” means services that may have an effect on the health of individuals but are not health services or social care services;

1.6.4 “social care services” means services that are provided in pursuance of the social services functions of local authorities (within the meaning of the Local Authority Social Services Act 1970).

2. Background

2.1 The Joint Health and Wellbeing Strategy, which can be found here http://medwayjsna.info/downloads/Joint%20Health%20and%20Wellbeing%20Strategy%202018-2023.pdf, is based around five themes:

- Giving every child a good start;
- Enabling our older population to live independently and well;
- Preventing early death and increase years of healthy life;
• Improving physical and mental health and well-being; and
• Reducing health inequalities.

2.2 At the Health and Wellbeing Board Member Briefing Session on 2 July 2019, sub-groups of Members considered each of the themes and began to explore ways in which actors in the system can collaborate to advance progress within each theme.

3. Advice and analysis

3.1 There are many factors that influence the health and wellbeing of the population of Medway and changes in different areas are required to improve health and wellbeing.

3.2 Members of the Health and Wellbeing Board are in a unique position to be able to encourage and support key stakeholders in the system to make changes that will improve health and wellbeing.

3.3 Regular reviews of each theme of the Strategy will help to ensure that the focus is maintained on the key areas of the Strategy so that members of the Board, as key system leaders, are able to identify how they and the organisations they represent can support the system in taking action to improve health and wellbeing.

3.4 Appendix 1 contains a summary of information about Theme 1: Giving every child a good start. The “future state” section contains the priorities from the Strategy rephrased to describe how these priorities will look in a successful future state.

4. Risk management

<table>
<thead>
<tr>
<th>Risk</th>
<th>Description</th>
<th>Action to avoid or mitigate risk</th>
<th>Risk rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus is not maintained on five themes</td>
<td>If focus is not maintained on the key areas of the strategy the HWB may not drive change as effectively as it could</td>
<td>The HWB will regularly review each theme as per this paper</td>
<td>D-II</td>
</tr>
</tbody>
</table>

5. Consultation

5.1 Engagement with members of the public about the health and wellbeing needs of different areas of Medway took place through a series of community listening events as part of the development of the Health and Wellbeing Strategy. These events took place in six localities across Medway and formed part of a wider initiative to engage with local people and inform them about future developments taking place in the provision of health and social care services in Medway.
6. **Financial implications**

6.1 There are no direct resource implications that arise from this report. Funding of delivery actions is contained within relevant organisational budgets. Specific projects will be funded through the submission of business plans using the existing financial governance arrangements.

7. **Legal implications**

7.1 The Health and Social Care Act 2012 places a statutory duty on Medway Council and NHS Medway CCG, through the Health and Wellbeing Board, to publish a Joint Health and Wellbeing Strategy. The period that a JHWS must cover is not defined, however, the current JHWS covers 2018–2023.

8. **Recommendation**

8.1 The Health and Wellbeing Board is asked consider how they can support or encourage organisations in the system to take action to improve health and wellbeing with respect to Theme 1 of the Joint Health and Wellbeing Strategy.

**Lead officer contact**
Dr David Whiting, Consultant in Public Health, Medway Council, Gun Wharf. Tel: 01634 332636 Email: david.whiting@medway.gov.uk.

**Appendices**
Appendix A - JHWS Theme 1 Overview

**Background papers**
Medway’s Joint Health and Wellbeing Strategy 2018-2023
1) CURRENT STATE

- 14.9% of pregnant women were smoking through their pregnancy (Q3, 2018/19)
- 2.72% term babies with low birth weight (75 babies) (2017)
- 73.5% started breastfeeding (out of 797 maternities) (Q4 2018/2019)
- 46% babies totally or partially breastfed at 6-8 weeks (Q2 2018/19)
- 13.3% of children in reception year are overweight (2017/18)
- 10% of children in reception year are obese (2017/18)
- 13.5% of children in year 6 are overweight (2017/18)
- 20.8% of children in year 6 are obese (2017/18)
- 88% of children aged 5 years had had their second MMR vaccination (Q3 2018/2019)
- 72.8% five year olds have achieved a good level of development (2017/18)
- 595 admissions emergency admissions in children aged 0-14 (110 per 10,000) (2017/18)

2) BACKGROUND

- There is good evidence that investment in the early years of life (0–5 years) is highly effective in terms of the impact on future health and wellbeing and is highly cost-effective.
- What happens during these early years, starting in the womb, has lifelong effects on many aspects of health and wellbeing, from obesity, heart disease and mental health, to educational achievement and economic status.
- Ensuring that every child in Medway has a good start in life is therefore essential for the future success of Medway and the health and wellbeing of people in Medway.

For some aspects of child health and wellbeing Medway is doing well and we must maintain and build upon this level of performance.
- For others there are important and persistent issues where there are opportunities for improvement.

3) FUTURE STATE

- Parents have the knowledge, skills and opportunity to protect and nurture their children, so that:
  - Childhood obesity is reduced
  - Smoking in pregnancy is reduced or eliminated
  - Childhood vaccination rates are high enough to provide herd immunity
  - Looked-after children have good emotional wellbeing

4) How will we collaborate to create this future state, in the context of the Integrated Care System, Integrated Care Partnership (Medway and Swale) and Primary Care Networks? What can we do?

- Elected members
- Medway CCG
- Health Watch
- MCH
- Medway Foundation Trust
HEALTH AND WELLBEING BOARD
10 SEPTEMBER 2019

MEDWAY TASK FORCE

Report from: Neil Howlett, Community Safety Manager
Author: Neil Howlett, Community Safety Manager
Sharon Adley, Medway Task Force Manager (Kent Police)
Hannah Rourke, Community Safety Analyst

Summary

The Medway Task Force is a multi-agency initiative agreed as part of the Kent Police and Crime Commissioner’s Violence Reduction Challenge. The aim of this initiative is to tackle and reduce violent crime by looking at causational factors and context.

This briefing is to seek the support of the Health and Wellbeing Board.

1. Budget and Policy Framework

1.1 The Police and Crime Commissioner, Matthew Scott, has proposed the inception of a Task Force in Medway based upon the concept of the Margate Task Force. This proposal forms part of his Violent Crime Reduction Strategy which has involved key stakeholders from partnership agencies, including Councillor Adrian Gulvin as Portfolio Holder for Resources and Chairman of the Community Safety Partnership.

1.2 The creation of the Task Force is consistent with the strategic priorities set out within the council plan. The Task Force is resourced from within existing budgets of partner agencies.

2. Background

2.1 The Medway Task Force is based upon the Margate Task Force model which sees partner agencies co-located to allow for better and more efficient working. Medway’s Task Force will be based in the Medway Council Offices at Gun Wharf to facilitate the co-located set up. The Task Force will not duplicate current work streams, but rather seek to join partners together to look at key gaps in intelligence and working practices. The main aim is to reduce violent crime; this will be achieved through focusing on vulnerable people, both children and adults, as well as tackling crime types which lead to vulnerability. The Task Force will also seek, as one of its main objectives, to
improve accessibility to commissioned services. A large part of this work will be based around ‘Contextual Safeguarding.’

2.2 The overarching aspiration is for the Task Force to adopt an integrated and committed partnership approach, utilising joint information sharing under the Kent and Medway Information Sharing Agreement, with a clear focus on identified vulnerability and threat, harm and risk to reduce crime and anti-social behaviour across Medway. Analysis of wide ranging datasets and hot-spotting is contingent to its success. They will need to tackle complex issues to immediately safeguard, mitigate risk and divert from criminality through early intervention, improving the lives of Medway’s children, young people, and vulnerable adults and improving community cohesion in our wider diverse communities.

2.3 The Chief Constable has committed police resources, including a Task Force lead officer, with a clear focus on keeping Medway safe in line with Kent Police’s strategic aims and objectives through targeted and integrated working. This would be additional to the work already undertaken by the Medway Community Policing Team and the Medway Community Safety Unit.

2.4 The wider strategic aims and objectives are to contribute to keeping Medway a safe place to live, work, learn and visit are proposed as follows:

- Reduce crime and anti-social behaviour
- Reduce the risk to vulnerable people
- Diversion through early intervention
- Reduce escalation of offending
- Adopt a partnership approach to problem solving
- Ensure the ‘Voice of the Child’ is heard at every contact
- Enhance data sharing to improve the effectiveness of interventions and safeguarding
- Crime prevention
- Improve community cohesion.

2.5 The function and responsibility of the Medway Task Force is designed to:

- Promote and deliver integrated and collaborative working in the areas of Medway based upon analytical data, vulnerability factors and the level of threat risk and harm.
- Develop and utilise information sharing to enhance and promote an ethos of effective and efficient operational delivery and safeguarding of vulnerable people.
- To develop a comprehensive understanding of communities within Medway enabling the optimum utilisation of resources to improve quality of life factors.
- To undertake detailed analysis of complex data to identify emerging trends and produce problem profiles to tackle violent crime, making short, medium and long term recommendations.

2.6 In terms of accountability and governance, it is recommended that this be discharged through a Governance Board, separate from existing boards, which consists of senior officers from partner agencies, including Medway
Council – Front Line Services, Community Safety, Public Health and Adult/Children’s Services. This board will be chaired by Medway Council Chief Legal Officer. There will be a separate strategy document, tactical delivery plan, communications strategy and risk register – all of which will be subject to performance monitoring and effectiveness evaluation. The Task Force will be an integral component within the Community Safety Partnership (CSP) reporting into the CSP and being subject to the same scrutiny process within the Council. The Task Force update will also be reported annually into the Health and Wellbeing Board in conjunction with the CSP update.

3. **Advice and analysis**

3.1 The Task Force aims to establish an approach to sustainability to ensure community ownership and public trust, which are essential to securing lasting social change.

3.2 The Task Force will aim to increase sustainable outcomes through the application of an enhanced public/private/voluntary sector integrated service model. This will include developing community stewardship in micro-locations of most complex need, with an aim to reduce long-term agency demand.

3.3 The Medway Task Force has liaised extensively with the Margate Task Force – managers and partnership staff, both past and present and will seek to develop best practice accordingly. The Task Force lead officer is cognisant of other multi-agency initiatives which have taken place in Medway, namely Street Week, which was co-ordinated by Job Centre Plus, Department of Work & Pensions. Street Week has evolved within Margate and will be considered as a potential tactic moving forward; however since this initiative there are a number of new multi-agency work streams within Medway which have arisen and it is vital that the work of the Medway Task Force complements these existing initiatives.

4. **Risk management**

4.1 This report reflects the importance of constructive dialogue with our partner organisations, commissioned services and the third sector and also reflects the importance of coordinated and collaborative working.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Description</th>
<th>Action to avoid or mitigate risk</th>
<th>Risk rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competing demands on agency staff within the Task Force</td>
<td>Changes in leadership, staffing or resources could reduce the involvement of key agencies</td>
<td>Engagement of strategic partners within the governance arrangements</td>
<td>D3</td>
</tr>
<tr>
<td>Too many objectives across a wide geographical area</td>
<td>The Task Force is spread too thin and has insufficient resources to deal with a high number of work streams</td>
<td>Prioritisation based on strategic analysis; clear objective setting and governance arrangements</td>
<td>D3</td>
</tr>
</tbody>
</table>
5. Consultation

5.1 Consultation was initially carried out by the Police and Crime Commissioner (PCC) in January 2019. There has been ongoing consultation through the PCC’s Violence Reduction Challenge and through engagement by the Medway Task Force lead officer.

6. Financial implications

6.1 There are no direct financial implications arising from this report.

6.2 Support for the Task Force will need to come from existing resources. There have been concerns raised that this may lead to an increased pressure on existing resources; however, to generate greater cost savings, efficiencies and effectiveness, this can be achieved through the use of shared commissioning and a joint case management approach (in comparison to standard community safety and single agency functional models).

7. Legal implications

7.1 There are no direct legal implications arising from this report.

8. Recommendations

8.1 The Health and Wellbeing Board is asked to:

8.1.1 note the progress towards establishing the Medway Task Force; and

8.1.2 note the governance model set out at paragraph 2.6 of the report.

Lead officer contact
Neil Howlett,
Community Safety Manager.
Community Safety Unit, Medway Police Station, Purser Way, Gillingham, ME7 1NE
Telephone - 01634 331183.
Email - neil.howlett@medway.gov.uk

Appendices
None

Background papers
None
HEALTH AND WELLBEING BOARD
10 SEPTEMBER 2019

SOCIAL ISOLATION TASK GROUP:
THE IMPACT OF SOCIAL ISOLATION IN MEDWAY –
PROGRESS REPORT

Report from: James Williams, Director of Public Health
Author: Clare Ebberson, Consultant in Public Health
Bill Ronan, Public Health Projects Officer
Jon Pitt, Democratic Services Officer

Summary

In January 2019, the Social Isolation Task Group review entitled ‘The Impact of Social Isolation in Medway’ was agreed by Cabinet. Prior to publication, this report had been presented to and considered by, the Health and Adult Social Care Overview and Scrutiny Committee in December 2018 and the Health and Wellbeing Board in February 2019.

The Task Group report considered the impact of social isolation and loneliness in Medway. It made a number of recommendations for actions that the Council and other organisations could take to reduce social isolation locally.

The attached progress report (Appendix 1) summarises progress against each of the review’s recommendations.

1. Budget and Policy Framework

1.1 Under Chapter 4 of the Constitution (Part 5 – Overview and Scrutiny Rules - paragraph 21.1 (xvii)), each overview and scrutiny committee has the responsibility to appoint time limited Task Groups to undertake in-depth reviews. The overall programme of reviews are agreed each year by the Business Support Overview and Scrutiny Committee. Review findings and recommendations are presented to the Council, Leader and Cabinet as appropriate. The review topic, ‘The Impact of Social Isolation in Medway’ falls within the remit of the Health and Adult Social Care Overview and Scrutiny Committee. The report recommendations are also relevant to the work of the Health and Wellbeing Board.

1.2 The recommendations arising from the review are consistent with the Council’s Policy Framework.
2. **Background**

2.1 On 30 November 2017 the Business Support Overview and Scrutiny Committee identified a number of topics for the undertaking of in-depth scrutiny reviews, one of which was Social Isolation. The Task Group commenced its work in May 2018.

2.2 The Membership of the Task Group included Councillors Purdy (Chairman), Aldous, McDonald, Price and Wildey.

2.3 The findings of the Task Group were first reported to the Health and Adult Social Care Overview and Scrutiny Committee in December 2018. The report was presented to Cabinet in January 2019, with Cabinet having accepted all the recommendations. In February 2019, the report was also considered by the Health and Wellbeing Board.

2.4 The attached progress report (Appendix 1) provides an update on the progress made against the recommendations of the review thus far.

3. **Conclusions and Recommendations of the Social Isolation Task Group**

3.1 The conclusions of the task group are outlined in the Social Isolation Task Group report, which is included as a background paper. The Task Group made 23 recommendations, spanning a range of areas, which can be seen in Appendix 1.

4. **Progress against task group recommendations**

4.1 There has been substantial work undertaken over the last six months in relation to implementation of the reports recommendation. This section provides a highlight of the major achievements to date:

- The development and launch of a local campaign to reduce social isolation and loneliness in Medway called “A Better Medway - Together”. The campaign focuses on raising awareness of community assets in Medway where local people can make connections with others, and supporting local people to make a pledge to reduce isolation by connecting with others in their community. 85 pledges have been made within the first month of the campaign.

- The establishment of a Medway social prescribing network and securing of European funding to further expand social prescribing in Medway, to support an additional 1,000 people in Medway through the programme.

- The launch of a Medway ‘Connect Well’ website, a searchable online database of organisations and activities in Medway, administered by Medway Voluntary Action (MVA).

- Development of new social isolation training, which has been delivered to over thirty newly recruited social isolation champions representing departments across the Council.
A review of the Staying Connected guide has been completed, including consultation with partners, and recommendations for a new, improved version of the guide developed.

4.2 Further updates on the progress against the recommendations are included in the ongoing action plan at Appendix 1.

5. Risk management

5.1 There are no risks directly arising from the report. The impact of the recommendations contained in Appendix 1 are focused on helping to reduce social isolation in Medway and, as such, no risks are identified to delivery.

6. Financial implications

6.1 There are no direct financial implications arising from this update report.

7. Legal implications

7.1 There are no legal implications arising from this update report.

8. Recommendation

8.1 The Health and Wellbeing Board is asked to note the progress made against the Task Group recommendations.

Lead officer contacts
Clare Ebberson, Consultant in Public Health
Telephone: 01634 332633 Email: clare.ebberson@medway.gov.uk

Jon Pitt, Democratic Services Officer
Telephone: 01634 332715 E-mail: jon.pitt@medway.gov.uk

Appendices
Appendix 1 – Social Isolation Task Group Progress Report

Background papers
Social Isolation Task Group Report
This page is intentionally left blank
## Recommendations of the Social Isolation Task Group – ‘The Impact of Social Isolation in Medway’

<table>
<thead>
<tr>
<th>Recommendation No.</th>
<th>Text of Recommendation</th>
<th>Update July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>That Cabinet asks the Chief Finance Officer to investigate how Council Tax and benefit related correspondence could be utilised to send out information about social isolation and to work with Public Health and Voluntary Sector Partners to identify what information could be provided.</td>
<td>The opportunity to include a link to the online “Staying Connected” Booklet as part of Council corporate communications in the autumn is being scoped by finance. This booklet outlines services and support for over 55s who may be lonely or isolated.</td>
</tr>
<tr>
<td>2</td>
<td>That Cabinet requests that Bereavement Services consider how to engage, with appropriate sensitivity, with individuals observed to repeatedly visit Medway cemeteries alone, in order to establish whether the person feels isolated or lonely and if so, to signpost them to appropriate services, for example those in the Staying Connected resource.</td>
<td>Bereavement services staff have attended social isolation training and evaluation shows staff have increased knowledge of services available and how to signpost people to support. Bereavement services have updated their website to include the Staying Connected booklet. Staying Connected booklets are now available at Medway crematorium and at Council owned cemeteries.</td>
</tr>
</tbody>
</table>
| 3                  | That Cabinet requests that Housing Management / Strategic Housing:  
  i) Works with contractor Mears and MHS Homes to further develop community involvement activities within social housing developments in Medway which aim to promote community connectedness and reduce isolation.  
  ii) Investigates the feasibility of people living in sheltered housing, who are not otherwise visited by friends or relatives on a regular basis, receiving regular weekend visits, linking up with the voluntary sector. | i) Reducing loneliness and social isolation is addressed at ongoing meetings with contractors Mears and MHS Homes. This includes awareness of support available across Medway. MHS Homes are also a member of the Medway Social Isolation Network.  
   ii) An item is scheduled for the September social isolation network to look at housing and isolation and identify opportunities for partners to work more closely together. |
<table>
<thead>
<tr>
<th>Recommendation No.</th>
<th>Text of Recommendation</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>iii)</td>
<td>Investigates the possibility of establishing a Homeshare scheme in Medway.</td>
<td>iii) A meeting is taking place with a provider of a Homeshare scheme in Medway in August to explore opportunities and benefits that a similar scheme in Medway could provide.</td>
</tr>
<tr>
<td>4</td>
<td>That Cabinet requests that Public Health further investigates the ‘Chatty Café Scheme’ and other similar schemes, including the Places of Welcome Scheme run by the Diocese of Rochester, with a view to encouraging cafes in Medway to participate and to consider whether local venues could be encouraged to offer a similar service.</td>
<td>Criteria for a Medway “Talkative Tables” scheme are in development, and it is planned to consult partners in the social isolation network on these in the autumn. A range of voluntary sector organisations also run schemes across Medway aimed at encouraging conversations e.g. dementia cafes and the rural café bus in HOO (delivered by Action in Rural Kent).</td>
</tr>
<tr>
<td>5</td>
<td>That Cabinet requests that Partnership Commissioning investigates the possibility of the Council supporting widening the offer of Community Interest Companies in Medway, such as Walderslade Together and Hoo Peninsula Cares, to enable similar provision for other parts of Medway.</td>
<td>An evaluation of the outcomes of wHoo Cares and Walderslade Together, as part of the development of a wider social prescribing initiative is currently being undertaken. The outcome of this work will inform how best to take forward initiatives like this across Medway.</td>
</tr>
<tr>
<td>6</td>
<td>That Cabinet requests that Partnership Commissioning, in conjunction with local voluntary sector organisations, investigates existing volunteer databases and investigates the need for and feasibility of establishing a Medway database of volunteers, if a suitable existing database cannot be identified.</td>
<td>Medway Voluntary Action currently hosts a database for both voluntary groups and potential volunteers in Medway. The “VC direct” database has over 900 voluntary sector groups listed. The Medway Volunteer Network, helps and advises interested people to volunteering opportunities across Medway <a href="http://www.medwayvoluntaryaction.org.uk/Volunteering-Volunteers">http://www.medwayvoluntaryaction.org.uk/Volunteering-Volunteers</a></td>
</tr>
<tr>
<td>7</td>
<td>That Cabinet requests that Departmental Management Teams consider appointing a lead champion for reducing</td>
<td>Lead champions have been recruited for service areas across the Council.</td>
</tr>
<tr>
<td>Recommendation No.</td>
<td>Text of Recommendation</td>
<td>Update</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>1</td>
<td>social isolation and promoting community connectedness for each service area, particularly frontline services and that, led by Public Health, this group of officers meet as a task and finish group.</td>
<td>July 2019</td>
</tr>
<tr>
<td>A new social isolation training session has been developed in 2019 and is being delivered, and over thirty lead champions from across the Council have been trained to date. Evaluation forms demonstrate that the training is improving awareness of social isolation and knowledge about what support is available for residents and how to signpost people to it. Leads are sharing information with their teams through team meetings and other forums.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>That Cabinet requests that Social Isolation Awareness training is delivered to key frontline staff and that training is offered to Members as part of the Councillor induction process following the next Medway Council elections in May 2019.</td>
<td>See update for action 7. In addition, Public Health induction was provided for Councillors in June 2019 with an overview of public health topics including social isolation. Options for a bespoke social isolation training session for Councillors as part of the ongoing member development programme are being discussed with Member Services for later in the year.</td>
</tr>
<tr>
<td>9</td>
<td>That the Procurement and Partnership Commissioning Teams give consideration to how the Council’s procurement and commissioning arrangements could encourage organisations tendering for Council and jointly commissioned services to ensure that their staff and models of service delivery contribute to the reduction of social isolation and promotion of community connectedness in Medway.</td>
<td>Procurement and Partnership Commissioning teams have awarded procurements which address social isolation. Work is ongoing to make all bidders aware of signposting literature (e.g. Staying Connected) and spreading the message through all procurement activities.</td>
</tr>
<tr>
<td>10</td>
<td>That information on the impact of Social Isolation and Loneliness be collected as follows:</td>
<td>i) The June 2019 staff survey included a question related to social isolation, by asking staff if they feel they have opportunities to connect with colleagues. The question asked colleagues to score how much they agreed or disagreed with the following statement: “I feel part of the</td>
</tr>
<tr>
<td>i) Via a question relating to social isolation / loneliness to be included in the annual staff survey.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendation No.</td>
<td>Text of Recommendation</td>
<td>Update July 2019</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>11</td>
<td>ii) That opportunities to include the impact of social isolation and loneliness within impact assessments carried out in relation to Council policies be explored.</td>
<td>ii) Scoping work is underway looking at best practice and how this is incorporated in impact assessments in other areas.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>That Cabinet:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>i) Agrees to designate the Cabinet Member for Adults’ Services as a Medway Social Isolation Ambassador, who will take the lead in representing the Council at external events and functions relevant to social isolation and loneliness and would promote action to raise awareness of the issues and actions necessary to help tackle social isolation and loneliness in Medway and promote community connectedness.</td>
<td>Councillor Brake is fulfilling the role of Social Isolation Ambassador as part of his portfolio for Adults’ Services. Councillor Brake took part in an interview with BBC Radio Kent in June 2019 to discuss social isolation and promote the launch of Medway’s campaign to tackle loneliness and isolation in Medway “A Better Medway – Together”.</td>
</tr>
<tr>
<td></td>
<td>ii) Acknowledges that in addition to the appointment of a Medway Social Isolation Ambassador, all Councillors should play a wider community role in</td>
<td></td>
</tr>
<tr>
<td>Recommendation No.</td>
<td>Text of Recommendation</td>
<td>Update</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td>helping to identify socially isolated or lonely people and signposting them to appropriate sources of advice and support.</td>
<td>July 2019</td>
</tr>
<tr>
<td>13</td>
<td>That Cabinet requests that the Health and Wellbeing Board and the Health and Adult Social Care Overview and Scrutiny Committee both have an active role in monitoring implementation of the recommendations of the Task Group.</td>
<td>A six month progress monitoring report will be presented/provided to both of these Boards/Committees.</td>
</tr>
<tr>
<td>14</td>
<td>That Cabinet:</td>
<td>i) The Medway ‘Connect Well’ Website was launched in June 2019. It is a searchable online database of organisations and activities in Medway, administered by Medway Voluntary Action (MVA). <a href="https://www.connectwellmedway.org.uk/">https://www.connectwellmedway.org.uk/</a></td>
</tr>
<tr>
<td></td>
<td>i) Expresses its support for the development of social prescribing in Medway and of an associated directory of services, subject to appropriate funding being secured and requests that this work is promoted across the Council to enable staff to signpost isolated individuals to appropriate support.</td>
<td>People who aren't able to access it electronically can be supported over the phone by MVA to access the information.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medway Council have additionally secured some European funding to launch a new social prescribing service that specifically supports socially isolated older people (over the age of 65) to become less socially isolated. This programme will see three new link workers employed, and over the three-year programme they aim to support over 1,000 people living in Medway.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Medway Social Prescribing Network was also formed in December 2018, which is made up of a range of voluntary, public, health and academic sector partners. This network aims to support the coordination and ongoing development of the six social prescribing schemes happening across Medway. The network is also in place to</td>
</tr>
<tr>
<td>Recommendation No.</td>
<td>Text of Recommendation</td>
<td>Update</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------</td>
<td>--------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>July 2019</td>
</tr>
<tr>
<td>ii)</td>
<td>Emphasises the importance of ensuring that adequate provision is made for people who are unable or unwilling to access information via the internet e.g. if an online directory of services is developed.</td>
<td>support the development of the wider system dependencies that need to be in place to have a fully functioning social prescribing system. One of these system dependencies is the Connect Well Medway Directory of Services described above, with the ambition of providing a single portal for residents to find local activities. These activities have been through a self-validated quality assurance process, before being registered on the system. The range of activities includes physical activity, arts and a wide range of other social groups, mainly provided by the voluntary and community sector. These activities provide a wide opportunities for people that are socially isolated to participate in. The system has an inbuilt referral system that allows individuals to self-refer to services or health and social care professionals to refer to activities and track the output of those referrals.</td>
</tr>
<tr>
<td>iii)</td>
<td>Requests that consideration be given with regard to whether any in-kind, non-financial support could be provided to local voluntary organisations where their activities or planned activities directly contribute to reducing social isolation or loneliness in Medway</td>
<td>ii) The Medway ‘Connect Well’ Website offers people online support. Additional telephone support is offered to people who are unable or unwilling to access information electronically. The Council are supporting voluntary sector organisations to raise awareness of their services/support that contributes to reducing isolation. For example, through the “A Better Medway – Together” social media campaign to tackle isolation in Medway, third sector partners’ are offered the opportunity to promote their services/activities through A Better Medway’s communications channels, and through inclusion in the</td>
</tr>
<tr>
<td>Recommendation No.</td>
<td>Text of Recommendation</td>
<td>Update</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>15</td>
<td>That the Communications and Marketing team investigates the following, subject to resources being available: i) Undertaking a public campaign focusing on actions individuals and communities can take to promote community connectedness and contribute to reducing isolation and loneliness. ii) Promotion of activities and events run by local organisations that aim to reduce social isolation and loneliness and connect communities.</td>
<td>July 2019 “Staying Connected” guide. Support is also offered through the social isolation network, which is administered by Medway Council including sharing of best practice, funding opportunities etc. A new social media campaign to tackle isolation and loneliness in Medway was launched in June 2019 (loneliness awareness week). The campaign is called “A Better Medway – Together”. <a href="https://www.medway.gov.uk/community">https://www.medway.gov.uk/community</a> The campaign focuses on: • Supporting the community to make more connections with others by asking people to make a pledge to connect with others. Pledges can be made by individuals or organisations, for example, pledges could include saying hello to your elderly neighbour, hosting a coffee morning or volunteering at a community event. • Raising awareness of activities, services and support in Medway that residents can access to connect with others and reduce loneliness, including featuring at least one activity or service weekly on social media where residents can connect with others. • 85 pledges have been made in the first month of the campaign. • An example of one pledge was Great Lines Parkrun, whose pledge was to ask those attending Parkrun during loneliness awareness week to: a)</td>
</tr>
<tr>
<td>Recommendation No.</td>
<td>Text of Recommendation</td>
<td>Update July 2019</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------</td>
<td>-----------------</td>
</tr>
</tbody>
</table>
| 16                | That Cabinet requests that Public Health ensures / continues to ensure that copies of the 'Staying Connected' booklet are available in key locations, such as libraries, cemeteries / funeral directors and that consideration is given to producing a version of the booklet aimed at younger adults. | Staying Connected booklets are distributed to a range of locations including libraries, sport centres, crematoriums and to people in their homes through Kent Fire and Rescue Safe and Well visits.  
Over 750 physical booklets have been distributed during 2019. Distribution has taken place through a range of public engagement events (Focus on days; Pensioner forum; and Medway Mile). The booklets are also available at a range of locations across Medway, for example libraries, council offices and crematoriums.  
The booklets have further been distributed to people in their own homes who may be isolated through Kent Fire and Rescue’s safe and well home visits. The booklets can also be downloaded from the A Better Medway website.  
A review of the Staying Connected Guide was completed. |
<p>|                   | say hello to someone new at Parkrun or b) bring someone new along to Parkrun. | |
|                   | • The A Better Medway – Together campaign is performing well on social media. For example, the campaign launch post received almost 4,000 social media impressions (number of times the post was displayed on users’ newsfeeds). The launch facebook post was “liked” 242 times and shared 37 times. Examples of local projects which help people connect with others highlighted as part of the campaign are being viewed by over 1,000 people. The campaign can be followed on the “A Better Medway” social media pages or by following #MedwayTogether | |</p>
<table>
<thead>
<tr>
<th>Recommendation No.</th>
<th>Text of Recommendation</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>in July 2019 with the help of Kent University. It is planned that future versions of the staying connected booklet will be expanded to list opportunities for a wider age range of people to reduce loneliness and social isolation in Medway.</td>
</tr>
<tr>
<td>17</td>
<td>That Cabinet requests that the Council takes opportunities to engage with central Government’s work on reducing social isolation and loneliness in Medway, including opportunities to highlight key issues and good practice in Medway.</td>
<td>Medway continues to engage with the national work around loneliness, for example linking the launch of the A Better Medway Together Campaign to the national Loneliness Awareness Week. The pensioners’ information and advice fair, hosted by MP Tracey Crouch, was also attended and Staying Connected promoted.</td>
</tr>
<tr>
<td>18</td>
<td>That Cabinet requests that Medway Ethnic Minority Forum [now Medway Diversity Forum] be invited to join the Social Isolation Network with a view to discussing ways in which social isolation and loneliness can be addressed amongst BAME (Black, Asian and Minority Ethnic) communities.</td>
<td>Medway Diversity Forum are a member of the Medway Social Isolation Network.</td>
</tr>
<tr>
<td>19</td>
<td>That Cabinet recommends that:</td>
<td>Arriva have been invited to engage with and attend the Medway Social Isolation Network meetings. A discussion with Arriva will take place to investigate initiatives such as introducing ‘Chatty Buses’ routes. Arriva staff will be invited to attend the loneliness and social isolation training module, to further raise awareness of the issues with staff. This is ongoing and a discussion with Norse is planned to progress this recommendation. An initial meeting was held with transport to discuss this recommendation and it was felt that routine bus routes may provide more opportunities for conversations as the Villager service often runs day</td>
</tr>
<tr>
<td></td>
<td>i) Arriva be invited to join the Social Isolation Network with a view to discussing the part it can play in helping to address social isolation and loneliness in Medway.</td>
<td></td>
</tr>
<tr>
<td>Recommendation No.</td>
<td>Text of Recommendation</td>
<td>Update</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>20</td>
<td>That Cabinet requests that evidence around the role of technology in reducing social isolation is reviewed and opportunities explored for a pilot within Adult Social Care / Public Health.</td>
<td>July 2019</td>
</tr>
<tr>
<td></td>
<td>Cabinet has recently approved the Carers’ Strategy and action plan, which includes consideration of social isolation. Partnership Commissioning are working with colleagues to ensure opportunities are explored to embed social isolation throughout their work. This will include offering opportunities, where appropriate, to pilot technological advancements that may reduce social isolation. The use of Wider use of Telecare and Telehealth and technology solutions are also being considered. Partnership working between Adult Social Care and Public Health will look at opportunities to attract funding to expand the use of technology.</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>That Cabinet commends the significant amount of work to address social isolation and loneliness already taking place across the Council and requests that consideration is given as to how the need to address these challenges could be taken into account as part of departmental service plans.</td>
<td>The Business Intelligence team are undertaking work to explore opportunities to embed social isolation within service plans and induction.</td>
</tr>
<tr>
<td>22</td>
<td>That the voluntary sector in Medway be encouraged to continue working with the Council to reduce social isolation, for example by attending the Social Isolation Network and supporting the Government Strategy and public campaigns aimed at reducing isolation.</td>
<td>The Medway Social Isolation Network (MSIN) meets regularly and is well attended. The network is engaged with over 30 local organisations. A Medway social isolation newsletter for professionals has been introduced in 2019 and three newsletters have been produced and distributed so far.</td>
</tr>
<tr>
<td>Recommendation No.</td>
<td>Text of Recommendation</td>
<td>Update</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>23</td>
<td>That Cabinet requests that the Social Isolation Network reviews the national strategy against actions taking place in Medway and identifies any gaps for possible actions to be further investigated by the Council / partners.</td>
<td>July 2019</td>
</tr>
</tbody>
</table>

In January 2019 the Medway social isolation network reviewed the action plan against the national strategy. The action plan was felt to be fit for purpose in light of the national strategy and no additional gaps/actions were identified by partners.
This page is intentionally left blank
HEALTH AND WELLBEING BOARD
10 SEPTEMBER 2019

DEVELOPMENT OF SINGLE KENT AND MEDWAY CLINICAL COMMISSIONING GROUP

Report from: Dr Peter Green, CCG Clinical Chair, Medway CCG
Dr Bob Bowes, GP Clinical Chair, Kent and Medway System Commissioner Steering Group
Glenn Douglas, Accountable Officer Kent and Medway CCGs

Author: Mike Gilbert, Transitional Director of Corporate Affairs, Kent and Medway CCGs

Summary

This report provides a high level summary of the work to date in developing an integrated care system across Kent and Medway and in particular the development of a single CCG and the Medway and Swale Integrated Care Partnership (ICP).

This report will be accompanied by a presentation on the health and care system transformation and a presentation on the ICP which will be available after the meeting.

The Health and Adult Social Care Overview and Scrutiny Committee considered an update on the development of a single Kent and Medway Clinical Commissioning Group on 20 August 2019. The Comments of this Committee are set out in section 3 of the report. The Health and Wellbeing Board is asked to note and comment on the proposals.

1. Budget and Policy Framework

1.1 The NHS Long Term Plan sets an expectation that Integrated Care Systems will be established across the country by April 2021. These will be based on existing Sustainability and Transformation Partnership (STP) footprints, with the driver and intended benefits being the refocus of commissioning and care provision on population health needs and addressing health inequalities (unacceptable differences in health and life expectancy for some communities compared to others).

1.2 The national Plan is clear that each Integrated Care System (ICS) will need streamlined commissioning arrangements to enable a consistent set of decisions to be made at system level. This will involve a single CCG for
each ICS area. CCGs will become leaner, more strategic organisations that support care providers (through integrated care partnerships) to partner with other local organisations to deliver population health, local service redesign and implement the requirements of the Long Term Plan.

1.3 In Kent and Medway, work along the lines of the Long Term Plan has been underway for many months. We recognise that whilst Kent and Medway has many achievements to be proud of over the past six years and previously, there are a number of ongoing core issues that our current commissioning groups have not been able to address and which have impacted negatively on care and outcomes. These include:

- non delivery of key access and care standards, including for cancer, diagnostics and emergency care
- fragmented provision across a number of services, most notably children’s services
- chronic workforce issues in many areas and particularly within primary care
- inefficient service provision, resulting in less than optimum patient experience/outcomes and unsustainable recurrent financial problems across much of Kent and Medway
- prevention not being consistently prioritised.

1.4 These are not just challenges for us: the need to improve population health and wellbeing, patient experience and quality of care, and to make best use of NHS resources (staff, funding and buildings) was set out in the Five Year Forward View and has formed the basis for the work of all NHS organisations and for sustainability and transformation partnerships ever since.

1.5 As a result system leaders in Kent and Medway have been developing plans for an integrated care system to address these issues through:

- reduced duplication of management and clinical effort, enabling reinvestment of resource in to the development and delivery of local care
- consistent outcomes being set at a ‘system’ level to reduce health inequalities, whilst enabling local partnerships greater freedom to decide how they develop and offer care to meet these outcomes
- accelerated decision making and a more collective and responsive approach to addressing major challenges across Kent and Medway and reducing inequity of care
- less competition and greater collaboration between partners
- reinvigorated primary care services working as equals alongside the larger local providers.

1.6 Through the STP Programme Board, local leaders commissioned the development of a System Transformation Programme Initiation Document
(PID). The PID outlines the initial case for change and governance framework required to deliver the various programmes of work to implement an integrated care system by April 2021. Noting that the PID is a dynamic document that will evolve over a period of time, the Programme Board approved the first version of the PID in June 2019. This is now being approved by the constituent partners. A copy of the PID is attached at Appendix 1.

1.7 As the PID makes clear, we firmly believe that developing a single CCG as part of a new Kent and Medway integrated care system is a real opportunity for us to achieve commissioning at scale by knowledgeable local clinicians from across the patch, backed up by local service design and delivery, by partnerships focused on patient needs. A Kent and Medway CCG will enable us to:

- overcome the fragmentation that undermines our current effectiveness
- offer consistent support to the new primary care networks enabling them to develop rapidly everywhere in Kent and Medway to play their full part in the new health and care system
- better develop the pipeline and mix of staff that the NHS needs, including new roles to extend the care available to support people’s mental and physical health and wellbeing through primary care networks, providing a much more holistic approach
- describe the needs of our whole population and develop outcomes for ICPs to deliver in ways tailored to their local populations
- strengthen the focus on righting health inequalities
- take on some of the assurance and regulatory functions currently delivered by NHS England and NHS Improvement.

1.8 Medway Council is actively involved in the system transformation work at a number of levels, including membership of the following key oversight and management groups:

- STP Programme Board
- STP Non-Executive Directors Oversight Group
- System Transformation Executive Board
- System Commissioner Governance Oversight Group
- Kent and Medway STP Clinical and Professional Board
- Medway and Swale Integrated Care Partnership Board

1.9 The Kent and Medway Joint Health and Wellbeing Board, an advisory joint sub-committee of Medway’s and Kent’s respective Health and Wellbeing Boards has also received system transformation updates.
2. Update on System Transformation Developments

2.1 Set out below are key milestones and next steps:

2.1.1 Ongoing engagement with the members of the CCGs to agree to progress actions to move to a single CCG:

The proposal to merge the existing CCGs into a Kent and Medway system commissioner (alongside the establishment of local integrated care partnerships and primary care networks), is being led and driven by the eight CCG GP clinical chairs. In turn the clinical chairs are having considerable discussions with their respective GP memberships across Kent and Medway and with the Local Medical Committee (LMC).

2.1.2 A number of meetings have already taken place with GPs regarding proposals to develop a single CCG by April 2020 and feedback from these discussions is helping shape and refine the proposals. Examples include ensuring the ‘golden-thread’ of GP clinical leadership is apparent across all levels of the new care system; having GP representation on the CCG Governing Body from each of the current constituent areas, including both Medway and Swale; and ensuring there is an effective and clear engagement framework whereby local issues and concerns can be played into local and system wide governance processes.

2.1.3 A further example is our commitment to ensure that current primary care commissioning/customer care teams remain locally focused and contactable.

2.1.4 GPs are also represented, and co-chair, the Kent and Medway Clinical and Professional Board and the Primary Care Board. The former is expected to become the quasi ‘clinical cabinet’ of the proposed new CCG, ensuring further clinical and professional representation and input into the statutory health commissioning organisation.

2.1.5 Each of the CCG Governing Bodies and GP memberships will be asked to vote on the proposal to merge the CCGs to form a single Kent and Medway CCG prior to the formal application being made to NHS England by 30 September 2019.

2.2.1 Support and development of Primary Care Networks to ensure readiness for funding and emerging functions in 2019/20:

Forty of 42 Primary Care Networks have been formally registered across Kent and Medway. This includes seven networks covering the whole of Medway between them and three networks which similarly cover the whole of the Swale CCG area. Each network has appointed a local GP clinical director.

2.2.2 Primary Care Networks are groups of practices working together and with community, mental health, social care, pharmacy, hospital and voluntary services in their local area to deliver proactive, personalised, coordinated and more integrated health and social care. They typically cover populations of 30,000 to 50,000 registered patients to best meet the needs of local neighbourhoods.
2.2.3 Networks went live from 1 July 2019 and they are now providing extended access to primary care services through this joint partnership working. Networks will be expected to take on additional local care services as they become fully established over the coming months and work as part of the emerging local Integrated Care Partnerships. As part of this there is recognition that a significant programme of support and development will be required to ensure each network is able to take on these responsibilities and work to reinvigorate primary care across the system.

2.3.1 **Provider led development of the Integrated Care Partnerships:**

Four Integrated Care Partnerships have now been confirmed which between them cover the whole of Kent and Medway: Medway and Swale ICP, East Kent ICP, West Kent ICP, and Dartford, Gravesham and Swanley ICP. Medway and Swale ICP will cover the whole of the existing Medway and Swale CCG areas.

2.3.2 Integrated care partnerships will be provider led collaboratives, including primary care and voluntary sector organisations, each operating across a population of around 250,000 to 500,000. This is a fundamental shift from the competitive internal market that has existed in the NHS for almost 30 years. ICPs will hold a single contract with the Kent and Medway CCG and will decide collectively how services are to be developed and provided to meet the outcomes set by the CCG. Importantly, this will include determining the service offer for preventative, well-being and local care services. ICPs will need to be fully authorised by the CCG before they can hold a contract.

2.3.3 It is expected that ICPs will become fully established across Kent and Medway from April 2021. In the period April 2020 to April 2021, it is planned that the Kent and Medway CCG will retain all of the existing CCG responsibilities, with the majority of CCG commissioning staff remaining in their current portfolio areas. However, during the year it is expected that staff and functions will start to work in shadow ICP and PCN form, ultimately with staff transferring to the new arrangements by April 2021. This will leave the single CCG to focus on its strategic and ‘at-scale’ commissioning responsibilities.

2.3.4 Whilst the ICPs are in their early stages of development, good progress is already being made by Medway and Swale ICP. Medway Council is actively involved in the ICP leadership board and working groups.

2.4.1 **Submission to NHS England in June to establish and operate as a System Commissioner and Integrated Care System from April 2020.**

Further national guidance has been received from NHS England on the timetable for application for CCG merger:

- 30 September deadline for CCG’s to apply for merger
- October 2019 – Regional review panel to review application
November 2019 – National review panel to review regional recommendation and determine approval or refusal (notification to CCGs is expected by 30 November 2019)

April 2020 – Merger of CCGs and formal establishment of single CCG for Kent and Medway

April 2021 – national expectation that all areas of the country will be functioning as integrated care systems with ICPs operating.

2.5.1 Continue exploratory discussions with local authorities on the alignment and integration of health and social care commissioning

Medway Council and Kent County Council are actively involved in the system transformation programme. Discussion are ongoing regarding current and future commissioning arrangements, building on the solid arrangements already in place within Medway.

3. Health and Adult Social Care Overview and Scrutiny Committee – 20 August 2019

3.1 The Development of a Single Kent and Medway Clinical Commissioning Group was considered by the Health and Adult and Social Care Overview and Scrutiny Committee on 20 August 2019 and the discussion was as follows:

3.2 A presentation was given to the Committee on the proposals, the key points of which were as follows:

- A strategic commissioning function was needed to enable more effective planning and commissioning of services, based upon local needs. This would be realised through the establishment of a single Kent and Medway Clinical Commissioning Group (CCG).
- It was anticipated that, nationally, single CCGs would be created to match Sustainability and Transformation Plan (STP) footprints. A single CCG would be able to achieve scale efficiencies that could not be achieved by the existing 8 Kent and Medway CCGs. There was a need to reduce CCG running costs by 20%.
- Services were not currently as joined-up as they could be, with there being too many individual agencies and it was acknowledged that there was currently too much inequality and not as much prevention work as there could be. Differences in life expectancy between areas needed to be addressed.
- Government policy had acknowledged the internal health market was not working to improve quality or reduce costs. The internal NHS market was being replaced by a culture of collaboration and mutual responsibility.
- The health system also faced a number of workforce related challenges.
- It was anticipated that the establishment of a single CCG would help facilitate the commissioning of the services required to meet need rather than blanket commissioning by area.
- Integrated Care Partnerships (ICPs) would include acute hospitals, primary care, community services the voluntary sector, council services, the ambulance service and mental health providers. Four Integrated Care Partnerships would cover Kent and Medway, including one for the Medway and Swale area. The Integrated Care Partnerships would work
collaboratively to provide services commissioned by the single CCG. The Sustainability and Transformation Plan and Medway CCG was working closely with Medway Council to develop this collaborative working.

- **Primary Care Networks** would help facilitate groups of GPs to work collaboratively to deliver services to populations of 30 to 50 thousand. This would enable pooling of resources and a greater focus on the holistic needs of the local population, including preventative work. The Networks would be able to draw on local intelligence to identify and address local need, with analysis having already been undertaken by the Council’s Public Health function. Seven Primary Care Networks had been established in Medway and three in Swale.

- The single CCG would use findings of population needs assessments to identify and prioritise service provision in conjunction with partners. The Kent and Medway Joint Health and Wellbeing Board would have an important role.

- Development of this work was being overseen by the Sustainability and Transformation Plan Programme Board, which was attended by the Leader of the Council.

3.3 **Members asked a number of questions as follows:**

**Business case, funding, staffing and the role of Medway** – A Member raised concern that they had not seen a business case, that there may not be sufficient staff and funding available and that the Medway and Swale Integrated Care Partnership area was too small. The Committee was advised that the proposals aimed to make commissioning more efficient through collaborative working. Multi-disciplinary working was likely to make GP practice more attractive as a career and the aim was to persuade more people entering the profession to train, live and work locally. The total population of Medway and Swale was about 400,000, which equated to around a quarter of the population of Kent and Medway as a whole.

3.4 **Role of CCGs and need for change** – A Committee Member was extremely concerned as he considered that the presentation undermined assurances that the Committee had previously been given that effective partnership working was taking place, that health inequalities were being effectively addressed and that workforce and value for money challenges were being tackled effectively. The Member was also concerned that there had been many changes to health service commissioning already and asked whether there would be further changes in the future. The Clinical Chair of the Kent and Medway System Commissioner Steering Group said the strategic commissioning capacity needed to improve while ensuring local needs were addressed. It was acknowledged that CCGs had not always had access to staff numbers or budgets required. The majority of factors that influenced life expectancy were social rather than being directly health factors. It was considered that a more collaborative approach, that was not dependent on an internal market, would help to address inequalities more effectively.

3.5 The Clinical Chair of Medway CCG said that under the current system, acute and community providers often did not work together effectively to resolve issues, instead looking to commissioners to do so. The development of a more collaborative working environment would help to reconfigure relationships. Much successful prevention work was already taking place.
covering a wide range of health challenges, such as smoking, diabetes and cardiovascular conditions.

3.6 It was recognised nationally that existing CCGs were not delivering as much as they could, hence the wish to reframe the way they operated. There could not be guarantees that there would not be further restructures in the future but this would be determined by Government.

3.7 **Financial Savings, stroke services, commissioning challenges and GP numbers** – A Committee Member considered that the proposed changes were motivated by the need to make financial savings of £44 million, which had subsequently increased to £46 million. The Member had not seen figures to indicate how much the changes would cost or how the restructuring would impact on the ability to realise savings. The decision taken not to establish a hyper acute stroke unit in Medway was a particular concern in view of the acuity and number of patients in Medway. Patient transport and dermatology were examples of where there had been significant commissioning related challenges. It was asked how capacity had been strengthened to avoid similar occurrences in the future and how services outside the scope of a single CCG would be commissioned. The Member also asked whether the system would have capacity to adequately address health needs and inequalities and whether the local shortfall of GPs would be addressed.

3.8 The Clinical Chair of Medway CCG acknowledged that budgeting for prevention could be challenging as it required current spending to realise future benefit. It was hoped that the proposals would help to facilitate an increase in preventative and collaborative work. There was unlikely to be an increase in the number of GPs per person but the extension of multi-disciplinary working, involving other medical professionals, would help to address patient needs. Some complex services commissioned by NHS England would continue to be commissioned by that organisation but the majority would be commissioned by the single CCG. It was anticipated that future commissioning would be undertaken more collaboratively and would be better placed to meet local needs.

3.9 The Clinical Chair of the Strategic Commissioner Steering Group said that the framework for Integrated Care Partnerships did not make them more likely to lead to privatisation and that it was envisaged that the proposals would enhance joint working. Although there was an ongoing need to do commissioning efficiently and make savings where possible, the driver of the proposals was not the need to save money, rather they were about making better use of existing resources. This could be better achieved through the creation of a single Kent and Medway CCG. A single Accountable Officer for the Kent and Medway CCGs had been appointed in April 2018 and savings had already being made.

3.10 **Probity** – A Member asked whether there were appropriate safeguards in place to prevent inappropriate contracting of services from persons or organisations that those involved in the commissioning process had a personal connection to.

3.11 NHS representatives in attendance felt that the way in which the question about probity had been asked was inappropriate. The Committee was advised that declarations of interest had to be made at CCG meetings, in a similar way
to which they were made at the Council and that there were thorough processes in place to deal with potential conflicts. It was considered that establishment of a single CCG would be likely to lead to greater transparency as decisions would no longer be taken by eight separate CCGs. The Committee accepted assurances that the questions raised were not directed at those present.

3.12 **Public Meetings** – A Member expressed concern that the Joint Meeting of Clinical Commissioning Groups, that had made the decision in relation to the Kent and Medway Stroke review, had concluded in private due to disruption caused by some audience members. This had also resulted in Medway Councillors having to leave the meeting. Following a question about Medway Council processes, the Democratic Services Officer advised that there was provision for the press and public to be required to leave a Medway Council meeting if there was repeated disruption and following warnings from the Chairman.

3.13 **Population increases** – In response to a Member question that asked whether population increases were taken into account when funding was allocated to an area, the Clinical Chair of Medway CCG said that funding was determined by a national formula that was based on the population at a point in time. Ensuring that resources available matched growth was therefore a challenge. The centralisation of some services was necessary in order to ensure that specialised 24/7 care could be provided. This required there to be sufficient staff and patient numbers within the catchment area.

3.14 **Voluntary Sector Support** – In response to a question about engagement with the voluntary sector, the Committee was advised that some CCGs had engaged closely with the voluntary sector in relation to social prescribing. It would be important for Integrated Care Partnerships to have a close relationship with voluntary organisations. The skill for the single CCG would be to set outcomes based contracts that would require Integrated Care Partnerships to involve all partners. The Deputy Managing Director of Medway CCG added that the voluntary sector was a key workstream for Medway CCG and that it had performed better than the national average in terms of voluntary sector engagement.

3.15 **Stroke Review and Integrated Care Partnership Geography** – A Committee Member questioned whether the conclusion that a single CCG could be more effective than eight separate Kent and Medway CCGs cast doubt on the Kent and Medway Stroke Review decision as this had been made within a structure that was considered to no longer be suitable. It was also asked which specific areas would fall within the Medway and Swale Integrated Care Partnership area.

3.16 The Sustainability and Transformation Partnership Director of System Transformation said that the existing CCGs had come together to develop the Stroke Review process and that the review was considered to have followed an appropriate process. The Clinical Chair of Medway CCG said that the population covered by the Medway and Swale Integrated Care Partnership included all patients registered with practices in the Medway and Swale area. This included those living outside Medway and Swale who were registered with one of these practices.
3.17 **Decision**

The Committee

i) Noted and commented on the update provided.

ii) Requested that:

a) Details of CCG and Sustainability and Transformation Partnership meetings be provided to the Committee, to enable Members to attend those meetings open to the public.

b) Details of current Council representation at Sustainability and Transformation Partnership meetings be provided to the Committee.

4. **Risk management**

4.1 There is a full risk management framework in place for the system transformation programme. Risks are proactively managed through the overall risk register and each of the programme risk registers, and reported through the governance framework to the STP Programme Board as required.

4.2 Current material risks relate to: ensuring sufficient resourcing of the programmes alongside delivering business as usual; securing the CCG Governing Bodies and GP Membership approvals to apply for merger; ensuring effective support arrangements are in place to enable ICPs and PCNs to fully establish themselves; and ensuring ongoing and effective engagement with the various stakeholders across Kent and Medway.

5. **Engagement**

5.1 As part of our application, we are required to evidence how we have effectively engaged and discussed our proposals with a range of stakeholders, including the public and Healthwatch. We also need to evidence how we have taken their comments on board as part of our proposals.

5.2 In June we published the Programme Initiation Document (PID) as outlined above and this is being considered at public board meetings across Kent and Medway. In addition, we have produced a public summary of the PID (attached at Appendix 2), along with frequently asked questions, and a supporting presentation to engage with patients, public and hard to reach groups. We are running an on-line survey which asks the public for their views and comments by 16 August. These will be used to refine our proposals prior to going to Governing Bodies in September.

5.3 We have worked closely with our Kent and Medway STP Patient and Public Participation Group (PPAG), which has been supporting us to engage with members of the public and giving us their feedback.

5.4 As part of our on-going plan to engage with stakeholders on the proposal for a single CCG, we plan to publish our case for change over the coming weeks. This will outline the challenges facing the health and wellbeing of
people across Kent and Medway, how we plan to address these and the associated benefits to patients, staff and other stakeholders in developing an integrated care system and single CCG across Kent and Medway.

5.5 We have written to all key stakeholders including local MPs and local and district councils, copy of letter dated 29 July to Medway Council attached at Appendix 3.

Links to the Long Term Plan

5.6 In response to the Long Term Plan and to support the development of our local five year plan of which system transformation is a clear part of, we are also engaging on a number of priorities where the public can have their say to help shape our future plans. For example, we know we need to improve children's services across Kent and Medway and in particular the equity of care received; something we believe could best be supported by a single commissioner. We have worked with Healthwatch Medway and Healthwatch Kent to speak to children, young people, parents and families and are currently expanding on this work with the development of surveys and other engagement activity.

5.7 The plan will be a continuation of our work to date and support the move towards becoming an integrated care system. It will be a shared plan between the NHS and local authorities and will reflect the commitment in Kent and Medway to join up public health, health and social care services to improve the health and wellbeing of the population.

5.8 It will cover delivering a new service model for the 21st century; increasing the focus on population health and becoming an integrated care system; prevention; further progress on care quality and outcomes; giving our staff the backing they need; delivering digitally enabled care; and using taxpayer’s investment to maximum effect. Within sections on prevention, care quality and outcomes we will cover: improving performance on waiting times for A&E, referral to treatment, and cancer; addressing dementia diagnosis rates; transformation of urgent and emergency care; five year prevention plans on smoking, alcohol and obesity; and confirming increased investment in mental health for adults and children and young people.

5.9 Throughout the summer, we are running a range of engagement activities to test our thinking and help shape the plan and our local priorities to tackle local health inequalities. We are also reviewing existing patient and public engagement feedback on the key themes of the NHS Long Term Plan, so our plan is aligned to the wealth of local feedback we already have on how health and care services need to improve.

5.10 The first draft of our response to the Long Term Plan will also be submitted to NHS England and NHS Improvement at the end of September, with a final version incorporating their feedback submitted for sign off in November. The plan and an easy read summary will be published following NHS England and NHS Improvement review and approval. Engagement with stakeholders across Kent and Medway will continue beyond the publication of the plan.
6. Financial implications

6.1 There are no financial implications to Medway Council arising directly from this report.

7. Legal implications

7.1 A number of formal commissioning agreements are held between the Council and Medway CCG. Subject to the application to merge being successful, these agreements will need to be reviewed prior to any novation, alteration or cessation.

8. Recommendations

8.1 The Health and Wellbeing Board is asked to:

8.1.1 note the comments of the Health and adult Social Care Overview and Scrutiny Committee; and

8.1.2 note and comment on the update.

Lead officer contact

Simon Perks
Director of System Transformation
Kent & Medway STP
Email: simon.perks@nhs.net

Appendices

1. Kent and Medway System Transformation Programme Initiation Document
2. Public summary of PID
3. Letter to stakeholders, including Medway Council, dated 29th July 2019

Background Papers

None
Kent and Medway System Transformation Programme

Programme Initiation Document (PID)
24/05/19
Programme Initiation Document (PID)

Document Control

a. Document Identification

<table>
<thead>
<tr>
<th>Programme</th>
<th>System Transformation Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author(s)</td>
<td>M. Ridgwell and I. Chana</td>
</tr>
<tr>
<td>Version</td>
<td>0.8</td>
</tr>
<tr>
<td>Status</td>
<td>Draft for discussion</td>
</tr>
<tr>
<td>Last updated</td>
<td>24/05/19</td>
</tr>
<tr>
<td>Approved by</td>
<td>Unapproved</td>
</tr>
</tbody>
</table>

b. Document History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Status</th>
<th>Author</th>
<th>Comment / Changes from Prior Version</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0</td>
<td>13/03/19</td>
<td>Draft</td>
<td>M. Ridgwell</td>
<td>PID Framework</td>
</tr>
<tr>
<td>0.1</td>
<td>21/03/19</td>
<td>Draft</td>
<td>M. Ridgwell</td>
<td>PID Framework and system commissioner content</td>
</tr>
<tr>
<td>0.2</td>
<td>26/03/19</td>
<td>Draft</td>
<td>M. Ridgwell</td>
<td>PID overarching programme and system commissioner content</td>
</tr>
<tr>
<td>0.3</td>
<td>29/03/19</td>
<td>Draft</td>
<td>M. Ridgwell</td>
<td>PID overarching programme, system commissioner content and outline programme content</td>
</tr>
<tr>
<td>0.4</td>
<td>08/04/19</td>
<td>Draft</td>
<td>M. Ridgwell</td>
<td>Incorporates comments from SP and MG</td>
</tr>
<tr>
<td>0.5</td>
<td>14/04/19</td>
<td>Draft</td>
<td>M. Ridgwell</td>
<td>Incorporates comments from meeting with BB, RB, SP and MG</td>
</tr>
<tr>
<td>0.6</td>
<td>26/04/19</td>
<td>Draft</td>
<td>M. Ridgwell / I. Chana</td>
<td>Review of MG, RB and MR amends</td>
</tr>
<tr>
<td>0.7</td>
<td>01/05/19</td>
<td>Draft</td>
<td>M. Ridgwell / I. Chana</td>
<td>Review following meeting with ICP leads</td>
</tr>
<tr>
<td>0.8</td>
<td>24/05/19</td>
<td>Draft</td>
<td>M. Ridgwell / I. Chana</td>
<td>Following feedback from STP PB members and input from ICP Leads</td>
</tr>
</tbody>
</table>

c. Document Purpose and Scope

The purpose of this document is to define the direction and scope of the Kent and Medway system transformation programme, which focuses on the development of a Kent and Medway Integrated Care System. This document is the reference document for the management and the assessment of this programme. It outlines the objectives, benefits, scope, delivery method, structure and governance in order to deliver the required changes.
## Contents

1. **Executive summary** ........................................................................................................................................ 4
   1.1 Vision ......................................................................................................................................................... 4
   1.2 Case for change .......................................................................................................................................... 4
   1.3 Overarching model ..................................................................................................................................... 4
   1.4 High level programme plan ....................................................................................................................... 5
   1.5 Resourcing / costs ...................................................................................................................................... 7
   1.6 Initial assessment of risks ........................................................................................................................... 8

2. **Programme definition** .................................................................................................................................... 9
   2.1 System Vision ............................................................................................................................................. 9
   2.2 Case for Change ........................................................................................................................................ 10
   2.3 Kent and Medway Integrated Care System model .................................................................................... 12
   2.4 Interim Operating Model for 2019/20 ...................................................................................................... 15
   2.5 Programme objectives .............................................................................................................................. 17
   2.6 Assumptions ............................................................................................................................................. 18

3. **Programme Governance** .............................................................................................................................. 18
   3.1 High-level Programme Structure .............................................................................................................. 18
   3.2 Overarching governance arrangements ................................................................................................. 20
   3.3 Cross cutting workstreams and deliverables ............................................................................................. 23
   3.4 Role descriptions ...................................................................................................................................... 25
   3.5 Key roles ................................................................................................................................................... 26

4. **High Level Programme Plan** ......................................................................................................................... 27

5. **Overall Resource Requirements (resource plan)** .......................................................................................... 28

6. **Programme benefits and risks** ...................................................................................................................... 30
   6.1 Benefits realisation ................................................................................................................................... 30
   6.2 Programme Impact Assessment ............................................................................................................... 31

7. **Risks and Issues** ........................................................................................................................................... 31
   7.1 Management of risk ................................................................................................................................. 31
   7.2 Initial assessment of programme risks .................................................................................................... 32

8. **Communication and engagement** ................................................................................................................ 34
   8.1 Communication and Engagement principles ........................................................................................... 34
   8.2 Key audiences and stakeholders .............................................................................................................. 34
   8.3 Communication Tools ............................................................................................................................... 39

9. **Programme Acceptance Sign-off** .................................................................................................................. 41
**1 EXECUTIVE SUMMARY**

**1.1 Vision**

As set out in Kent and Medway’s clinical vision and strategy, ‘Quality of life, quality of care’, we want the population of Kent and Medway 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. We also know that a strong physical and mental health and social care system is pivotal to achieving our vision and that developing our workforce is critical. To help us do this, we want to promote Kent and Medway as a great place to live, work and learn, showcasing the benefits of joining our ambitious and forward-looking health and care system.

We want 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.

To achieve this vision and clinical strategy, we know that we will need to organise our system differently, seizing on opportunities to drive quality and reduce variation in outcomes, whilst ensuring a focus on ‘place’ and supporting a flexible approach to delivery. Our working proposal is to create a Kent and Medway integrated care system, which will include a system commissioner, four place-based integrated care partnerships and primary care networks to deliver improved quality and provision of care and patient outcomes for our population. The totality of this work is the Kent and Medway System Transformation Programme.

**1.2 Case for change**

The commissioning and provision of health and social care across Kent and Medway continues to face a number of strategic and operational challenges. In order to continue delivering services and for these services to be sustainable and responsive to the needs of the population, we need to change the way we do things. Responding to these challenges requires a whole system transformation of how we commission and deliver services. Future models need to be financially sustainable, demonstrate operational effectiveness through improved outcomes, deliver safe and high quality care and, importantly, be responsive to the health and care needs of the population of Kent & Medway.

**1.3 Overarching model**

Becoming an integrated care system (ICS) will support the delivery of joined up personalised care and improve the quality of physical and mental health and care services across Kent & Medway; and we have already made significant progress in this regard. The ICS has the following key components:

- **Primary care networks (PCNs)**, as outlined in the NHS Long Term Plan and enabled through the new GP contract, which support the delivery of primary care at scale, with expanded teams involving primary and community care, social care and voluntary sector partners. This will enable PCNs to be ‘fit for the future’ to discharge their new obligations.

- **Four place-based integrated care partnerships (ICPs)**, that are alliances of NHS providers working together to deliver care by collaborating within their local geography. They will determine and secure
Programme Initiation Document (PID)

The delivery of care through integrated working, operating across populations of around 250,000 to 700,000. The intention is to establish the following place-based ICPs will be established:

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

The system requirement for any at scale ICP will also be examined (e.g. to support more specialist mental health services).

- A single system commissioner (SC), delivered through the establishment of a single Kent and Medway CCG covering our population of circa 1.8 million. The new single CCG would not simply be a coming together of the current CCGs with the same responsibilities but would set strategic direction, establish the financial framework for the system and have an assurance function. Its focus would be on a much wider population needs basis as outlined in the table below and will contribute to and facilitate improvements in outcomes and patient experience.

This signals a significant transformation of health and social care commissioning and provision to support quality improvement, personalised care, and reduced variation. The development of strong relationships and partnerships across providers in different settings and sectors form a critical part of the success of delivering this change.

The ability to work as a whole system, both commissioning (including joint commissioning with our two local authority partners) and provision, will strategically strengthen the planning of services in response to population needs and expected outcomes, as well as the management of resources and their deployment. It is anticipated that the ability to work as a system will also offer opportunities to preside over key activities such as financial arrangements and incentives, in line with single system control totals.

1.4 High level programme plan

For the System Commissioner and Primary Care Network projects, the following high-level milestones will be kept under review (individual ICP milestones are under development and will presented in their individual plans, which will supplement this document):

<table>
<thead>
<tr>
<th>Milestone or Phase</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>All PCNs submit registration information to CCGs</td>
<td>May 2019</td>
</tr>
<tr>
<td>Outline support from CCGs to continue to proceed with the establishment of a single CCG as the vehicle for the system commissioner</td>
<td>May 2019</td>
</tr>
<tr>
<td>Establish leadership arrangements in transition for the four integrated care partnerships</td>
<td>May 2019</td>
</tr>
<tr>
<td>Integrated care partnerships outline development plans in place</td>
<td>May 2019</td>
</tr>
<tr>
<td>CCGs confirm PCN coverage and approve GMS/APMS/PMS contract variations</td>
<td>May 2019</td>
</tr>
<tr>
<td>Governing Bodies agree Statement of Intent / outline application for CCG merger - to be submitted to NHSE Region for initial review</td>
<td>July 2019</td>
</tr>
</tbody>
</table>
Primary care access extended contract DES live for 100% of country | July 2019
---|---
Development and sign off of a single primary care strategy with implementation plan, aligning with the response to the Long Term Plan | August 2019
Development and sign-off of any option for an at-scale integrated care partnership, to deliver Long Term Plan requirements for Mental Health Provider Collaboratives | August 2019
Submission of Kent and Medway response to the NHS Long Term Plan (anticipated date subject to guidance from NHS E) | August 2019
Agreement of Kent and Medway human resources, assurance and financial frameworks (to support development of system commissioner and integrated care partnerships) | September 2019
Governing bodies and GP Membership approve formal application for CCG merger – application to be submitted by no later than 30 September | September 2019
Appointment of CCG(s) permanent Accountable Officer | September / October 2019
Application to be considered by NHSE and formal notification of authorisation (with conditions) | October / November 2019
Assuming the Committee gives approval, the final detailed proposal on the proposed change submitted | January 2020
New system commissioner arrangements come into force | April 2020
National primary care network services start | April 2020

A range of early priorities (deliverables) have been identified which include:

i. Development of ICP project plans

ii. Development of principles and the framework, including the assurance framework, that will cover the development of ICPs

iii. Development of the outline ICP contract framework (recognising that initially the relationship between partners in the ICPs is likely to be based on a range of contractual agreements)

iv. Launch of an analytics strategy, which includes details of population health management and segmentation that will be delivered at all levels of the ICS

v. Identification of current commissioning functions and an outline assessment of where these will be delivered within the future system architecture

vi. A robust communications and engagement plan (covering all key stakeholders but particularly NHS boards, CCG governing bodies, GP member practices and local authorities)

vii. Development of the draft constitution

viii. Plan for allocating resources based on population needs
1.5 Resourcing / costs

The following outlines the key resourcing requirements and at this point has a greater focus on the system commissioner project. It is recognised that there will be individual requirements for the four place-based ICPs dependent on the pace and rate of maturity. Identifying these requirements is work in progress and some initial thinking has been captured in the early draft ICP plans, although Section 3 of this document provides details of key senior roles aligned to the development of ICPs. Similarly, the Primary Care Board has been working on a single primary care strategy and PCN development and, as part of this, will make a case for any additional resource required. This work is currently resourced from within the existing STP team.

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
<th>Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Chair (Bob Bowes, Clinical Chair, West Kent CCG)</td>
<td>Provides clinical leadership, direction and mentorship across the whole programme (including chairing the System Commissioner Steering Group).</td>
<td>Existing CCG 0.4 WTE</td>
</tr>
<tr>
<td>Project Lead Director (Simon Perks, System Commissioner)</td>
<td>Chairs System Commissioner Working Group. Member of System Commissioning Executive Board. Provides executive leadership and oversight of the system commissioner programme through transition and up to planned ‘go live’ in April 2020. Responsible to AO and CCG Chairs for programme delivery.</td>
<td>Existing CCG 1 WTE</td>
</tr>
<tr>
<td>Director of Corporate Services, Mike Gilbert,</td>
<td>Provides day to day programme management and direction of system commissioner work programme. Responsible to Senior Sponsor and Clinical Chair for ensuring the programme successfully delivers agreed milestones. Professional responsibility for all aspects of governance surrounding the work programme and establishment of a single CCG</td>
<td>Existing CCG 0.7 WTE</td>
</tr>
</tbody>
</table>
| System commissioner (including potential merger of the CCGs) | In recognition of the complexity and scale of the programme, additional programme management resources will also be required from CCGs:  
  - 2 x Programme Manager (Band 8a). Responsible for day to day co-ordination of the underpinning work streams, programme reporting, over-sight of programme risk management and co-ordination of core programme resourcing.  
  - Business Support Manager – 1 wte (Band 7). Day to day support to System Commissioner Programme. The BSO will provide support to ensuring the programme’s rigour, through monitoring and reporting of progress and overseeing all aspects of business support.  
  - Administrative support – 1 wte (band 4). Provides dedicated day to day support of system commissioner programme including formal and informal reporting, diary management and support to the Steering Group and Joint Committee | 2 x AfC 8a 1 x AfC 7 1 x AfC 4 |
| Overarching system transformation programme, and interim ICS | Where appropriate existing programme management resources will be aligned from the STP to support the system transformation programme across the different core projects, including Finance | From STP |
programme initiation document (pid)

<table>
<thead>
<tr>
<th>operating model</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Digital</td>
<td></td>
</tr>
<tr>
<td>- workforce / human resources</td>
<td></td>
</tr>
<tr>
<td>- communications and engagement</td>
<td></td>
</tr>
<tr>
<td>- business management support</td>
<td>Existing resource will be used more flexibly and rather than initiating new parallel workstreams the intent is to build upon and, where necessary, redirect existing STP workstreams.</td>
</tr>
</tbody>
</table>

1.6 Initial assessment of risks

The following table provides an initial view on the key risks and issues associated with the System Transformation Programme:

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of a coherent and shared strategic vision across Kent and Medway</td>
<td>Development of a robust JSNA for Kent and Medway, which identifies the key priorities and actions required to effect population improvement. JSNA to inform resource prioritisation and integration of physical and mental health care.</td>
</tr>
<tr>
<td></td>
<td>Robust communications and engagement with key stakeholders – members, governing bodies, provider boards, primary care etc. Development of narrative with consistent messages and tangible benefits</td>
</tr>
<tr>
<td></td>
<td>Demonstrable programme of clinical and leadership engagement, supported by communications and engagement, with key stakeholders and audience groups</td>
</tr>
<tr>
<td>A lack of consistency across place-based ICPs that jeopardises the delivery of objectives or sees development adversely affected in one area compared to others</td>
<td>System Transformation Executive Board to manage interdependencies and individual developments of ICPs ensuring alignment to the entirety of the System Transformation programme and a clear governance framework within the STP/ICS</td>
</tr>
<tr>
<td>Lack of support for model from NHS England and Improvement</td>
<td>Early engagement on model with NHSE/I to ensure oversight of proposed plans</td>
</tr>
<tr>
<td>Lack of support for model from CCGs</td>
<td>Clinical leadership at the heart of the engagement approach with demonstrable and targeted programme of clinical engagement supported by the delivery of effective communications and engagement activities identified in the communications plan. Ensure two-way communication channels are in place for member practices and regular updates on progress to governing bodies through formal meeting papers and ad hoc briefings as required.</td>
</tr>
<tr>
<td>Lack of support of model from CCG member practices</td>
<td>As above</td>
</tr>
<tr>
<td>Lack of funding and resources for local authorities’ impact on ability to support the emerging ICS</td>
<td>Early engagement with local authorities to help shape the direction of travel for the Kent and Medway</td>
</tr>
<tr>
<td>Lack of support from provider organisations</td>
<td>Demonstrable and targeted programme of clinical and leadership engagement supported by the delivery of effective communications and engagement activities identified in the communications plan.</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Limited resources to take forward programme including financial and workforce</td>
<td>Progress and risks to delivery to be managed by programme governance and into the STP programme board</td>
</tr>
<tr>
<td>Maintaining and improving quality and performance of services during a period of uncertainty and change</td>
<td>To be managed locally via statutory bodies</td>
</tr>
<tr>
<td>Maintaining and improving financial performance during a period of uncertainty and change</td>
<td>To be managed locally and via the STP Finance Group as per existing governance arrangements</td>
</tr>
<tr>
<td>Overall affordability given the challenged financial positions / the programme of work does not address the financial challenge faced by commissioners and providers</td>
<td>To be managed locally and via the STP Finance Group as per existing governance arrangements</td>
</tr>
<tr>
<td>Fragility of primary care impacts on delivery of the local care model and primary care network</td>
<td>Interdependency to be managed via existing governance arrangements as well as System Transformation Executive Board</td>
</tr>
<tr>
<td>Timescales for PCN establishment lead to lack of effective representation of primary care within ICPs in the design phase</td>
<td>To be managed through both the Primary Care Board and the System Transformation Executive Board</td>
</tr>
<tr>
<td>Adherence to current rules on competition and regulation challenge the implementation of the ICP model (competition, choice and regulatory approval of options may delay or possibly prevent the implementation of the preferred options)</td>
<td>To be managed and worked on through early engagement with regulators and System Transformation Executive Board</td>
</tr>
<tr>
<td>Significant changes to working assumptions has potential to derail programme delivery in terms of progress against plan, finance and reputation</td>
<td>To be managed and worked on through early engagement with regulators and System Transformation Executive Board</td>
</tr>
</tbody>
</table>

### 2 PROGRAMME DEFINITION

#### 2.1 System Vision

We want the population of Kent and Medway to be as healthy, fit (physically and mentally) and independent as possible, participating in their local economies and communities, and being able to access the right help and support. We also know that a strong physical and mental health and social care system is pivotal to achieving our vision and that developing our workforce is critical. We want Kent and Medway to be a great place to live, work and learn.

We want to create 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.
To achieve this, we have developed a clinical vision for Kent and Medway – *Quality of Life, Quality of Care* – comprising the following principles:

**Quality of Life:**
- Focusing on the whole person and what matters most to them
- Prevention as the starting point, for all people and pathways, recognising the greater scale of impact that we can have by avoiding ill health in the first place as well as preventing the development of secondary conditions
- Aspiring to protect the vulnerable and how best to access more geographically or culturally remote groups
- Caring for the person, not just the condition – applying interventions that address the interactions between mental and physical health, social and general wellbeing, and wider determinants of health (e.g., housing)
- Supporting people to maintain their physical and mental health, including promoting a healthy living environment and targeted support for people with complex or long-term conditions

**Quality of Care**
- Aspiring to ensure people can access care and support in the right place at the right time
- Striving to achieve the best outcomes and highest standards of care by adopting evidenced based practice, applying best practice guidelines and embracing research and development
- Continually assessing our performance, always learning (including from mistakes) and making changes to improve
- Embracing the use of technology and sharing information
- Equipping our workforce to provide the best quality of care, both in terms of numbers, training and support.

To achieve our vision and clinical strategy, we know that we will need to organise our system differently, seizing on opportunities to drive quality of care and reduce variation. Our working proposal is to create a Kent and Medway integrated care system, which will include a system commissioner, four place-based integrated care partnerships and developing our primary care networks (serving populations of 30,000 to 50,000). The totality of this work is the Kent and Medway System Transformation Programme.

### 2.2 Case for Change

The commissioning and provision of health and social care across Kent and Medway continues to face a number of strategic and operational challenges. In order to continue delivering services and for these services to be sustainable and responsive to the needs of the population, we need to change. Responding to these challenges requires a whole system transformation of how we commission and deliver services. Future models need to be financially sustainable, demonstrate operational effectiveness through improved outcomes, deliver safe and quality care and importantly, be responsive to the physical and mental health and care needs of the population of Kent & Medway.

Over the last four years, efforts to address the challenges outlined in the case for change have been focussed on promoting integration through new care and service models. More recently across Kent &
Medway we have seen the benefits that integrated working brings to the care for the local population through outcomes, quality standards and operational efficiencies. At this stage of the transformation, it is widely recognised that changes to how the system is structured, the redistribution of functions both locally and at a Kent & Medway level, through to more comprehensive integrated working will deliver benefits and improvements.

The publication of the national NHS Long Term Plan in January 2019 has further strengthened the need for integration and integrated care models with the expectation that current STP areas transition to Integrated Care Systems by April 2021. The development work to date across Kent and Medway meets this objective, putting us firmly on the path to establishing the system commissioning function. It also helps with the development of place-based Integrated Care Partnerships (ICPs), further aligning the local commissioning and provision of physical and mental health and social care based on local needs and in a way that is accessible and responsive. In addition to the ICPs, there will be other developments to support a more focused response to individuals needs such as the development of Primary Care Networks in increasingly aligning local health, social, community and primary care.

Our published case for change also shows that:

- **Every day 1,000 people (about 1 in 3 people in hospital at any one time) in Kent and Medway are stuck in hospital beds** when they could get the health and social care support they need out of hospital if the right services were available.

- **We need to focus more on supporting people so they don’t get ill in the first place**: Around 1,600 early deaths each year could have been avoided with the right early help and support for example to help people maintain a healthy weight, stop smoking and drink responsibly.

- **GPs and their teams are understaffed, with vacancies and difficulties recruiting**: If staffing in Kent and Medway was in line with the national average there would be 245 more GPs and 37 more practice nurses.

- **The Care Sector in Kent and Medway has a recruitment and retention problem** which means that the Local Care intention of supporting people at home might not be possible for everyone.

- **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 to help people manage conditions they live with every day and to prevent them getting worse.

- **Some services for seriously ill people in Kent and Medway find it hard to run round-the-clock, and to 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 achieve this for all patients.

- **Planned care – such as going into hospital for a hip operation or having an x-ray – is not as efficient as it could be**: There is variation across Kent and Medway in how often people are referred to specialists and variation in the tests and treatments people get once they have been referred.

- **Cancer care does not always meet national standards**: waiting times for diagnostic tests, to see a specialist and for treatment, are sometimes longer than national standards.

- **People with mental ill health have poor outcomes**: the average life expectancy for people with severe mental illness is 15–20 years less than the average for other adults, due to being less likely to having physical health needs met.
We are not able to live within our means: it is estimated that by the end of this financial year (2018/19) the NHS in Kent and Medway will have overspent its planned budgets by £75m, excluding the benefit of non-recurrent support from the commissioner support fund and provider support fund, which reduces this overspend to circa £46m.

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.

To address these challenges, we need to fundamentally look at how we commission and deliver care. We have started to do this through several approaches, including the Kent and Medway stroke review and East Kent Transformation Programme. However, we now need to look at some of the core principles that govern how care is delivered and support the integration of service provision to deliver a better patient experience, improved outcomes and equity of outcomes for different population groups) and make best use of our scarce resources (not just in relation to the funding available to us but also in relation to making the best use of our staff, estates and other key enablers of high quality care).

2.3 Kent and Medway Integrated Care System model

This section details the overall ambition for the Kent and Medway Integrated Care System model that we are working to deliver. It does not cover the interim operating model which is detailed in Section 2.4

This ambition and future model often referred to as an ‘end state’ has a number of key components:

- **Primary care networks**, serving populations of 30,000 to 50,000, as outlined in the NHS Long Term Plan and enabled through the new GP contract, which support delivery of primary care at scale

- **Four place-based integrated care partnerships**, that determine and secure the delivery of care through integrated working, operating across populations of around 250,000 to 700,000 (individual ICP milestones are under development and will be presented in their individual plans, which will supplement this document):
  - East Kent Integrated Care Partnership
  - Dartford, Gravesham and Swanley Integrated Care Partnership
  - Medway and Swale Integrated Care Partnership
  - West Kent Integrated Care Partnership

- **A single system commissioner**, delivered through the establishment of a single Kent and Medway CCG covering our population of circa 1.8 million (i.e. the number of people registered with our GP practices). The new single CCG would not simply be a coming together of the current CCGs with the same responsibilities. Its focus would be on a much wider population needs basis as outlined in the table below.

The following diagram outlines the future Kent & Medway Integrated Care System architecture:
More information on these key building blocks is detailed below:

| Primary Care Networks | Primary Care Networks have been an emerging concept over the last few years as part of the development of primary care, and more broadly local care provision at scale. The Long Term plan formalised the development of Primary Care Networks as a key function and way of further enhancing the integration of primary and community care, which we describe as local care. Primary Care Networks across Kent & Medway will act as the local vehicles for integration of health and social care services, crossing organisational boundaries in the public, private and voluntary sectors based on local population and individual needs. They will support the delivery of multidisciplinary services to meet the needs of the population as defined across the whole of Kent and Medway.

The outline above, pending further development, discussion and agreement, signals a change to the way in which health and potentially social care services have been commissioned to date. Future commissioning and delivery will take advantage of models that:

- Focus on and are responsive to the needs of the population of Kent & Medway
- Seek to be sustainable in their delivery considering key factors such as workforce, standards of care, co-ordination of health and social care needs and financial affordability
- Are forward looking and innovative and make improvement to the operational challenges facing current provision
- Champion integration and focus on the patient experience and improved outcomes across health, social care and general wellbeing. |

| Integrated Care Partnerships | Integrated Care Partnerships represent a provider led collaborative, operating most effectively |
| Care Partnerships | across a population of 250,000 to 700,000. The logic behind this is the achievement of sufficient scale to collectively look at how services are provided and the benefits, in particular around collective working to offer existing and new models of care that are more effective in responding to people’s needs. This use of new and alternative models including ways of working can also support the achievement of improved outcomes, greater efficiency in terms of the use and deployment of resources (e.g. workforce, estate, adoption of new technology) and potentially greater cost effectiveness and output that aligns to a single system control total. The working proposal for Kent & Medway based on population size, is for four place-based ICPs. These will be in East Kent, Dartford Gravesham and Swanley, Medway & Swale and West Kent. Key functions of the place-based Integrated Care Partnerships include:  
  • Accountability for the physical and mental health of their whole population including development and delivery of care and well-being solutions to ensure this  
  • Focus on responding to population health needs and the provision of programmes that promote prevention and address health inequalities and inequality in health outcomes  
  • Ensure a focus on population health; more than the sum of individual care pathways  
  • Assure and oversee the quality of services and care provided. This assurance role will need further scoping in line with changes in NHS England and Improvement  
  • Support organisational development to enable cultural change and thus deliver integrated working at executive, managerial and practitioner level  
  • Local route for escalation and risk management within the system  
  • Local contract management and the increased use of alternative contract forms to support integrated delivery  
  • Taking account of and addressing the needs of their population, particularly in order to address the wider determinants of health, improve prevention and reduce health inequalities  
  • Designing pathways that both deliver the required outcomes and can be delivered within the particular ICP’s circumstances. This design will be clinically and professionally led within the ICP and be able to demonstrate compliance with best practice and wide clinical, public and political engagement.  
  • Delivering care within the ICP’s capitated budget  
  • Having aligned incentive contracts and sub-contracts which foster collaboration within and outside the ICP.  
  • Monitoring and achieving quality standards with robust measures to address failings  
  • Monitoring the care delivered and reporting on performance (including patient experience) compared to design. |  |
|---|---|
| The Kent and Medway System Commissioner | A single Clinical Commissioning Group (CCG) will be responsible for delivering a number of functions. As a system commissioner, it will be responsible for:  
  • Defining the needs of the population of Kent and Medway down to a population level of 30-50k  
  • Setting the outcomes to be delivered in addressing those needs, including emphasising prevention and addressing health inequalities and inequality in health outcomes  
  • Allocating capitated budgets within new financial frameworks that encourage Integrated Care Partnerships to focus on population health  
  • Providing oversight and offering strategic solutions to K&M wide functions such as Strategic Estates, Digital, Workforce, and Finance.  
  • Supporting and delivering the organisational development of providers to become members of Integrated Care Partnerships. |
The above components come together, with other elements, to form the Kent and Medway ICS. However, the ICS also operates within a wider context (e.g. the regulatory framework). An early priority will be development of the framework and principles within which the ICS, system commissioner and ICPs will develop. This work will be developed in partnership with stakeholders such as Local Authorities, not only including social care and public health, but also District Councils and voluntary sector to ensure person centred planning that supports the delivery of care and wellbeing solutions.

2.4 Interim Operating Model for 2019/20

As a working assumption during the 2019/20 transition period there will be a clear distinction between the role of the STP / ICS and the CCGs (or the CCG if the merger to create a single organisation is supported). These will be described in an interim operating model.

There are two key components to the interim operating model that will operate during 19/20:

a. A CCG joint committee to which CCGs, if supported by their governing bodies, can delegate a range commissioning functions and responsibilities

b. An interim STP / ICS operating model based on a range of delegated functions (this will see the STP / ICS focus on developing the system functions that will be required for an Integrated Care System, including those areas that have been directed for development by NHS England and Improvement).

A Kent and Medway Joint Committee has been established that will provide a vehicle during transition for the commissioning of a range of key services. This has been established by the CCGs with the intent of commissioning responsibilities being delegated to this in order to:

- Ensure consistency of approach across Kent and Medway
- Address a range of performance and quality challenges (recognising that some services are more optimally commissioned at a Kent and Medway level)
- To model Kent and Medway level working as a precursor to the formal establishment of the Kent and Medway System Commissioner
An interim STP / ICS operating model that will utilise the current programme governance structure to develop system functions. The scope of this programme will be driven by those areas identified by NHS England and Improvement for requiring a system approach. It is important to note the interim operating arrangement does not supersede or undermine the role and accountability of individual organisations. Rather it reflects the need to collectively:

- **Identify system priorities, including to:**
  - provide a forum for partners to identify and address the critical strategic issues that will shape the planning and delivery of better health and care in the region
  - provide collective leadership and strategic oversight of areas of work that require a system approach

- **Delivery of system priorities, including to:**
  - target management, including clinical management, resources on the high priority (high risk) areas within the system.
  - oversee the implementation of the annual operating plans and mandated policy, interpreting the requirements to fit with the local challenges and circumstances of the system, ensuring that strategies, plans and work programmes are aligned to its delivery
  - ensure that the system makes best use of all appropriate tactics and levers available to support the delivery of national and local priorities for better health and health care. Best of use of resources also?
  - Ensuring consistent and clear messaging with our internal and external stakeholders, including ensuring collective management and protection of our reputation

- **Assurance and performance management, including to:**
  - monitor performance and delivery
  - hold each other to account for delivery of strategies, policies and agreed targets

- Support service improvement, including capturing and disseminating best practice from within the system, nationally and internationally, challenging the whole system to improve aspirations, performance, capability and delivery

The interim operating model will need to recognise that the Integrated Care System will hold a number of assurance and oversight functions, alongside strategic planning functions, and these will be developed further as part of the programme of work outlined in this document, in a framework that covers:

- Annual planning
- Assurance and delivery
- Resilience (following the establishing of a system “winter function” in 18/19)
- Quality
- Strategic planning and programme delivery

Transitional arrangements will be kept under ongoing review and will be dynamic. This will include working with NHS England and Improvement to plan the delegation of a range of functions to the ICS.
2.5 Programme objectives

The System Transformation Programme aims to:

a. deliver improved quality and provision of care and patient outcomes for our population

b. improve the use of available resources (both financial and staffing)

In order to realise the above aims, the primary objective of the programme is to establish a Kent and Medway Integrated Care System, which will be achieved through the successful delivery of a number of core projects (the secondary objectives), namely:

1. Establishment of local primary care networks covering a registered patient population of 30,000 to 50,000.

2. Establishment of four place based Integrated Care Partnerships, similarly responsible for developing and implementing formal partnership arrangements that enable each to hold an appropriate contract and deliver integrated care services for their local population. The four ICPs will mature at different rates and as a result they will exercise different functions based on their levels of maturity.

3. Establishment of an interim operating model (transitional arrangements during 19/20) including:
   a. CCG joint committee to which CCGs, if supported by their governing bodies, can delegate a range commissioning functions and responsibilities
   b. An interim range of delegated functions to the Kent and Medway STP / ICS

4. Establishment of the Kent and Medway system commissioner (through the statutory vehicle of a single CCG achieved through the merger of eight CCGs to a single CCG, ideally by April 2020.

The constituent project groups and workstreams will develop or have assigned specific objectives (the deliverable for workstreams are outlined in this document at Section 3.3). A number of additional key enabling objectives for the programme, which support the overarching aims, have been identified:

5. Organisation (system) development plan to support the development of system leadership within PCNs, ICPs and the system commissioner, which recognises:
   • a move from competition to collaboration
   • the integration of health and social care
   • the integration of physical and mental health
   • the integration of commissioning and provision
   • the cultural changes that are needed to support the above
   • the importance of having the right people in the right roles

6. A revised financial framework that outlines how funding will flow through the whole system (supporting a move away from historic contracting arrangements that have been support by Payment by Results)

7. Development of a Kent and Medway approach to population health management

8. Robust communications and engagement plans and activities to support and facilitate understanding amongst key audiences and stakeholders.
It is recognised that these Kent and Medway system-wide objectives will exist alongside local objectives and priorities, which will be further developed by the emerging PCNs and ICPs.

### 2.6 Assumptions

It will be necessary to identify and adopt a range of assumptions to facilitate this significant programme of work to be taken forward. The range of assumptions that will be adopted will increase and change as the programme of work progresses. It is important that these are accurately recorded and continually tested to ensure they remain valid and are robust (i.e. are valid constructs that enable the programme to continue to be progressed). The following assumptions will also be reported as part of the overall risk management approach to delivery of the entirety of the System Transformation Programme.

The following provide an initial assessment of assumptions:

<table>
<thead>
<tr>
<th>Assumption</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support from CCGs and membership</td>
<td>Assumes there will be support for the proposed system model as outlined in this document</td>
</tr>
<tr>
<td>Support from Provider Organisations</td>
<td>Assumes there will be support for the proposed system model as outlined in this document</td>
</tr>
<tr>
<td>Support from NHS E / I</td>
<td>Assumes NHS England will support the development of a single CCG through their mandated process</td>
</tr>
<tr>
<td>Implementation timing</td>
<td>Assumes a single CCG will be implemented by April 2020.</td>
</tr>
<tr>
<td></td>
<td>Assumes ICPs will start to evolve during 2019/20 but will take longer to develop and mature. Assumption is that all ICPs will be fully in place and holding contracts by 2021</td>
</tr>
<tr>
<td>Collaborative versus organisational focus</td>
<td>Assuming providers will support development of ICPs and that organisations will support place based working rather than a focus on their individual organisations, sharing clinical and business risk</td>
</tr>
<tr>
<td>Supporting from local authorities</td>
<td>Assuming LAs will support, including in relation to a Medway and Swale ICP</td>
</tr>
<tr>
<td>Delegation of function from NHS England</td>
<td>Assuming NHS E / I functions around local assurance and EPRR will be delegated to ICSs</td>
</tr>
<tr>
<td>The STP / ICS working alongside the CCC(s)</td>
<td>As a working assumption during transition there will be a clear distinction between the role of the STP / ICS and the CCGs (or the CCG if the merger to create a single organisation is supported), which ascribes functions as follows:</td>
</tr>
<tr>
<td>during transition but acknowledge these</td>
<td>• CCCs (potentially in due course) - CCG functions other than those listed below</td>
</tr>
<tr>
<td>functions are likely to come together as the</td>
<td>• STP / ICS - Functions delegated or directed by NHS England (e.g. assurance, resilience planning)</td>
</tr>
<tr>
<td>ICS arrangements mature</td>
<td>• STP / ICS - Over-arching strategic and programme planning</td>
</tr>
</tbody>
</table>

### 3 PROGRAMME GOVERNANCE

#### 3.1 High-level Programme Structure
Programme Initiation Document (PID)

This programme consists of a number of core constituent projects, aligned to our system integration model and supported by a range of cross cutting work streams. This programme initiation document outlines these and their key deliverables and milestones. Within this programme we are utilising the following definitions:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme</td>
<td>A group of related projects and change management activities that together achieve beneficial change for an organisation.</td>
</tr>
<tr>
<td>Project</td>
<td>A unique, transient endeavour, undertaken to achieve planned objectives, which could be defined in terms of outputs, outcomes or benefits. A project is usually deemed to be a success if it achieves the objectives according to their acceptance criteria, within an agreed timescale and budget</td>
</tr>
<tr>
<td>Workstream</td>
<td>Thematic portfolio of programmes or projects and processes that are strategically selected and managed to advance business goals</td>
</tr>
</tbody>
</table>

The core constituent projects and cross-cutting workstreams, that sit within the programme, are outlined in the diagram below:

The core constituent projects, as detailed above, will each require their own project plans, which will be developed alongside this document. These will be agreed, managed and coordinated through the programme governance structure detailed later in this document.
### 3.2 Overarching governance arrangements

The governance framework for the System Transformation Programme is outlined in the diagram below. The governance frameworks for the individual system commissioner and the four Integrated Care Partnership projects will be developed in more detail in their individual project plans but will exist and operate within the governance framework detailed below. The development of PCNs is led by the Primary Care Board and will report into the System Transformation Executive Board with progress against plan.

**ICS Transitional Programme Governance (1/4/19 to 31/3/20)**

![Diagram of governance structure]

Note: some STP work streams will need to be potentially realign, either on content, timelines or formal reporting with the system commissioner work.

The following table outlines the role of each of the groups in the above diagram:

<table>
<thead>
<tr>
<th>Group</th>
<th>Role</th>
<th>Frequency</th>
<th>Chair</th>
<th>Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>STP Programme Board (The renaming of this group to the ICS Partnership Board will be considered as part of the programme)</td>
<td>Provides oversight of wider ICS development and the development and implementation of countywide programmes of work to deliver immediate and medium-term priorities. Programmes include productivity, local care, workforce, primary care and digital.</td>
<td>Monthly</td>
<td>STP Chief Executive</td>
<td>Representation from all STP core partner organisations (see Section 12.3 for list)</td>
</tr>
<tr>
<td>Non-Executive Director (NED)</td>
<td>Provides independent scrutiny and oversight of the STP Partnership Board</td>
<td>Monthly</td>
<td>STP Chair</td>
<td>STP Chair, 2 x Provider NEDs,</td>
</tr>
</tbody>
</table>
### Programme Initiation Document (PID)

<table>
<thead>
<tr>
<th>Oversight Group</th>
<th>and its programmes of work, including development of the Integrated Care System.</th>
<th>2 x CCG independent members, 2 x Upper Tier LA elected Members</th>
</tr>
</thead>
</table>
| **CCG Joint Committee(s)** | - Delegated Authority from CCG governing bodies for a range of commissioning responsibilities (e.g. Stroke, Cancer and in due course: Children’s services, Mental Health etc...)  
- Responsible for determining joint commissioning agenda and priorities | Monthly | Stroke: Independent Chair  
K&M Joint Committee - CCG Clinical Chair  
East Kent: Independent Chair | Representatives from each CCG Governing Body (incl AO, MDs, Clinical Chairs and independent lay members) |
| **System Transformation Executive Board** | - Responsible for the monitoring delivery of overall programme objectives  
- Principles and Coordinates and supports the ICS development (spanning both the ICP and system commissioner development)  
- Ensures consistency of approach whilst also supporting local flexibility and autonomy  
- Provides senior executive leadership  
- Framework for ICP development  
- Development of an assurance and regulatory framework | Monthly | STP CEO / AO  
STP CEO / CCG single accountable officer - Chair,  
STP Deputy CEO  
Senior sponsor, Chair of SCOG, senior sponsors for four ICP Steering Groups,  
CEO, KMPT  
Kent County Council lead director  
Medway County Council lead director  
Co-chair of Primary Care Board |
| **System Commissioner Steering Group** | Responsible for delivery of project objectives that include but not limited to:  
- Commissioning transformation and development of the System Commissioner  
- Merger of eight CCGs to form the single, Kent and Medway CCG | Monthly | Bob Bowes, Clinical Chair, WK CCG  
K&M Accountable Officer, CCG Clinical Chairs, Managing Director EK & MNWK, STP Deputy Chief Executive, Workstream team, Lay members for EK and MNWK and Lead Directors Kent County Council & Medway Council |
| **System Commissioner Governance Oversight Group** | To provide providing scrutiny, advice and guidance to the System Commissioner Steering Group | Monthly | Mike Gilbert, Director of Corporate Affairs  
CCG Lay member (Governance Leads) and CCG Company Secretary |
<p>| <strong>ICP Steering</strong> | - Responsible for delivery of the ICPs | As per | WK: Mile Scott, To be identified |</p>
<table>
<thead>
<tr>
<th>Groups x 4 (place-based)</th>
<th>and delivery of agreed system and local objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• PCN development (working with the Primary Care Board)</td>
</tr>
<tr>
<td></td>
<td>• Identification of priorities</td>
</tr>
<tr>
<td></td>
<td>• Designing pathways that deliver required outcomes and can be delivered particular ICP circumstances (e.g. constraints on workforce, estates, etc...), clinically led in the ICP and demonstrate compliance with best practice and engagement with, clinicians, the public and politicians</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>local agreement</th>
<th>CEO MTW</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EK: Paul Bentley, CEO KCHFT</td>
</tr>
<tr>
<td></td>
<td>North Kent: Louise Ashley, CEO, DGT</td>
</tr>
<tr>
<td></td>
<td>Medway and Swale: James Devine, CEO, MFT</td>
</tr>
</tbody>
</table>

| through individual ICP project plans (and recommended to include LMC representation to facilitate representation of general practice) |

<table>
<thead>
<tr>
<th>K&amp;M Clinical and Professional Board</th>
<th>• Advises the STP Programme Board and CCG’s Joint Committee on all clinically and professionally related matters</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Provides collective clinical and professional leadership to the Kent and Medway system</td>
</tr>
<tr>
<td></td>
<td>• Leads the development of the clinical and professional content of Kent and Medway level strategies</td>
</tr>
<tr>
<td></td>
<td>• Oversee the work of the clinical and innovation workstreams</td>
</tr>
</tbody>
</table>

| Monthly | CCG Clinical Chair / Provider Medical Director |

| Representation from all STP core partner organisations (see Section 8) |

<table>
<thead>
<tr>
<th>Primary Care Board (PCN Development)</th>
<th>• Provides strategic leadership to the Primary Care workstream</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Ensures that the programme delivers its milestones and outcomes on time and to budget (based on agreed plan TBD)</td>
</tr>
<tr>
<td></td>
<td>• Ensures that risks to implementation are identified and effectively managed</td>
</tr>
<tr>
<td></td>
<td>• Ensures that the programme engages effectively with all necessary stakeholder groups in the development of proposals, including championing the programme across Kent and Medway</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monthly</th>
<th>Joint Chairs: one CCG Clinical Chair and one LMC Member</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CCG, LMC, GP Federations, PCCCs, mental health, PPAG, NHSE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>System Commissioner / Future Functions Working Group and work streams</th>
<th>Reports to System Commissioner Steering Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Responsible for developing and overseeing implementation of future system commissioner functions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monthly</th>
<th>System commissioner lead director</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CCG Senior Managers and Subject Matter Experts</td>
</tr>
<tr>
<td></td>
<td>SC Programme Director to chair</td>
</tr>
</tbody>
</table>
3.3 Cross cutting workstreams and deliverables

Based on the constituent projects, objectives and key deliverables outlined within this document, a number of cross-cutting workstreams are proposed. The following table outlines the proposed key workstreams. Membership will be determined by the Senior Sponsor for the constituent project in consultation with the System Commissioner, Executive, ICP Steering Groups and Primary Care Board.

<table>
<thead>
<tr>
<th>Cross cutting workstream</th>
<th>ICS / SC / ICP / PCN</th>
<th>Lead</th>
<th>Deliverables</th>
</tr>
</thead>
</table>
| Human Resources & OD           | ICS / SC / ICP / PCN | Becca Bradd, STP Workforce Programme Director                        | • Develop an HR Framework for bringing together commissioners and, in due course, any changes to providers around the development of ICPs  
• Develop a programme that guides leadership development of ICPs and PCNs with a focus on population health (at all management and clinical levels)  
• Develop the OD programme for the ICS (all components) that promotes learning organisations / collaborations and recognises the evolutionary nature of system transformation  
• Design of the human resources function across the system  
• Design of the workforce planning function across the system |
| Commissioning                  | SC                   | Adam Wickings, Chief Operating Officer, West Kent / Lorraine Goodsell, Deputy Managing Director, East | • Description of commissioning functions in each part of the new system model*  
• Identify areas of commissioning that need to be undertaken jointly between health and local authorities (public health and social care) |
<table>
<thead>
<tr>
<th>Programme Initiation Document (PID)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Finance (via the existing K&amp;M Finance Group)</strong></td>
</tr>
<tr>
<td><strong>SC</strong></td>
</tr>
<tr>
<td><strong>Reg Middleton, WK Director of Finance</strong></td>
</tr>
<tr>
<td><strong>Description of commissioning functions in each part of the new system model</strong></td>
</tr>
<tr>
<td><strong>Development of capitated (or other) budgetary framework</strong></td>
</tr>
<tr>
<td><strong>Framework that incentivises collaboration and is outcome focused with a shift to improving population health outcomes and improving inequalities (including to support benefits realisation)</strong></td>
</tr>
<tr>
<td><strong>Business Intelligence / Population segmentation / population health management / Health needs assessment</strong></td>
</tr>
<tr>
<td><strong>ICS / SC / ICP / PCN</strong></td>
</tr>
<tr>
<td><strong>Ivor Duffy, EK Director of Finance</strong></td>
</tr>
<tr>
<td>• Launch the analytics strategy and put in place resourcing and governance to ensure delivery</td>
</tr>
<tr>
<td>• Describe and make available population down to PCN level</td>
</tr>
<tr>
<td>• Define relationship and put on a more formal basis relationship between SC and HWBBs</td>
</tr>
<tr>
<td>• Define outcomes based on identified priorities, including emphasising prevention and health inequalities</td>
</tr>
<tr>
<td>• outcomes framework (including to support benefits realisation)</td>
</tr>
<tr>
<td><strong>Digital</strong></td>
</tr>
<tr>
<td><strong>ICS / SC / ICP / PCN</strong></td>
</tr>
<tr>
<td><strong>Andrew Brownless, Chief Information Officer</strong></td>
</tr>
<tr>
<td>• Network model</td>
</tr>
<tr>
<td>• Identify core systems / Integration / standardisation of core systems</td>
</tr>
<tr>
<td>• At individual practitioner level provide tools to risk stratify and cohort patients</td>
</tr>
<tr>
<td>• Link with Local Authorities digital strategies to create an integrated approach</td>
</tr>
<tr>
<td>• Digital innovation approach through Innovation Collaborative</td>
</tr>
<tr>
<td><strong>Communications and engagement</strong></td>
</tr>
<tr>
<td><strong>ICS / SC / ICP / PCN</strong></td>
</tr>
<tr>
<td><strong>Julia Rogers, K&amp;M Director of Communications and Engagement</strong></td>
</tr>
<tr>
<td>• Reactive responses against plan to media enquiries</td>
</tr>
<tr>
<td>• Staff and stakeholder briefings</td>
</tr>
<tr>
<td>• Design and implement effective strategic and operational communications and engagement function across the system (including co-production)</td>
</tr>
<tr>
<td>• Working with the existing Patient and Public Advisory</td>
</tr>
</tbody>
</table>
Group to co-design the new model of patient engagement across all levels of the future system architecture.

- Development of outcome-based contracts, including performance management and escalation framework
- ICP MOU / contractual framework that focuses on wider determinants of health, prevention and outcomes framework, including framework for approval of sub-contacting that foster collaboration within and without of the ICP

- Describe corporate risk identification and escalation process
- Indemnity framework, recognising the collaborative framework in which ICPs and PCNs will operate

- Best practice framework – process that drives optimum and innovative outcomes
- Quality framework, including metrics and governance structure for oversight and route for clinical risk identification and risk escalation

- Planning (including major service reconfigurations)
- Resilience
- Performance / assurance (including in relations to effectiveness of outcomes-based commissioning, and oversight of the best value test)
- Assurance and license of system commissioner, ICPs and other constituent bodies
- Service / System Improvement
- Direct commissioned services and identify list of service that should be commissioned at a Kent and Medway level

### 3.4 Role descriptions

The following table provides a description of key roles within the programme:

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior sponsor</td>
<td>Executive level lead (normally a chief executive or clinical chair) who acts as the sponsor for a core project (noting the programme also has an overall senior sponsor) The sponsor is accountable for ensuring that the work is governed effectively and delivers the objectives that meet identified need. They are also responsible for championing the programme at a senior level to secure commitment and buy-in.</td>
</tr>
<tr>
<td>Project Lead</td>
<td>Responsible for the day-to-day delivery of their core constituent project or work area they are responsible for.</td>
</tr>
</tbody>
</table>
Programme Initiation Document (PID)

<table>
<thead>
<tr>
<th>Role</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director</td>
<td>supporting, including achievement of key deliverables within the specified timeline</td>
</tr>
<tr>
<td>ICP GP Lead</td>
<td>A GP practicing in the ICP area who represents GPs and providers within discussions and acts as an interface with the emerging PCNs to ensure the system transformation programme is driven by and reflects general practice, the emerging PCNs and wider clinical considerations.</td>
</tr>
<tr>
<td>ICP non-executive lead</td>
<td>A non-executive director from one of the provider organisations that is a partner within the emerging ICP, responsible for representing non-executive board member, including liaising with their peers, and holding the programme to account for delivery of its strategic aims, ensuring value for money and that risks are being appropriately managed.</td>
</tr>
<tr>
<td>Workstream Lead</td>
<td>Thematic lead for a portfolio of projects and / or deliverables linked to one or more of the core constituent projects. The workstream lead is responsible for the day-to-day management of their workplan, including the coordination of projects and change management activities. They are responsible for identifying the resource needed to deliver identified benefits.</td>
</tr>
</tbody>
</table>

3.5 Key roles

The following table details the individuals who will be fulfilling the key roles for the constituent core projects:

<table>
<thead>
<tr>
<th>Role</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall senior sponsor for System Transformation Programme</td>
<td>• Glenn Douglas, STP Chief Executive / CCG Accountable Officer</td>
</tr>
</tbody>
</table>
| System Commissioner (including interim CCG operating model) | • Senior sponsor: Dr Bob Bowes, Clinical Chair, WK CCG  
• Project Lead Director: Simon Perks, Director of System Transformation |
| West Kent ICP                          | • Senior sponsor: Miles Scott, Chief Executive, Maidstone and Tunbridge Wells NHS Trust  
• ICP GP lead: Dr Sanjay Singh  
• ICP non-executive lead: John Goulston, Chairman, Kent Community Health NHS Foundation Trust  
• Project lead director: Amanjit Jhund, Director of Strategy, Planning and Partnerships, Maidstone and Tunbridge Wells NHS Trust |
| East Kent ICP                         | • Senior sponsor: Paul Bentley, Chief Executive, Kent Community Health NHS Foundation Trust  
• ICP GP lead: Dr Sadia Rashid  
• ICP non-executive lead: Stephen Smith, Chairman, East Kent Hospitals University NHS Trust  
• Project lead director: Tbc |
| North Kent ICP                        | • Senior sponsor: Louise Ashley, Chief Executive, Dartford, Gravesham and Swanley NHS Foundation Trust  
• ICP GP lead: Tbc  
• ICP non-executive lead: Tbc  
• Project lead director: Sue Braysher, Director of System Transformation, Dartford, Gravesham and Swanley NHS Foundation Trust / Dartford, Gravesham and Swanley CCG |
| Medway and Swale ICP                  | • Senior sponsor: James Devine, Chief Executive, Medway Foundation NHS Trust / Martin Riley, Chief Executive, Medway Community Healthcare |
• ICP GP lead: Tbc
• ICP non-executive lead: Tbc
• Project lead director: James Lowell, Director of Planning and Partnerships, Medway Foundation NHS Trust

Interim ICS operating model
• Senior sponsor: Michael Ridgwell, Deputy STP Chief Executive
• Project lead director: Ravi Baghirathan

4 HIGH LEVEL PROGRAMME PLAN

For the System Commissioner and Primary Care Network projects, the following high-level milestones will be kept under review (individual ICP milestones are under development and will presented in their individual plans, which will supplement this document):

<table>
<thead>
<tr>
<th>Milestone or Phase</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>All PCNs submit registration information to CCGs</td>
<td>May 2019</td>
</tr>
<tr>
<td>Outline support from CCGs to continue to proceed with the establishment of a single CCG as the vehicle for the system commissioner</td>
<td>May 2019</td>
</tr>
<tr>
<td>Establish leadership arrangements in transition for the four integrated care partnerships</td>
<td>May 2019</td>
</tr>
<tr>
<td>Integrated care partnerships outline development plans in place</td>
<td>May 2019</td>
</tr>
<tr>
<td>CCGs confirm PCN coverage and approve GMS/APMS/PMS contract variations</td>
<td>May 2019</td>
</tr>
<tr>
<td>Governing Bodies agree Statement of Intent / outline application for CCG merger - to be submitted to NHSE Region for initial review</td>
<td>July 2019</td>
</tr>
<tr>
<td>Primary care access extended contract DES live for 100% of country</td>
<td>July 2019</td>
</tr>
<tr>
<td>Development and sign off of a single primary care strategy with implementation plan, aligning with the response to the Long Term Plan</td>
<td>August 2019</td>
</tr>
<tr>
<td>Development and sign-off of any option for an at-scale integrated care partnership, to deliver at Long Term Plan requirements for Mental Health Provider Collaboratives</td>
<td>August 2019</td>
</tr>
<tr>
<td>Submission of Kent and Medway response to the NHS Long Term Plan (anticipated date subject to guidance from NHS E)</td>
<td>August 2019</td>
</tr>
<tr>
<td>Agreement of Kent and Medway human resources, assurance and financial frameworks (to support development of system commissioner and integrated care partnerships)</td>
<td>September 2019</td>
</tr>
<tr>
<td>Governing bodies and GP Membership approve formal application for CCG merger – application to be submitted by no later than 30 September</td>
<td>September 2019</td>
</tr>
<tr>
<td>Appointment of CCG(s) permanent Accountable Officer</td>
<td>September / October 2019</td>
</tr>
<tr>
<td>Application to be considered by NHSE and formal notification of authorisation (with conditions)</td>
<td>October / November 2019</td>
</tr>
<tr>
<td>Assuming the Committee gives approval, the final detailed proposal on the proposed</td>
<td>January 2020</td>
</tr>
</tbody>
</table>
However, a range of early priorities (deliverables) have been identified which include:

i. Development of ICP project plans

ii. Development of principles and the framework, including the assurance framework, that will cover the development of ICPs

iii. Development of the outline ICP contract framework (recognising that initially the relationship between partners in the ICPs is likely to be based on a range of contractual agreements between the ICPs and the system commissioner encompassing the services delivered by each ICP. This contract should include: activity; performance trajectories; quality measures; and financial values)

iv. Launch of an analytics strategy, which includes details of population health management and segmentation that will be delivered at all levels of the ICS

v. Identification of current commissioning functions and an outline assessment of where these will be delivered within the future system architecture

vi. A robust communications and engagement plan (covering all key stakeholders but particularly NHS boards, CCG governing bodies, GP member practices and local authorities)

vii. Development of the draft constitution

viii. Plan for allocating resources based on population needs

ix. Continuing involvement with the Patient and Public Advisory Group to ensure patient voice is at heart of plans and embedded within new system

5 OVERALL RESOURCE REQUIREMENTS (RESOURCE PLAN)

The following outlines the key resourcing requirements and at this point has a greater focus on the system commissioner project. It is recognised that there will be individual requirements for the four ICPs dependent on the pace and rate of maturity. Identifying these requirements is work in progress although Section 3 of this document provides details of key senior roles aligned to the development of ICPs.

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
<th>Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Chair (Bob Bowes, Clinical Chair, West Kent CCG)</td>
<td>Provides clinical leadership, direction and mentorship across the whole programme (including chairing the System Commissioner Steering Group).</td>
<td>Existing CCG 0.4 wte</td>
</tr>
</tbody>
</table>
## Programme Initiation Document (PID)

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
<th>Responsible to</th>
<th>Existing CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Project Lead Director (Simon Perks, System Commissioner)</strong></td>
<td>Chairs System Commissioner Working Group. Member of System Commissioning Executive Board. Provides executive leadership and oversight of the system commissioner programme through transition and up to planned ‘go live’ in April 2020. Responsible to AO and CCG Chairs for programme delivery.</td>
<td></td>
<td>Existing CCG 1 wte</td>
</tr>
<tr>
<td><strong>Mike Gilbert, Director of Corporate Services</strong></td>
<td>Provides day to day programme management and direction of system commissioner work programme. Responsible to Senior Sponsor and Clinical Chair for ensuring the programme successfully delivers agreed milestones. Professional responsibility for all aspects of governance surrounding the work programme and establishment of a single CCG</td>
<td></td>
<td>Existing CCG 0.7 wte</td>
</tr>
</tbody>
</table>
| **System commissioner (including potential merger of the CCGs)**   | In recognition of the complexity and scale of the programme, additional programme management resources will also be required from CCGs:  
  - 2 x Programme Manager (Band 8a). Responsible for day to day co-ordination of the underpinning work streams, programme reporting, oversight of programme risk management and co-ordination of core programme resourcing.  
  - Business Support Manager – 1 wte (Band 7). Day to day support to System Commissioner Programme. The BSO will provide support to ensuring the programme’s rigour, through monitoring and reporting of progress and overseeing all aspects of business support.  
  - Administrative support – 1 wte (band 4). Provides dedicated day to day support of system commissioner programme including formal and informal reporting, diary management and support to the Steering Group and Joint Committee |                | 2 x Afc8a, 1 x Afc7, 1 x Afc4 |
| **Overarching system transformation programme, and interim ICS operating model** | Where appropriate existing programme management resources will be aligned from the STP to support the system transformation programme across the different core projects, including  
  - Finance  
  - Digital  
  - Workforce / human resources  
  - Communications and engagement  
  - Business management support  

Existing resource will be used more flexibly and rather than initiating new parallel workstreams the intent is to build upon and, where necessary, redirect existing STP workstreams. |                | From STP |
| **Patient involvement volunteers**                                  | Input from patient members of the Patient and Public Advisory Group including attendance at system transformation meetings and discussions within the main PPAG meetings |                |              |
## 6 PROGRAMME BENEFITS AND IMPACT

### 6.1 Benefits realisation

Inherent within the objectives of this programme of work is the intent to deliver a range of benefits, aligned to the two over-arching objectives of the system transformation programme, namely to:

- Deliver improved quality and provision of care and patient outcomes for our population; and
- Improve the use of available resources (both financial and staffing).

Before we start each stage of the transition, we aim to identify and quantify the intended benefits to patients, our teams and the system and track these through the programme. Any proposals that are identified will need to specify and quantify the anticipated benefits, how these will be delivered and monitored (e.g. a benefits realisation plan). It will also be necessary to be clear on who any planned benefit will accrue to. To support these intentions we will deliver a clear outcomes framework for each of the above two over-arching objectives. Below is a high-level outline of our initial thinking on the benefits associated to our objectives, as follows:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Benefit (note this is not an exhaustive list and will be updated as the programme progresses)</th>
<th>Beneficiary</th>
<th>Measured through</th>
</tr>
</thead>
</table>
| Deliver improved quality and provision of care and patient outcomes for our population | - Improved outcomes against a range of indicators as outlined in the joint strategic needs assessment (JSNA)  
- Improved performance against NHS Constitution targets  
- Improved performance against NHS Long Term Plan priorities (recognising these include indicators within the JSNA and NHS Constitution target)  
- Improved self-management and prevention | Patient and local populations | Outcomes framework to be developed not only as part of the system transformation programme but linked to the long term plan and the JSNA |
| Deliver Improved use of available resources (both financial and staffing) | - Delivery of nationally mandated 20% reduction in management costs  
- Financial performance within the agreed system control total  
- Development of new workforce models to:  
  - address workforce shortages  
  - meet increasing demand  
  - support staff  
  - support service innovations | Organisations  
Patients and public  
Staff | Outcomes frameworks to be delivered in relation to:  
- Finance (as part of the long term plan)  
- Patient experience  
- Staff experience (e.g. as measured through staff surveys) |
Alongside identifying the benefits of any proposed options, the cost of proposals will need to be quantified as part of a detailed options appraisal. Not only will the return on investment of any proposals need to be quantified but proposals will need to deliver the mandated management savings that CCGs and NHS England need to deliver, in order to increase investment in frontline services.

### 6.2 Programme Impact Assessment

This programme of work has the potential to have a significant impact on the delivery of local health and social care. As part of the programme any changes to the way care is delivered will be assessed to determine the impact on patients, particularly those with protected characteristics. The impact will be assessed against a range of domains, and the following provides an indicative list of the domains that will be considered:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>Rating the impact of the proposal on patient safety</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>Rating the impact of the proposal on the clinical effectiveness of patient care</td>
</tr>
<tr>
<td>Experience</td>
<td>Rating the impact of the proposal on the patient experience of care delivery</td>
</tr>
<tr>
<td>Other impacts</td>
<td>Rating the impact of the proposal on other services, patient groups, staff or reputation of the organisations</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>Rating the impact on those in a specific group as outlined in the Equality Act 2010 and also including other hard to reach groups.</td>
</tr>
<tr>
<td>Prevention</td>
<td>Rating the impact of the proposal on the ability to deliver the prevention agenda</td>
</tr>
</tbody>
</table>

Any changes proposed around individual services may also require individual integrated impact assessments and if necessary public consultation.

### 7 RISKS AND ISSUES

#### 7.1 Management of risk

A comprehensive risk register will be produced and the risks will be managed in accordance with recognised NHS risk management processes. A risk register will be developed and kept updated for the project. Risks will be identified and assessed using the following grid:

\[
\text{Risk score} = \text{Impact} \times \text{Likelihood}
\]

<table>
<thead>
<tr>
<th>Impact</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rare</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Unlikely</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Possible</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Likely</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Almost certain</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>
Programme Initiation Document (PID)

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

- **1 - 3** Low risk
- **4 - 6** Moderate risk
- **8 - 12** High risk
- **15 - 25** Extreme risk

Any risk red or amber rated risk of 8 or greater will be discussed at the following groups (see governance arrangements – Section 3.2):

i. System Transformation Executive Board  
ii. System Commissioner Steering Group  
iii. ICP Steering Groups

The above will support the mitigation of risks and escalate to individual organisations and the STP Programme Board as necessary. The register will also track risk in order that the above groups are able to determine the efficacy of the identified mitigations.

### 7.2 Initial assessment of programme risks

The following table provides an initial view on the key risks and issues associated with the System Transformation Programme.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
</table>
| Lack of a coherent and shared strategic vision across Kent and Medway | Development of a robust JSNA for Kent and Medway, which identifies the key priorities and actions required to effect population improvement. JSNA to inform resource prioritisation and integration of physical and mental health care.  
Robust communications and engagement with key stakeholders – members, governing bodies, provider boards, primary care etc. Development of narrative with consistent messages and tangible benefits  
Demonstrable programme of clinical and leadership engagement, supported by communications and engagement, with key stakeholders and audience groups |
| A lack of consistency across place-based ICPs that jeopardises the delivery of objectives or sees development adversely affected in one area compared to others | System Transformation Executive Board to manage interdependencies and individual developments of ICPs ensuring alignment to the entirety of the System Transformation programme and a clear governance framework within the STP/ICS |
| Lack of support for model from NHS England and Improvement          | Early engagement on model with NHSE/I to ensure oversight of proposed plans                                                                                                                                |
| Lack of support for model from CCGs                                 | Clinical leadership at the heart of the engagement approach with demonstrable and targeted programme of clinical engagement supported by the delivery of effective communications and engagement activities |
Programme Initiation Document (PID)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of support of model from CCG member practices</td>
<td>As above</td>
</tr>
<tr>
<td>Lack of funding and resources for local authorities’ impact on ability to support the emerging ICS</td>
<td>Early engagement with local authorities to help shape the direction of travel for the Kent and Medway Integrated Care System</td>
</tr>
<tr>
<td>Lack of support from provider organisations</td>
<td>Demonstrable and targeted programme of clinical and leadership engagement supported by the delivery of effective communications and engagement activities identified in the communications plan.</td>
</tr>
<tr>
<td>Limited resources to take forward programme including financial and workforce</td>
<td>Progress and risks to delivery to be managed by programme governance and into the STP programme board</td>
</tr>
<tr>
<td>Maintaining and improving quality and performance of services during a period of uncertainty and change</td>
<td>To be managed locally via statutory bodies</td>
</tr>
<tr>
<td>Maintaining and improving financial performance during a period of uncertainty and change</td>
<td>To be managed locally and via the STP Finance Group as per existing governance arrangements</td>
</tr>
<tr>
<td>Overall affordability given the challenged financial positions / the programme of work does not address the financial challenge faced by commissioners and providers</td>
<td>To be managed locally and via the STP Finance Group as per existing governance arrangements</td>
</tr>
<tr>
<td>Fragility of primary care impacts on delivery of the local care model and primary care network</td>
<td>Interdependency to be managed via existing governance arrangements as well as System Transformation Executive Board</td>
</tr>
<tr>
<td>Timescales for PCN establishment lead to lack of effective representation of primary care within ICPs in the design phase</td>
<td>To be managed through both the Primary Care Board and the System Transformation Executive Board</td>
</tr>
<tr>
<td>Adherence to current rules on competition and regulation challenge the implementation of the ICP model (competition, choice and regulatory approval of options may delay or possibly prevent the implementation of the preferred options)</td>
<td>To be managed and worked on through early engagement with regulators and System Transformation Executive Board</td>
</tr>
<tr>
<td>Significant changes to working assumptions has potential to derail programme delivery in terms of progress against plan, finance and reputation</td>
<td>To be managed and worked on through early engagement with regulators and System Transformation Executive Board</td>
</tr>
</tbody>
</table>

The above will be assessed and mitigations further developed as part of the programme risk register.
COMMUNICATION AND ENGAGEMENT

8.1 Communication and Engagement principles

In order to undertake large-scale transformation that affects staff, patients and the public alike, we need to ensure that we have developed a robust communications and engagement strategy, which is founded on the following principles:

- **Considered and accurate** – Good communications starts and ends with getting the basics right. We must make sure all communications consider the needs of the intended audience and deliver accurate and consistent messages to all group.

- **Targeted and tailored** – Consistent doesn’t need to mean the same. There are a broad range of stakeholders in this project with different areas and levels of interest. We must make sure we target the right messages using the right channels for different audiences.

- **Inclusive and meaningful** – Staff and stakeholders affected by this programme are spread across a large geography, come from multiple organisations and diverse backgrounds. We need to ensure we have effective systems and channels in place to reach everyone. Seeking the views and involvement of staff and other stakeholders must have a purpose and offer a genuine opportunity for the views provided to shape the direction of the programme.

- **Timely** - Communications and engagement that is either premature or late loses impact; failing to deliver its objective and wasting resources. All communications and engagement activity must be delivered at a time that’s appropriate for the message and the audience. Staff directly affected by the proposals should receive updates directly and ahead of external announcements.

- **Honest** – Linked to meaningful communications and engagement we need to be open and honest about progress of the program and the areas where people can genuinely influence the work. There will be many questions asked before we have definitive answers. We must be honest about what we can confirm or when we are likely to be able to provide clarity.

8.2 Key audiences and stakeholders

The communications and engagement function has undertaken stakeholder and audience mapping and analysis over the past two months and this will be subject to regular review. This work has identified the broad categories of key audiences and stakeholders outlined in the following table:

<table>
<thead>
<tr>
<th>Key audience/stakeholder group</th>
<th>Rationale for engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients and the public</td>
<td>Patients and the public are likely to respond with greater interest when specific services or facilities are affected by change, however they are an important audience for this work as they can provide challenge, support and insight for how the new structures will operate most effectively for the populations they serve. We anticipate</td>
</tr>
</tbody>
</table>
that engagement on the development of the five year plan will see greater levels of patient and public engagement with the aim of eliciting feedback and insight from those groups or individuals most impacted by the plans or who use services highlighted as priority areas e.g. Children’s services, mental health, primary care, cancer.

Our communications and engagement activity on system transformation should ensure that we are transparent, honest and present a ‘case for change’ that moves on from a description of challenges to a clear ‘offer’ for patients about how the new arrangements will benefit them.

We should also be mindful of the fact that local campaigners and activists are showing a keen interest in other STP-related plans and workstreams and we must anticipate high levels of scrutiny from these groups and individuals as work progresses.

| Staff across all commissioner and provider organisations including those outside of the traditional health economy in LAs, VCSE and private providers | Gaining buy-in and support for the future structure of health and care services is vital. Staff at all levels and within all organisation types need to feel that they have the opportunity to help shape the ‘new world’. Within CCGs, CSU and the STP, shifts in organisational structures, specifically the creation of a single CCG, raise questions for staff who will be concerned about their future job role, place of work etc. At provider level, the development and implementation of ICPs may require staff to work differently and they will have questions about how change can benefit them and their patients and teams. They may be concerned about the future of their role or where they will work. VCSE, LAs and private providers all play an integral role in the delivery of care and with a greater drive towards integration, staff will need to understand and have the opportunity to shape the future structure of health and care services. Again, anxieties about job roles, location and security will need to be anticipated and addressed to ensure that these groups are supportive of future plans. |
| GP members | Reflecting the importance of primary care within the LTP and the growing role of PCNs in changing and improving the experiences and outcomes of people who are accessing care. We will make a concerted effort to offer opportunities and methods of engagement to ensure that GP members are reassured about the future and have their concerns listened to and understood. Gaining buy-in and support for the future structure of health and care services is vital. GP members need to feel that they have the opportunity to help shape the ‘new world’ and should be engaged in the process of shaping the future landscape. |
| Decision-makers | Within the scope of the new ICS including CCG governing bodies, provider boards – key groups who will be responsible for steering development of plans – especially those relating to the establishment of an ICS and its component parts – and who will give the go-ahead for changes to organisational structures |
| Politicians and elected representatives | Including MPs, county and district councillors, Health and Wellbeing Board Members, relevant oversight and scrutiny committees. Many of these groups are already engaged in the STP’s work via existing channels and relationships including regular meetings, briefings and formal interactions at scrutiny boards and committees. We have provided new briefings on the system transformation work and will look to step up engagement on ICS, ICP and PCN development. These groups will also be engaged around local five year plan priorities and we will ensure that activity is aligned accordingly. |
Programme Initiation Document (PID)

Professional bodies
LMC, BMA, staff-side representatives and organisation, trades unions – these groups have important insights about issues affecting workforce and are key influencers amongst staff groups and members. Engagement to understand concerns and anxieties about the future – as well as opportunities for meaningful engagement – will be scoped.

Regulators
We will continue to work with colleagues in NHSE/I to develop and refine our plans.

Community and patient voice
Including our local Healthwatch networks who already play an important part in shaping and informing our work and who have links to diverse and often overlooked groups and organisations. We also have ongoing relationships with other community groups, charities, patient voice organisations and social enterprises and will continue to engage with these groups so that our work has the breadth and depth required to ensure that the patient voice is enshrined at the heart of our plan development.

When the above broad categories of stakeholders are considered within the context of the Kent and Medway system this identifies the following list of key stakeholders;

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>ROLES</th>
<th>KEY ROLES FILLED BY</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPAG and local patient groups</td>
<td>STP Programme Board</td>
<td>Nominated PPAG representatives</td>
</tr>
<tr>
<td></td>
<td>Non-Executive Director (NED) Oversight Group</td>
<td></td>
</tr>
<tr>
<td></td>
<td>System Commissioner Steering Group Members</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Joint Committees</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical and Professional Board</td>
<td></td>
</tr>
<tr>
<td></td>
<td>East Kent ICP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>West Kent ICP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DGS ICP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medway / Swale ICP</td>
<td></td>
</tr>
<tr>
<td>Dartford and Gravesham NHS Trust</td>
<td>STP Partnership Board</td>
<td>CEO</td>
</tr>
<tr>
<td></td>
<td>DGS ICP</td>
<td>Director of Transformation</td>
</tr>
<tr>
<td></td>
<td>Clinical and Professional Board</td>
<td>Trust Medical Director</td>
</tr>
<tr>
<td>East Kent Hospitals University NHS</td>
<td>STP Partnership Board</td>
<td>CEO</td>
</tr>
<tr>
<td>Foundation Trust</td>
<td>East Kent ICP</td>
<td>Trust Chair</td>
</tr>
<tr>
<td></td>
<td>Clinical and Professional Board</td>
<td>Trust Medical Director</td>
</tr>
<tr>
<td>Kent County Council</td>
<td>STP Partnership Board</td>
<td>Leader of the Council</td>
</tr>
<tr>
<td></td>
<td>System Commissioner Steering Group</td>
<td>Cabinet Member for Social Care and Public Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Corporate Director Adult Social Care and Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Director of Public Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Corporate Director Adult Social Care and Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Director Strategic Commissioning</td>
</tr>
<tr>
<td>Organisation Name</td>
<td>Committee Name</td>
<td>Chair</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------</td>
<td>-------</td>
</tr>
<tr>
<td>Kent and Medway CCGs</td>
<td>STP Programme Board</td>
<td>2 x Independent Members</td>
</tr>
<tr>
<td></td>
<td>Non-Executive Director (NED) Oversight Group</td>
<td></td>
</tr>
<tr>
<td></td>
<td>System Commissioner Steering Group Members</td>
<td></td>
</tr>
<tr>
<td></td>
<td>System Commissioner Governance Oversight Group</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Joint Committees</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical and Professional Board</td>
<td></td>
</tr>
<tr>
<td></td>
<td>East Kent ICP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>West Kent ICP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DGS ICP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medway / Swale ICP</td>
<td></td>
</tr>
<tr>
<td>Kent and Medway Community NHS Foundation Trust</td>
<td>STP Partnership Board</td>
<td>CEO</td>
</tr>
<tr>
<td></td>
<td>East Kent ICP</td>
<td>Trust Chair</td>
</tr>
<tr>
<td></td>
<td>West Kent ICP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical and Professional Board</td>
<td></td>
</tr>
<tr>
<td>Kent and Medway NHS and Social Care Partnership Trust</td>
<td>STP Partnership Board</td>
<td>CEO</td>
</tr>
<tr>
<td></td>
<td>Clinical and Professional Board</td>
<td>Trust Medical Director</td>
</tr>
<tr>
<td></td>
<td>Non-Executive Director (NED) Oversight Group</td>
<td>Chair – Trust Chair</td>
</tr>
<tr>
<td>Kent and Medway Sustainability and Transformation Partnership</td>
<td>STP Partnership Board</td>
<td>Chair - STP CEO</td>
</tr>
<tr>
<td></td>
<td>System Transformation Executive Steering Group</td>
<td></td>
</tr>
<tr>
<td>Non-Executive Director (NED) Oversight Group</td>
<td>STP CEO</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>CCGs Joint Committee</td>
<td>STP Deputy CEO</td>
<td></td>
</tr>
</tbody>
</table>

### Maidstone and Tunbridge Wells NHS Trust
- **STP Partnership Board**
- **West Kent ICP**
- **Clinical and Professional Board**
- **Non-Executive Director (NED) Oversight Group**

### Medway Local Authority
- **STP Partnership Board**
- **Medway and Swale ICP**
- **Clinical and Professional Board**
- **Non-Executive Director (NED) Oversight Group**

### Medway NHS Foundation Trust
- **STP Partnership Board**
- **Medway & Swale ICP**
- **Clinical and Professional Board**

### NHS England / Improvement
- **STP Partnership Board**
- **CCGs Joint Committee**

### South East Coast Ambulance NHS Foundation Trust
- **STP Partnership Board**
- **Clinical and Professional Board**

### Medway Community Healthcare
- **STP Partnership Board**
- **Medway ICP**
- **Clinical and Professional Board**

### Virgin Healthcare
- **North Kent ICP**

### District and Borough Councils
- **Through engagement processes, particularly focused around the development of the ICPs**
- **As per local arrangements**
### 8.3 Communication Tools

A range of communication and engagements approaches, and methods, will be used, which will be tailored to meet the specific requirements of the intended audience. The following provides an indication of the approaches that are either in place or under consideration:

<table>
<thead>
<tr>
<th>Tool</th>
<th>Frequency</th>
<th>Responsible</th>
<th>Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting minutes</td>
<td>Every decision making meeting</td>
<td>Meeting Lead</td>
<td>Working group members</td>
</tr>
<tr>
<td>Newsletters</td>
<td>Monthly</td>
<td>Communications and engagement</td>
<td>All stakeholders</td>
</tr>
<tr>
<td>Meeting Packs</td>
<td>Monthly</td>
<td>Meeting Lead</td>
<td>Steering Committee members</td>
</tr>
<tr>
<td>CCG AO report</td>
<td>Monthly</td>
<td>Meeting Lead</td>
<td>CCG Governing Bodies and members</td>
</tr>
<tr>
<td><strong>Existing channels/tools/activity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Web – partner organisations websites and the well-established STP website.</td>
<td>Ongoing – scheduled activity in response to specific announcements, plans and on a reactive basis.</td>
<td>Communications and engagement</td>
<td>All stakeholders – we aim to publish as much material as possible on our websites in the interest of transparency. This has worked well during the stroke review and our work in east Kent, where we have also used various web presences to inform local audiences and stakeholders about forthcoming events and engagement opportunities and to host surveys and other feedback mechanisms.</td>
</tr>
<tr>
<td>Social media – at STP level we already utilise a wide variety of social media channels to engage with our audiences and stakeholders including Twitter, Facebook, YouTube and SoundCloud.</td>
<td>Ongoing – scheduled activity in response to specific announcements, plans and on a reactive basis.</td>
<td>Communications and engagement</td>
<td>All stakeholders - as these channels appeal to a significant segment of our audiences and our approach is ‘digital by default’, we will continue to maximise these channels within our communications and engagement activities.</td>
</tr>
<tr>
<td>STP stakeholder Bulletin</td>
<td>Monthly</td>
<td>CCGs</td>
<td>Circulated to distribution list of stakeholders who have ‘opted in’ to receive the bulletin. (We continue to work to drive up recipients following the introduction of GDPR in May 2018.)</td>
</tr>
<tr>
<td><strong>CCG websites and social media channels</strong></td>
<td>Ongoing – scheduled activity in response to specific announcements, plans and on a reactive basis.</td>
<td>CCGs</td>
<td>All stakeholders.</td>
</tr>
<tr>
<td><strong>Local and trade media</strong></td>
<td>Ongoing – scheduled activity in response to specific announcements, plans and on a reactive basis.</td>
<td>Communications and engagement</td>
<td>All stakeholders. Traditional media including local media outlets (print, online and broadcast) – we have excellent, long-established relationships with local media groups and individuals who report on our work on a regular basis. We will also continue to seek opportunities for proactive work with trade and professional media outlets (HSJ, Municipal Journal, Pulse etc.).</td>
</tr>
<tr>
<td><strong>Face to face briefings and meetings within individual organisations</strong></td>
<td>Tbc</td>
<td>Programme team and communications and engagement</td>
<td>Staff – we will harness established meetings and briefing sessions to engage with staff about developing plans.</td>
</tr>
<tr>
<td><strong>Development and implementation of new visual identity to support ICS</strong></td>
<td>In development</td>
<td>Communications and engagement</td>
<td>All stakeholders – although recommend that implementation is low key</td>
</tr>
<tr>
<td><strong>Ensure that key messages are included in communications and engagement work relating to the 19/20 Operational Plan and five year plan engagement</strong></td>
<td>Ongoing</td>
<td>Communications and engagement</td>
<td>All stakeholders as appropriate.</td>
</tr>
<tr>
<td><strong>Development of FAQs for different stakeholder audiences</strong></td>
<td>Ongoing</td>
<td>Communications and engagement with input from programme team</td>
<td>All stakeholders as appropriate.</td>
</tr>
<tr>
<td><strong>Briefing materials including PowerPoint slides, core content and graphics, targeted updates for different stakeholder groups</strong></td>
<td>Ongoing</td>
<td>Communications and engagement with input from programme team</td>
<td>All stakeholders as appropriate.</td>
</tr>
</tbody>
</table>

**Potential new channels/tools/activity**
Facilitated workshop with eight CCG clinical chairs | Tbc | Programme team, communications and engagement | Clinical chairs with outputs communicated to GP members, CCG staff etc

Staff and GP member deliberative events and workshops on specific areas of focus | Tbc | Programme team, communications and engagement | Staff, GP members

Case studies developed and tailored for key audiences and stakeholders – for use in web publication, media work, staff engagement, public-facing communications. | Tbc | Programme team, communications and engagement | All stakeholders

Development of a dedicated briefing session for all local MPs in Summer 2019 | Tbc | Communications and engagement | MPs and researchers.

9 PROGRAMME ACCEPTANCE SIGN-OFF

It is important that this PID is supported by organisations. It effectively forms a memorandum of understanding representing the stakeholder organisations commitment to work on this programme. This commitment to proceed is recognised as materially different to a formal sign-off of the outputs of this programme of work (e.g. by signing this PID organisations are only committing to proceed with the work outlined in this document and not to the service model or changes that may be proposed as a result of this work).

NAME OF ORGANISATION: Ashford CCG
Name: ___________________________ Date: ______________
Signature: ___________________________

NAME OF ORGANISATION: Canterbury and d Coastal CCG
Name: ___________________________ Date: ______________
Signature: ___________________________

NAME OF ORGANISATION: Dartford, Gravesham and Swanley CCG
Name: ___________________________ Date: ______________
Signature: ___________________________
<table>
<thead>
<tr>
<th>NAME OF ORGANISATION:</th>
<th>Dartford and Gravesham NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Date:</td>
</tr>
<tr>
<td>Signature:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME OF ORGANISATION:</th>
<th>East Kent Hospitals University NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Date:</td>
</tr>
<tr>
<td>Signature:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME OF ORGANISATION:</th>
<th>Kent Community Healthcare Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Date:</td>
</tr>
<tr>
<td>Signature:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME OF ORGANISATION:</th>
<th>Kent County Council</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Date:</td>
</tr>
<tr>
<td>Signature:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME OF ORGANISATION:</th>
<th>Kent Community Healthcare Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Date:</td>
</tr>
<tr>
<td>Signature:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME OF ORGANISATION:</th>
<th>Kent and Medway NHS and Social Care Partnership Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Date:</td>
</tr>
<tr>
<td>Signature:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME OF ORGANISATION:</th>
<th>Maidstone and Tunbridge Wells NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Date:</td>
</tr>
<tr>
<td>Signature:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME OF ORGANISATION:</th>
<th>Medway Community Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Date:</td>
</tr>
<tr>
<td>Signature:</td>
<td></td>
</tr>
<tr>
<td>NAME OF ORGANISATION</td>
<td>Name</td>
</tr>
<tr>
<td>----------------------</td>
<td>------</td>
</tr>
<tr>
<td>Medway CCG</td>
<td></td>
</tr>
<tr>
<td>Medway Council</td>
<td></td>
</tr>
<tr>
<td>Medway Foundation NHS Trust</td>
<td></td>
</tr>
<tr>
<td>South East Coast Ambulance Service NHS Foundation Trust</td>
<td></td>
</tr>
<tr>
<td>South Kent Coast CCG</td>
<td></td>
</tr>
<tr>
<td>Swale CCG</td>
<td></td>
</tr>
<tr>
<td>Thanet CCG</td>
<td></td>
</tr>
<tr>
<td>West Kent CCG</td>
<td></td>
</tr>
</tbody>
</table>
Helping local people live their best life

Improving health and care in Kent and Medway

Quality of life, quality of care www.kentandmedway.nhs.uk/ics
Introduction

People in Kent and Medway deserve safe, high-quality health and social care services that are joined-up and meet their needs now and into the future. This will help everyone live their best life, and get great treatment, care and support.

The NHS, social care and public health organisations in Kent and Medway have made progress by working together as the Kent and Medway Sustainability and Transformation Partnership.

We want to improve services for people in Kent and Medway so they:

• are more personalised to them and focused on the various health and care needs of individuals
• help people to stay healthy and, where possible, avoid ill health
• are easier to access, where possible locally in their community and out of hospital.

To do this, we need to change some things about the way we organise ourselves. We believe this will improve care for patients and help us meet rising demand for NHS and social care services.

Where are we starting from?

We have been working together since 2016 and achieved some real successes:

• more GP appointments, available from 8am to 8pm
• a new medical school approved in Canterbury to train NHS staff for the future
• better joined-up care for frail older people, co-ordinated through multi-disciplinary teams
• support in the community to avoid prolonged hospital stays
• joined-up services to help people improve their health with a one-stop service for people who want to lead a healthier lifestyle
• supported 27 local suicide and self-harm prevention projects
• a public consultation and decision to create hyper acute stroke units to save more lives
• a review of health and care services in east Kent which will lead to a public consultation
• we’ve also been looking at how we can spend money better and we saved £2m in 2017/18, through medicines projects and £1m in pathology
• we secured more than £25million in national funding for schemes including capital, estates and IT, plus support for GPs
• we invested in recruiting and retaining GPs
• Health and social care services worked better together than ever over winter 2018/19
• we’ve been listening to local people and patients groups; involving them in lots of our work.

We’ve had a lot of success. But we know there is more we need to do. You have told us health and care organisations need to work more closely together at every level, focusing more on preventing ill-health, to meet your needs and cope with rising demand. So, we’re making some changes...
Why do things need to change?

Until people need health and care services, most have no idea how many organisations there are or how complicated it can be to find the person you need to talk to.

Sometimes services duplicate one another. Sometimes there are gaps which can lead to problems going unrecognised and people missing out on the treatment and support they need.

Different health and care organisations have lots of competing priorities, which can sometimes stop them working together in the wider interest of patients.

And there’s no single organisation with an overview of the health needs of the whole of Kent and Medway, backed by the funding to deliver change.

All this means that health and care services are less effective, efficient and patient-centred than they need to be.

People who have several health conditions can find that no one sees the whole picture or supports them as a whole.

Other issues faced by health and care services are:

- population changes – more people need care, and many people living with complex disabilities or health problems need a great deal of care
- the number of people living in Kent and Medway is predicted to rise by 414,000 (almost a quarter) by 2031
- over 528,000 – that’s almost one in three – local people live with one or more significant long-term health conditions, including around 12,000 people with dementia
- many people (including children) have poor mental health, often alongside poor physical health
- unacceptable differences in health and life expectancy
- women in the most deprived areas of Thanet live on average 22 years less than those in the least deprived
- if staffing were in line with the national average, there would be 175 more GPs in Kent and Medway. Over half our practice nurses are aged over 50 and could retire within 10 years
- there is a shortage of skilled staff, especially senior hospital doctors, to cover rotas 24 hours a day, seven days a week
- services need to change to reflect advances in medicine and treatment
- modern lifestyles do not make it easy for people to lead healthy lives – which can increase their chances of long-term health problems
- in some parts of Kent and Medway around 25 per cent of people smoke. Around one in 10 adults are obese and more than a quarter don’t get enough physical activity
- we need to use our funding wisely and effectively to develop and deliver services that people need both now, and in years to come
- we cannot meet the current and future needs of local people with our existing budgets.

These issues are not just a problem for us in Kent and Medway or even in England – similar difficulties are affecting health and care systems in developed economies round the world.
What is the plan?

We want to make some organisational changes to enable us to provide better and more joined-up services.

This will see us become an integrated care system, in line with national policy, with:

- GP practices working together in networks – called primary care networks
- four new integrated care partnerships across Kent and Medway, drawing together all the NHS organisations in a given area and working more closely with social care
- a single clinical commissioning group for Kent and Medway, led by local doctors, to take a ‘bird’s eye view’ of health priorities for local people and look at where we can tackle shared challenges together such as cancer and mental health.

This will help us to deliver better care for local people including the commitments set out in the NHS Long Term Plan, published in January 2019.

What difference will it make?

For people living in Kent and Medway it will mean:

- more support to stay fit and well before things become a problem – including active reminders sent direct to you, and clinical initiatives to, for instance, identify people at higher risk of a stroke
- better access to the care you need, when you need it, in a way that suits you – whether that’s in the evenings or at weekends, over the phone, by video link or a standard face-to-face appointment, with a physiotherapist, nurse, clinical pharmacist, GP, or support from a non-medical service
- more care out of hospital, with staff working together as a single team to plan and support people with complex health and care needs stay as well as possible and get the care they need when they need it
- better identification of the issues that need tackling and a real focus on quality services, wherever they are provided.

For staff it will mean:

- making a bigger difference to local people – something we all strive to do
- higher job satisfaction and better work/life balance with each professional able to focus on what they do best
- greater resilience for teams and individuals supporting each other
- greater influence on how resources are used to best effect for patients.
Everyone involved in health and social care will be working together in different, more joined-up ways. From family doctors, to mental health staff, community teams and our major hospitals, we’re going to be pooling our resources, skills and expertise to make care and support better for our residents.

Integrated care system
All organisations in health and social care work together in different, more joined-up ways.

Single clinical commissioning group
Led by doctors and other healthcare professionals and focusing on the health needs of whole population, the commissioning group takes a bird’s eye view of the whole system.

Four integrated care partnerships (ICP)
New partnerships drawing together all the NHS organisations in a given area such as hospitals, general practice, community, mental health and social care.

Primary care networks (PCN)
Groups of GP practices will work together with expanded teams to offer you better access and an expanded range of support, quickly when you need it.

Keeping our population in good health
The new system will support 1.8 million people across Kent and Medway to get better joined-up care and to stay well.
To improve care for patients, GP practices have been working together and with other teams in local networks across Kent and Medway. This means patients can access a greater variety of services through their GP practice, sometimes needing to visit other surgeries within their network.

On 1 July 2019, groups of GP practices will form primary care networks. Networks, which will generally cover 30,000 to 50,000 people, can employ staff directly. From 1 July, they will all be providing bookable appointments in the evenings and at weekends, and are expected to provide further services over coming months and years. There will be about 42 primary care networks in Kent and Medway, each with an accountable clinical director.

As networks become established, patients will have access to a much wider team of experts. The plan is for there to be 20,000 more staff across the country by 2024, supplementing the care already provided by GP practices. New roles include clinical pharmacists, physician associates, physiotherapists, community paramedics and social prescribing link workers.

This is in addition to the specialist nurses, dementia and mental health workers, health and care co-ordinators and social care staff who will increasingly be working with GP practices in primary care networks as part of larger shared teams. They will plan how to keep people with the highest need well and ensure they get the right care quickly when they need it.

Working together in this way will strengthen GP practices, which are the bedrock of the NHS, and make sure that a wide range of care is available as locally as possible. Over time, primary care networks will be responsible for the majority of care and will provide a local, expert view of the health of their local population.

Dr Faye Hinsley

Dr Faye Hinsley is a GP at Headcorn Surgery in west Kent.

“It will be fantastic to have more health professionals in our team and we will be able to provide services that meet the specific needs of our communities, rather than referring them elsewhere.

“In the first year in particular, introducing clinical pharmacists and social prescribers will make a huge difference to the pressure on our GPs. Pharmacists will be assisting with the medication needs of our patients, which takes up a significant amount of GP time, and our social prescribers will be working to support people who feel socially isolated and help connect them with various existing community projects.

“In time, we will be able to partner directly with mental health support providers so that counselling is easier to access. We will be able to bring in nurses with specialist expertise and create opportunities for integrated volunteer support. In this way, the whole community will be able support the health and wellbeing of children and adults.”
One of the common problems people face is dealing with lots of different services provided by different organisations that don’t always talk to each other well. It’s frustrating for patients, carers and staff, in fact, for all of us.

To solve this, we’re creating integrated care partnerships (ICPs), bringing together all the different health and care organisations within a given area so they work as one. While each organisation will hold a budget, they will agree together how funding is spent locally. Primary care networks will be a major part of these partnerships and will deliver much of the care, including all the GP services. This is supported by national policy that puts the focus on collaboration and joined-up care.

We’re in the early stages of working out what our four integrated care partnership will look like and what their role will be but we expect ICPs to:

• free up staff to work in teams based on skills and patient needs, regardless of who they work for (children and young people, and people with long term conditions particularly benefit)

• help local people to support their health and wellbeing, focusing on the areas with greatest need

• reduce unacceptable differences in health and life expectancy by tailoring help to different communities in the way they need support (such as people with severe and enduring mental illness)

• design and deliver the best services to meet the needs of everyone they serve, within the funding available

• achieve the best value for money.

They also present the opportunity to work more closely with council colleagues whose role in care and preventing ill-health is critical. It’s not just about the obvious services – social care, public health – but also the importance of education, planning, housing, environmental health, leisure and more.

We’re proposing four integrated care partnerships from April 2020 based on how patients use hospital services: one each for east Kent; Dartford, Gravesham and Swanley; Medway and Swale; and west Kent.
At the moment, we have eight clinical commissioning groups (CCGs) across Kent and Medway. They are responsible for spending the health budget to meet local people’s needs.

This can mean variation in the services provided across the county and the effect on people’s health can be different. Sometimes, this is a good thing, because different populations need different services, but it doesn’t always work well and it can lead to increases in health inequalities and differences in life expectancy.

With the integrated care partnerships and primary care networks focusing on local populations, GPs leading the eight groups are considering merging the existing clinical commissioning groups to set up a single Kent and Medway CCG to focus on the health, wellbeing and care needs of the whole population.

They would delegate authority to a governing body, which would have GPs on it as well as other health professionals.

If governing bodies and GP members agree this is the right way forward, we will submit an application to NHS England in September 2019 and aim for the single commissioner to start in April 2020.

The Kent and Medway integrated care system

The NHS Long Term Plan published in January 2019 set out a clear expectation that integrated care systems (ICS) will cover all areas of England by 2021 and should aim to bring together local health and care organisations to redesign care and improve population health through shared leadership, responsibility and action.

In addition to the elements already described, we expect the Kent and Medway integrated care system to include the following by April 2021:

- a partnership board, representing commissioners and providers from across the health and care spectrum, as well as local government, the voluntary and community sector and other stakeholders
- patient and public representatives so patients help to shape their NHS in the new arrangements
- a clinical and professional board to provide clinical leadership
- formal partnership arrangements with elected members of local authorities through Health and Wellbeing Boards and Health Overview and Scrutiny Committees.
What’s next?

Over the coming months we will be:

• continuing to develop our plans for the new system including talking to GPs, staff, patients, local authorities, provider trusts, and our independent patient champions Healthwatch Kent and Healthwatch Medway

• launching our people strategy, which sets out how we will support our existing staff and look at ways to attract more health and care professionals to our area

• publishing a five year plan for our area – paying particular attention to children’s services, mental health and cancer

• publishing our primary care strategy – which sets out how we will support GPs across Kent and Medway to become networks of practices.

Have your say

While this booklet does not have all the answers, it sets out the reasons behind the plan, some of the intended benefits and what this means for you and our next steps.

We’ll keep talking to you, but for now, we’d like to know what you think. Your views will help shape our plans for the future.

1. Have we explained these plans clearly?

   ☐ Yes it’s very clear  ☐ It could be better explained
   ☐ It’s fairly clear  ☐ I don’t understand
   ☐ Not sure

2. If it’s unclear, what needs explaining better?

3. What benefits do you think the changes will bring?

4. What concerns do you have about the changes?

5. Any ideas, or other comments which could help us, help you?

Towards the end of the year, we plan to publish our response to the Long Term Plan. Our five year plan will set out how to deliver the ambitions of the NHS Long Term Plan in Kent and Medway.
Does this mean that local practices will close and people will be forced to travel long distances to big ‘hubs’ to seek advice and care?

No, the idea is that practices will pool resources and by working together they will be able to offer more services and facilities. You might need to travel to a different practice or facility if you are seeing a doctor in an evening or during a weekend or for a specific clinic or procedure, but you’ll have the opportunity to be seen much more quickly and by the right clinician for you. Everyone is different, but we believe that what patients value most highly is quick and stress-free access to care at a time that suits them.

How will ICPs work across Kent and Medway?

ICPs are alliances of health and care organisations who will work together to deliver care by collaborating within a defined geographical area. Locally serving between 250,000 and 700,000 people, ICPs will spearhead the drive to reduce health inequalities, put prevention to the fore, design and deliver care that meet patient needs and adhere to best practice standards, and get best value for money from the available budget.

Our clinical commissioning group governing bodies and trust boards will be looking at proposals to establish four ICPs covering West Kent, Dartford, Gravesham and Swanley, Medway and Swale, and East Kent incorporating commissioners and provider organisations to develop and deliver services.

When will the ICS come into being?

We will be working as an ICS by April 2021 although we anticipate much closer working across the health and care system in advance of that date, with a single CCG being established as part of this from April 2020.
Our vision is for everyone in Kent and Medway to have a great quality of life by giving them high-quality care.

Quality of life, quality of care

Stay in touch

Sign up for our monthly e-bulletin on our website www.kentandmedway.nhs.uk and connect with us:

- Kent and Medway health and care
- @KMhealthandcare
- Kent & Medway health + care plans

If you would like this booklet in a different format, please phone 01622 211940 or contact us using the details on page 18.
Establishing a single NHS Clinical Commissioning Group for Kent and Medway

Dear colleague,

Further to various meetings and discussions you may have been party to, we would like to update all council leaders and chief executives on our work towards merging the eight clinical commissioning groups (CCG) in Kent and Medway to form a single CCG for the whole area.

The development of a single CCG is part of our work to establish an integrated care system; in line with work happening across the country to deliver the NHS Long Term Plan. This is fundamentally about improving how health and care organisations work together to offer the best support to people living in their area. An integrated care system has three core elements, outlined below and summarised in the attached booklet:

- GP practices working together in networks – called primary care networks (PCNs)
- four new ‘integrated care partnerships’ across Kent and Medway, drawing together all the NHS organisations in a given area and working more closely with health improvement services and social care
- a single commissioning organisation for Kent and Medway, led by local doctors, to take a ‘bird’s eye view’ of health priorities for local people and look at where shared challenges, such as cancer and mental health, should be tackled together.

Our achievements
Since April 2013, when CCGs became responsible for planning and purchasing health services to meet the needs of our local populations, we have seen some real successes across the county which have confirmed the value of clinically-led commissioning:

- far more services provided out of hospital such as geriatrician clinics in Medway, Canterbury, Ashford; diabetes care, prevention and treatment in west Kent and Swale, cataract clinics in Herne Bay, the Healthy New Towns initiative in Ebbsfleet, urgent home visiting service in South Kent Coast, which improve convenience for patients and attendance rates, to name just a few
- the introduction of GP-led multidisciplinary teams working both proactively to manage the health of people with multiple conditions at risk of hospital admission and reactively, to treat them at home whenever possible when they suddenly deteriorate
- high-quality GP services sustained in the face of ongoing challenges with recruitment and retention, with practices supported to work closely together, improving resilience and maintaining services for patients
- redesigned eating disorder services which no longer limit access to those below a certain body mass index, or have an artificial divide between children’s and adult services, but instead focus strongly on early intervention for all ages.
Clinical knowledge, expertise and passion were key to driving through these improvements and only GP-led commissioning could have delivered them.

**Our frustrations**
However at the same time, the configuration of CCGs in Kent and Medway has made it difficult for us to:
- provide the coherent joined-up direction that providers in Kent and Medway need, eliminating confusion and duplication
- deal as effectively as we would wish with issues facing the provider trusts in the county, including performance against constitutional standards, other issues of quality, and overspends, maximising bang for our commissioning buck
- tackle issues affecting the whole population of Kent and Medway, such as cancer and children’s services, which need a single approach
- leveraging our collective knowledge, expertise and strength to improve population health and prevent illness, moving to outcomes-based not activity-focused commissioning.

**Local focus – primary care networks and integrated care partnerships**
We are aware that there may be concerns about a loss of local focus as the eight CCGs come together to form one. However, we believe that the new primary care networks and integrated care partnerships will strengthen the ability of the NHS to design and provide care tailored to the needs of its local communities and through greater partnership working build a more sustainable workforce.

The PCNs will assess unwarranted variations in health within their populations and work within ICPs to address them, ensuring that the focus is always on patient and population needs.

PCNs provide great opportunities for more multi-professional working and access to a wider skill mix to look after patients’ medical and non-medical needs. For example, from April 2021, every PCN is expected to have a social prescribing link worker, who will help patients to get the most out of community and voluntary support, reducing the impact of loneliness on their health.

ICPs will bring together PCNs and all the different health and care organisations as the key health and care partnership within a given area, to work as one, agreeing together how services are designed and delivered and funding for their area is spent. They will also take local responsibility for prevention and promoting the health and wellbeing for their populations. They will work for the good of the patient and the population rather than working in silos can happen now.

Outcomes-based commissioning by the single Kent and Medway CCG will enable this. For instance, if the CCG commissions ICPs to improve the proportion of people with severe and enduring mental illness who are in work, one may need to work with the voluntary sector to improve training and job opportunities, another with local councils on housing, and a third with the police on hate crime prevention: each taking the actions required to deliver the outcome for its population.

We are and will continue to engage with patient and public representatives to ensure the voice of the people we serve is clearly heard within the new arrangements.

**Benefits of a single CCG**
A Kent and Medway CCG will enable us to:
- overcome the fragmentation that undermines our current effectiveness
- offer consistent support to the new primary care networks (PCNs), enabling them to develop rapidly everywhere in Kent and Medway to play their full part in the new health and care system
- better develop the pipeline and mix of staff that the NHS needs, including new roles to extend the care available to support people’s mental and physical health and wellbeing through primary care networks, providing a much more holistic approach
- provide authoritative leadership to the new integrated care partnerships (ICPs) and let contracts that are both transformative and deliverable
- describe the needs of our whole population and develop outcomes for ICPs to deliver in ways tailored to their local populations
- strength the focus on righting health inequalities
- take on some of the assurance and regulatory functions currently delivered by NHS England and NHS Improvement.

**Best of both worlds**

We have heard from some that this is about re-creating structures of the past. That is not so. The very clear gain from the Health and Social Care Act was the introduction of GP-led commissioning. Managers and clinicians working together can do far more than either can do in isolation.

At the same time we need to recognise our limitations and how we can do things better. The proposed changes have been developed by the NHS for the NHS and have their roots in the very clear need for services to be high quality, integrated and sustainable.

We believe that a single commissioner as part of an integrated care system for Kent and Medway will enable us to achieve the best of both worlds: commissioning at scale by knowledgeable local clinicians from across the patch, and local service design and delivery, by partnerships focused on patient needs.

And, while we recognise the initial focus is on establishment of a system commission, we also recognise that the integrated care system is made up of the sum of its parts and equal focus is needed on the other elements.

Therefore, we would welcome the chance to come and discuss these changes with your members and seek your views on proposals for a single commissioner, the development of the integrated care system and how you would want to work with the system commissioner as part of a shared leadership model.

In September, we will need to submit our application to NHS England to obtain agreement for creating a single Kent and Medway CCG. We will be including views from stakeholders in the submission and, if you agree, we would like to include a letter of support from your council.

If you have any questions or would like to arrange a meeting to discuss the proposal in more detail, please contact Executive Assistant Mandy Cordwell by emailing mandy.cordwell@nhs.net or call 07920 765700. You can find more information on our website at www.kentandmedway.nhs.uk/ics and a link to the public survey, which is live until 16 August.

Yours faithfully,

Glenn Douglas
Accountable Officer
Kent and Medway CCGs

Ian Ayres
Managing Director
Medway, West and North Kent CCGs

Caroline Selkirk
Managing Director
East Kent CCGs

Inc: Summary booklet
This page is intentionally left blank
Summary

At a meeting of Medway Council on 25 April 2019, the Council requested a detailed report from Public Health team to the Medway Health and Wellbeing Board. This report determines the extent (if any) of food poverty within Medway and what action could be taken to facilitate the concept of food justice within Medway.

The following report sets out the related local data to indicate the levels of food poverty across Medway. It also highlights key elements of local action and possible options that could be progressed to address the issue of food poverty.

1. Budget and Policy Framework

1.1 In line with nationally agreed operating principles, the Health and Wellbeing Board will seek to:
- provide collective leadership to improve health and well-being across the local authority area, enable shared decision-making and ownership of decisions in an open and transparent way;
- achieve democratic legitimacy and accountability, and empower local people to take part in decision-making;
- address health inequalities by ensuring quality, consistency and comprehensive health and local government services are commissioned and delivered in the area;
- identify key priorities for health and local government commissioning and develop clear plans for how commissioners can make best use of their combined resources to improve local health and well-being outcomes in the short, medium and long term.

1.2 Food poverty, or household food insecurity, can be triggered by a crisis in finances or change to personal circumstances. It may also be a consequence of not being able to access a healthy diet or afford to eat well over a longer time period. The Department of Health defines food poverty as ‘The inability to afford, or to have access to, food to make up a healthy diet.’
1.3 Medway Council, local community groups and others are taking action to ensure people have access to appropriate diets, are able to eat and to address the root causes of people's difficulties.

2. **Background**

2.1 At a meeting of Medway Council on 25 April 2019, the Councillors present passed the following resolution:

"Council notes:

- There are 8 million people in the UK who have trouble putting food on the table according to the United Nations.
- Over 500,000 people used food banks in the UK last year; The Trussell Trust alone distributed over 1.3m three-day emergency food supplies to people in crisis in the financial year 2017-2018.
- 3m children are at risk of hunger during the school holidays.
- Around 10% of the NHS budget goes on treating diabetes and up to 1 million people live in food deserts in the UK.
- The Government's commitment to the UN's 17 Sustainable Development Goals (Global Goals), which commits governments to ending hunger, nationally and internationally, by 2030.

In light of the above, this Council requests a detailed report from Public Health assessing the extent of this issue within Medway specifically, to be brought before the Medway Health and Wellbeing Board, as the most appropriate forum for any action as appropriate, for considering and recommending any further in depth discussion at the earliest opportunity."

2.2 At the pre-agenda meeting on 3 June 2019, it was recommended that this report be added to the Board’s work programme with a date to be determined and pending further discussion with Board Members on the scope of the research.

2.3 Following the pre-agenda meeting, officers suggested the following scope for this report:

- establish the baseline utilising the Public Health Outcomes Framework (PHOF) and other relevant data, such as: children in low income families; fuel poverty data; food bank access data; and free school meals information, in order to set out the starting point compared to comparable areas.
- establish specific local activity happening to tackle food poverty, such as mapping food banks and the Council’s own projects e.g. holiday hunger clubs.
- review wider determinants and health inequalities issues, and consider future action needed and make any recommendations.

2.4 At the Health and Wellbeing Board meeting on 2 July 2019, the Board agreed the scope of this report.
2.5 The government have recently announced that Henry Dimbleby, co-founder of restaurant chain Leon and of the Sustainable Restaurant Association, has been appointed to lead the first major review of the UK food system in nearly 75 years. He will investigate the entire food system, from field to fork, and consider what changes are needed to ensure that it:

- delivers safe, healthy, affordable food, regardless of where people live or how much they earn;
- is robust in the face of future shocks;
- restores and enhances the natural environment for the next generation;
- is built upon a resilient and sustainable agriculture sector;
- is a thriving contributor to our urban and rural economies, delivering well paid jobs and supporting innovative producers and manufacturers; and
- does all of this in an efficient and cost-effective way.

2.6 His recommendations will result in a new National Food Strategy, set to be published in 2020.

3. **Baseline data**

3.1 **Public Health Outcomes Framework Indicators**

**Children in low income families**

3.1.1 This indicator suggests that Medway has a slightly higher number of children in low income families compared to the national average. This trend has been consistent for the last six years.
Five a day

3.1.2 This indicator suggests that adults in Medway consume less fruit and vegetables per day than the national average.

3.1.3 This pattern is consistent with the nearest CIPFA areas.
3.2 Food bank access

3.2.1 Medway Food Bank provided 5,835 clients with food packages in the period of April 2018-March 2019. From January 2019 to end of June 2019, compared to the same period as last year, the amount of client given packages has increased by 10%. Data provided by – Medway Food bank

3.3 State-funded nursery and primary schools - Number of pupils eligible for and claiming Free School Meals

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of children on school roll</th>
<th>Number of pupils taking a free school meal on census day</th>
<th>Number of pupils known to be eligible for and claiming free school meals</th>
<th>Percentage known to be eligible for and claiming free school meals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medway</td>
<td>25,858</td>
<td>2,433</td>
<td>3,300</td>
<td>12.8%</td>
</tr>
<tr>
<td>England</td>
<td>4,759,088</td>
<td>523,536</td>
<td>651,918</td>
<td>13.7%</td>
</tr>
</tbody>
</table>


3.4 Childhood obesity and underweight values

3.4.1 Medway’s National Child Measurement Programme data suggests that the predominant issue of concern is for obesity in children, rather than the volumes of those classified as underweight.
4. Local activity

4.1 Medway Food Bank provide a nutritionally balanced package that lasts 3 days. This can be accessed in Medway at 8 locations. After getting a voucher, nationally families have 3 days to collect a package, however in Medway they allow up to 7 days to collect one. The Food Bank work closely with Tesco and Asda due to national agreements with the Trussell Trust. They have local agreements with some Morrisons and Co-ops. The Trussell Trust is supportive of breastfeeding and therefore do have some formula food for infants, but do not actively promote or discuss unless necessary.

4.2 Holiday Kitchen – Cook, Eat and Play in schools is a Medway Public Health project. The project aims are to: improve family’s diets, health and wellbeing, increase confidence and cookery skills in the whole family and create an opportunity to work towards their 60 minutes of activity per day during the holidays and reduce isolation. The Public Health team worked in partnership with Fare Share Kent, Asda, Adult Education and local supermarkets who provided enrichment activities for families during the session. Last year, 15 sessions were delivered over 5 weeks in 5 venues across Medway. With the capacity of supporting 750 families, providing 520 meals with a 70% attendance rate. The project also created opportunities to sign post families to other Public Health services. Future plans for this project include supporting the Children and Family Hubs, using our partners in Adult Education and Supermarkets to provide a session from Tri Cookery to their target families. Due to vacant posts and maternity leave the team are unable to replicate the project from last year. Public Health aim to create a project plan for future work, in collaboration with Sports Development to provide the Model – Cook, Eat, Play across the schools again in all holidays to make it more sustainable and link with our colleagues in schools, social care and early help to work with target families.

4.3 From the last school visit data from 2016/2017, out of 74 Primary Schools contacted, 55 engaged. Seven of these did not have a breakfast club, 51 were paid breakfast clubs and 4 were free to pupils. More mapping of this is required in order to get a better picture of provision and access in Medway.

4.4 Fit and Fed Project is a project run by Medway’s Sports Development team using the charity Fare Share Kent to provide cold food provision and physical activity sessions in targeted schools. This runs in the holidays currently in Kingfisher Primary School, Luton School and Strood Leisure Centre.

4.5 Tri Cookery is a 6-week cookery programme working with families and adults separately. Families can be referred to this programme or self-refer. Participants improve family’s diets, create an opportunity to socialise and increase confidence in cookery skills. In the financial year 2018/2019, the Public Health team delivered 15 courses with 97 completers. The team would like to enhance this project in the future to deliver a target programme which provides the families with a ‘Food Pack’ of ingredients to go home and replicate from the skills gained in the session.

4.6 Little Food Explorers and Little Chefs are two Public Health offers provided to children and family hubs across Medway as a prevention service for the early
years. These programmes provide exposure to healthy foods, increased family bonding and tackle mild fussy eating issues. Little food explorers is based on the Start4life guidance on introducing solids, so builds confidence for parents as well as providing an opportunity to socialise and engage with other parents. Little Chefs builds basic cookery skills and exposure to healthy family recipes through cooking together.

4.7 Little Food Explorers in the period 2018/2019 saw 501 attendances at 80 sessions. Little Chefs, for the same period, saw 152 attendance from 39 courses. Target families can be referred to these programmes, however this referral pathway can really be improved to ensure those at risk of food insecurity are captured and referred to the programmes.

5. **Advice and analysis**

5.1 The data available, suggests that levels of food poverty in Medway are comparable to other areas with a similar profile. In order to fully quantify the issue of food poverty in Medway, it is recommended that the Director of Public Health be asked to develop an action plan to tackle food poverty which aims to ensure children in low income families (as defined by PHOF indicator 1.011) have appropriate access to food 365 days per year and all Medway residents are able to gain physical access to foods that promote physical and emotional health and wellbeing.

5.2 The Board are asked to consider these steps and agree how the Board and individual organisations can support each other and identify any priority actions to be pursued.

6. **Risk management**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Description</th>
<th>Action to avoid or mitigate risk</th>
<th>Risk rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of partner engagement</td>
<td>Food poverty is a wider determinant of health issues that is multi-faceted and complex. For this reason, it is essential that a wide range of public, voluntary and private sector partners support the action plan development</td>
<td>Broad engagement work required by all HWB Members in development of the project plan</td>
<td>D2</td>
</tr>
<tr>
<td>Insufficient data availability</td>
<td>In order to identify the key issues and most suitable priority actions, it is essential that we have sufficient data that is valid and reliable locally</td>
<td>Identification of available data sources and engagement with relevant intelligence teams at earliest opportunity</td>
<td>D3</td>
</tr>
</tbody>
</table>
7. **Financial implications**

7.1 There are no immediate financial implications arising from this report. Recommendations arising from the review will need to be delivered from within existing budgets. In compiling the suggested action plan, any resource implications will be considered.

8. **Legal implications**

8.1 There are no immediate legal implications arising from this report.

9. **Recommendations**

9.1 The Health and Wellbeing Board is asked to:

9.1.1 note the information included within this report and discuss how the Board and individual member organisations can continue to support the food justice agenda, identifying any priority actions.

9.1.2 request the Director of Public Health to develop an action plan to tackle food poverty which aims to ensure children in low income families have appropriate access to food 365 days per year and all Medway residents are able to gain physical access to foods that promote physical and emotional health and wellbeing.

**Lead officer contact**
Scott Elliott
Head of Health and Wellbeing Services
01634 333012
Scott.elliott@medway.gov.uk

**Appendices**
None

**Background papers**
None
10 SEPTEMBER 2019
HEALTH AND WELLBEING BOARD
BETTER CARE FUND

Report from: Ian Sutherland, Director of People, Children and Adults Services
Authors: Su Ormes, Head of Adults’ (25+) Partnership Commissioning and Better Care Fund
Jo Friend, Partnership Commissioning Programme Lead

Summary
This report presents Medway’s Better Care Fund plan for 2019/20 for the Board’s support.

1. Budget and Policy Framework

1.1 The Better Care Fund (BCF), established in 2015, is an ambitious programme spanning both the NHS and local government. The primary aim of the BCF is to facilitate integration between health and care organisations, in order to deliver person centered and coordinated services. It requires Clinical Commissioning Groups (CCGs) and Local Authorities, to enter into pooled budget arrangements and agree an integrated spending plan.

1.2 The BCF in Medway is a joint plan between NHS Medway Clinical Commissioning Group (the CCG) and Medway Council with Medway NHS Foundation Trust (MFT) as a key stakeholder.

1.3 A pooled budget for the BCF is administered in accordance with a Section 75 agreement between the CCG and the Council.

1.4 On 9 April 2019, the Cabinet agreed an extension of the existing BCF Plan and S75 arrangements to cover the period from 1 April 2019 to 31 March 2020 (decision no. 50/2019 refers). This ensured that the arrangements and services that sit within the BCF could be dealt with as seamlessly as possible pending publication of guidance and funding for 2019/20.
1.5 The BCF Plan 2017 – 2019 set out at Appendix A to the report, is presented to offer transparency to the Health and Wellbeing Board.

2. Background

2.1 Medway’s Joint Commissioning Management Group (JCMG) was established to lead on all elements of joint commissioning between the Council and the Clinical Commissioning Group, including BCF. This has enabled the sharing of information to inform local plans across the system and provided the flexibility to adapt to changes in need, performance or circumstance. This joint approach also ensures that the separate CCG and Council governance processes are fully informed e.g. the Health and Wellbeing Board, Medway CCG’s Governing Body and Medway Council’s Cabinet.

2.2 A number of innovative programmes have been initiated through the Medway BCF to reduce the pressure across the health and social care system. These include:

- The introduction of a new Care Navigation Service in May 2015, with recommissioning in 2018 to create our Wellbeing Navigation service
- The reconfiguration of Medway’s equipment service into one cohesive offer: Medway Integrated Community Equipment Service – MICES from July 2016
- The introduction of Home First, Medway’s ‘discharge to assess’ initiative in April 2016 which enabled the focus to move from a bed-based health and care economy towards one which is needs-based
- The commissioning of a new Intermediate Care and Reablement service in October 2016
- Establishment of new discharge pathways including a new pathway for non-weight bearing patients
- Commissioning of additional home care capacity to support winter hospital discharges.

2.3 BCF initiatives aim to improve the experience of those Medway residents in receipt of support from the health and social care system. Much effort has been made to ensure that respective parts of the health and social care system do not work in silos:

- The use of the NHS number across systems has been a BCF National Condition since inception. Medway Council is now compliant with this condition
- The Wellbeing Navigator service has been expanded to include community and acute services and has the potential to impact positively on many aspects of patient care, reducing the demand on GP and Hospital services
- Recommissioning of support to Carers and Carer organisations in Medway and the development of a carer’s strategy for 2019-2024.
3. **BCF Plan 2019/20**

3.1 Based on the original minimum CCG contribution for 2019/20 of £17.488m, there is in the region of £300k for 2019/20 currently unallocated.

3.2 Potential opportunities for further investment presented in Appendix B were recommended by Joint Commissioning Management Group on 22 August 2019. Officers will develop Project Overview Documents with more detailed costings and expected impact analysis, where required for approved projects.

3.3 JCMG will also consider additional options to spend against the currently unallocated funds.

3.4 As an extension to the 2017 – 19 plan in Appendix A, the BCF Plan 19/20 as shown in Appendix B is presented for review and support by the Health and Wellbeing Board.

4. **Advice and analysis**

4.1 On 9 April 2019, the Cabinet also agreed to delegate authority for the development and delivery of Medway’s Better Care Fund programme to the Director of People - Children and Adults Services, in consultation with the Medway NHS Clinical Commissioning Group Deputy Managing Director, Chief Legal Officer and the Portfolio Holder for Adults’ Services (decision no. 51/2019 refers).

4.2 The BCF 19/20 Plan is presented to the Health and Wellbeing Board, ahead of submission for regional and national approval on 27 September. This has been reviewed and is supported by the Joint Commissioning Management Group. The table below shows the timescales for approval of BCF plans:

<table>
<thead>
<tr>
<th>BCF planning submission from local Health and Wellbeing Board areas (agreed by CCGs and local government).</th>
<th>27 September</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scrutiny of BCF plans by regional assurers, assurance panel meetings, and regional moderation.</td>
<td>30 October</td>
</tr>
<tr>
<td>Regionally moderated assurance outcomes sent to Better Care Support Team</td>
<td>30 October</td>
</tr>
<tr>
<td>Cross regional calibration</td>
<td>5 November</td>
</tr>
<tr>
<td>Assurance recommendations considered by Departments and NHSE</td>
<td>5-15 November</td>
</tr>
<tr>
<td>Approval letters issued giving formal permission to spend (CCG minimum)</td>
<td>Week commencing 18 November</td>
</tr>
</tbody>
</table>

4.3 Equality issues will be taken into account as part of the planning process. Better integration of services should mean that people receive a more
consistent service across Medway. A diversity Impact Assessment has not been undertaken as this report does not make any new recommendations that would have a detrimental impact on services.

5. **Risk management**

5.1 Risk management is an integral part of the BCF plan and there is an embedded risk management plan within the Section 75 pooled budget agreement.

5.2 The majority of services within the BCF Plan 2017 - 19 are currently operational, and risks already assessed and owned. In the case of new services or major variations to existing services, business cases will be developed to ensure that they are fully costed, outcomes clearly stated and risks fully assessed. Business plans and Project Initiation Documents will be produced for all new projects in year and agreed by the Joint Commissioning Management Group. These plans will include robust mobilisation plans for each project, including key milestones, impacts and risks.

6. **Consultation**

6.1 At Medway’s Joint Commissioning Management Group on 22 August 2019 the BCF Plan for 2019/20 was approved.

7. **Financial implications**

7.1 The finances of the BCF are contained within a Section 75 agreement and this has been refreshed and signed by the CCG and Council in order to support the operation of BCF schemes in 2019/20.

8. **Legal implications**

8.1 There are no legal implications for the Board arising from this report

9. **Recommendation**

9.1 The Health and Wellbeing Board is asked to consider this report and support Medway’s Better Care Fund Plan in 2019/20.

**Lead officer contact**
Su Ormes, Head of Adults’ (25+) Partnership Commissioning and Better Care Fund, Gun Wharf, 01634 331280

**Appendices**
Appendix A – BCF Plan 2017 – 19
Appendix B – BCF Plan 2019 – 20

**Background papers**
None
Integration and Better Care Fund

Narrative Plan Template 2017/19

Better Care Support Team

MEDWAY
Contents

Introduction ........................................................................................................................................... 3
What is the local vision and approach for health and social care integration? .................... 4
Background and context to the plan ............................................................................................... 6
Progress to date ................................................................................................................................. 8
BCF Plan 2017 -2019 ...........................................................................................................................11
Risk and performance monitoring ................................................................................................. 13
National Conditions ......................................................................................................................... 18
Overview of funding contributions ................................................................................................. 20
Approval and sign off .........................................................................................................................22
Appendix 1 - DToC Plan on a Page.................................................................................................23
Introduction

This plan has been developed by Medway Council and Medway Clinical Commissioning Group. It has been approved by the Joint Commissioning Management Group and Medway Health and Wellbeing Board at its meeting on 12 September 2017.

The plan covers:

- the joint Medway Better Care Fund proposals for 2017 – 2019
- the iBCF proposals for 2017-18
- the Transforming Care Plan for 2018-20
- Section 75 Agreement which includes specific financial schedules for both the iBCF and Transforming Care Programme budget proposals

The plan has been signed off by:

The Accountable Officer for Medway CCG:
Caroline Selkirk

The Director of Children’s and Adults’ Services:
Ian Sutherland

The Lead Member for Children’s and Adults’ Services (Medway Council) Chair of the Medway Health and Wellbeing Board
Cllr David Brake
What is the local vision and approach for health and social care integration?

Medway Council and Medway CCG have a strong track record of joint working for the benefit of the population of Medway. We already have in place a joint commissioning team to ensure more integrated commissioning. The development of a Kent and Medway Strategic Transformation Plan (STP) has further highlighted the opportunities that closer working between the Council and the CCG would bring to the residents of Medway, including further joint work across a larger Kent and Medway footprint when it makes sense to do so.

Our vision is to move toward the Medway Model, a single commissioner, with shared provision. However, we need to recognise the views of our wider stakeholders and ensure that our plans realise a shared vision across health and social care. In the year ahead we will work towards realising this vision, focussing on developing people as well as processes. In children’s health and care services, we have already achieved an integrated commissioning model across Social Care, Public Health and the CCG with our ambitious children’s health tender. Good progress is being made to integrate adult health and care commissioning.

Our five key priority areas for integration in 2017 are:

1. Local model of care – implementing the next stage of delivering the Medway Model
2. Rationalisation of estate – consider the co-location of our frontline and back office teams and the need for flexibility in how we use our locations and buildings
3. Joint commissioning – building and developing our joint commissioning arrangements
4. Digital roadmap – recognising the huge enabling potential of information management and technology in supporting development of the Medway Model
5. Communications and engagement – creating a compelling, shared narrative and agreeing practical actions to support communications across Medway

Like all health and social care economies, Medway faces some significant financial challenges. Our BCF plan 2017 – 2019 has been developed to ensure a close fit with the emerging STP and will continue to provide a Medway-specific focus to that work, ensuring that Medway is able to address the priorities identified in the Five Year Forward View and the Council’s plan.

In Medway, shared leadership is demonstrated through the development of the new Medway Model for delivering integrated care and wellbeing. There has been significant system-wide engagement with providers (both health and social care), Council Members, GPs and the Acute Trust, in developing this model. The Medway Model puts the needs of residents before organisational need and is a key response to the Kent and Medway STP.
The Medway Model is based around six local geographies, building groups of extended practices and focuses care in each of these through a Healthy Living Centre (HLC), each with a population of between 30,000 and 50,000.

The health and social care system is being redesigned, so that people will need to make fewer trips to hospital and instead access the support they need at more specialist clinics provided in local surgeries. This will allow people to have one point of call for family doctors alongside teams of community nurses, social and mental health services, and better access to blood tests, dialysis or even chemotherapy closer to home. These changes will also join up the often confusing array of A&E, GP out of hours, minor injuries clinics, ambulance services and 111 so that Medway residents know where they can get urgent help easily and effectively, seven days a week.

The Medway Model

We have worked hard in Medway to understand the variation in health and social care outcomes across a wide range of indicators. Detailed analysis has been done for each of the groups of extended practices within the Medway Model. This analysis is data-driven and drawn from work undertaken by Public Health.
Background and context to the plan

Medway Unitary Authority (“Medway”) was formed in 1998 and consists of five main towns (Strood, Rochester, Chatham, Gillingham, and Rainham) and a number of smaller towns and villages, now contained within 22 electoral wards. While the towns are densely populated there are larger, much more sparsely populated rural areas in the Hoo Peninsula to the north of Medway, and the ward of Cuxton and Halling in the west.

There is one Acute Trust, Medway NHS Foundation Trust, serving around 300,000 people resident in Medway, according to figures produced by the Office for National Statistics in 2015.

Even though Medway has a slightly younger population than the national average, projections from 2015 to 2025 suggest that the number of people 65 years of age or over will increase by 24% to 53,000 and the number of people over 85 years will grow by 44% to 6,900. This growth will mean both an increase in support for older people will be needed, as well as a wider range of services to support a wider, and maybe more complex range of needs.

The number of people over 65 years with a limiting long-term illness is expected to increase significantly by 2030, which would have an impact on the demand on health services for the management of long term conditions such as dementia, heart disease and diabetes as the incidence of these conditions increases with age. The summary of Medway’s JSNA can be found here:

http://www.medwayjsna.info/jsna-summary.html

These changes in need will inevitably put additional demands on health and social care services in Medway. There are already signs of a trend in increased numbers of people with additional support needs and the Medway system reflects the national shortage of available specialist resources outside of the acute setting. In response to this, Medway will develop a system-wide response, removing traditional barriers across Health and Social Care - the Medway Model outlined above.

Within Medway, the Index of Inequality shows that the difference in life expectancy between the 10% most and least deprived in the population is 9.4 years for men and four years for women. The main disease contributors to the life expectancy gap are the same as the major causes of death, with circulatory disease and cancer contributing the most to the life expectancy gap.

The challenges of public sector funding as well as increased demand will mean that Medway Council and Medway CCG will need to deliver significant efficiency savings to achieve agreed outcomes, such as enabling the older population to live independently and well for longer; preventing early death; and increasing years of healthy life.

Medway has many challenges facing it over the next five years, not least the predicted rise in people aged over 65, and, with this, the potential for higher levels of morbidity and demand for care. Alongside this are a range of indicators which show that significant health inequalities still exist, which, if not addressed, will also increase the pressure on an already pressurised health and care system.
- Average Medway life expectancy is estimated at 81.7 years for women and 77.6 for men. People aged 85 and over make up 1.6% of Medway’s population (4,136 people according to 2010 estimates).
- An estimated 6,300 people of working age in Medway live with a moderate disability.
- An estimated 6,700 people in Medway live with sight loss.
- An estimated 6,400 people of working age in Medway live with moderate or severe hearing loss, meaning they require a hearing aid or support with different forms of communication such as lip reading or the use of British Sign Language.
- An estimated 2,727 people over 65 live with dementia in Medway.

Demand on health and social care is rising as the population is living longer, and experiencing more complex physical and mental health issues as they live those additional years. By 2035 over one fifth (21%) of Medway’s population will be aged 65 and over, up from 15% in 2014.

NHS Medway Clinical Commissioning Group (CCG) has consulted with stakeholders in shaping its mission and vision for the future that builds cohesion around the agreed focus for transformation in both the most effective clinical models of care and in the underpinning enabling strategy to develop strong provider networks with flexibility to adapt to changing need.

Medway CCG’s 5 year vision focuses on:

- Maximising health gain and reducing inequalities
- Securing sustainability and resilience through integration - to secure a seamless transition between providers where patients need the support or intervention of community care, secondary care, social services or the voluntary sector.
- Improving productivity and clinical effectiveness across all providers

Some of the increases in demand for health services will focus on the management of long term conditions such as dementia, heart disease and diabetes as the incidence of these conditions increases with age. With the increasing rise in the older population, will also come a risk of an increase in falls.

Medway’s Adult Social Care Strategy 2016 – 2020 “Getting Better Together” sets out a vision for adult social care in Medway based on 6 strategic priorities:

1. Prevention
2. Personalisation
3. Partnership
4. Integration
5. Innovation
6. Safeguarding

By focusing our actions and efforts on these key areas, and the CCG’s 5 year vision, we will strengthen and improve the support and care that we provide to residents in Medway.
One of the key areas of focus in social care for 2017-18 is the development of a ‘Three Conversation’ approach which will deliver more person centred care and support as well as help prevent, reduce and delay the development of longer term care needs. The implementation of this new model links directly into the system-wide activity to reduce delays to discharge, reduce 91 day re-admission rates and increase the amount of home-based care people receive.

Improving health and reducing reliance on health and social care for an increasing number of older people will require greater focus on early intervention, greater self management and better care coordination.

Medway’s BCF Plan, aligned to the delivery of the Medway Model, will target those most vulnerable in the community including people living in areas of greatest deprivation and in particular those with a mental health condition, to proactively help them access the advice and care they need for both their physical and mental wellbeing.

Increasing the resilience of carers will also be a priority, with proactive support for people in their own homes to enable people to live independently.

In terms of social care, needs increase significantly over the age of 85. Not only are the numbers of older people growing in Medway, as stated earlier, the complexity of the physical health and mental health problems that they are living with is also increasing. Currently there is too much of a dependency on residential care. This needs to change.

The direction of travel in Medway is towards independence, reablement and recovery. Over the next few years, Medway will make a significant shift from expenditure on traditional institutional style services such as care homes and day centres into services delivered in people’s own homes and in local communities.

For example, we are already seeing the amount spent on reablement services delivered at home increase. We will now work towards a reduction in the amount spent on residential care homes unless there is a specific, specialist need to provide care in those settings which cannot be accommodated at home.

Progress to date

Between 2015 -2017 Medway Council and Medway CCG put a number of initiatives in place to deliver the BCF plan. As a result we have:

- achieved 98% of the service users registered on our social care systems having an NHS number. We have worked with adult social care to retrospectively apply NHS numbers to all live cases. This has involved close working with the national records team

- reduced the DToCs to the national target of 3.5%. To support the delivery of the DToC target Medway has an integrated, multidisciplinary DToC process which provides weekly senior challenge. The contribution of this effort was recognised by the CQC Inspection of Medway Foundation NHS Trust in 2016 which noted ‘Medway has one of the lowest delays to transfer of care in the country’
• reduced bed days lost by nearly 30% through detailed and systematic examination and challenge to medically fit records to ensure delays where they happen are reduced to a minimum

• introduced a “discharge to assess” service, Home First, which has helped over 2500 people home from hospital

• demonstrated that through the roll out of Home First, the Intermediate Care and Reablement Services and MICES that 7-day working is achievable and 7-day working will be a key feature of BCF initiatives in Medway going forward.

In addition to developing approaches to provide integrated care for individuals already known to both health and social care services, we recognise the importance of prevention. To achieve that we continue to build on, and introduce initiatives that identify individuals before they require services, or that prevent an individuals’ health from deteriorating further, for example, in 2017/18 we will focus on reducing the number of conveyances to hospital from residential and nursing settings, through the frailty work being led by Medway and Swale Centre of Excellence (MASCOE).

We know that the key to managing demand and reducing pressure on the system is to prevent people from becoming ill in the first place, or ensuring that the system supports individuals to better manage their conditions, thus maintaining their health and well-being wherever possible. Medway Council is piloting a ‘Three Conversation’ approach to deliver an improved service to those contacting social care for advice and support. It is anticipated that this approach will be rolled out in 2017-18 across the health and care system.

Home First Discharge to Assess

Medway has an established service to deliver assessment and reablement at home. Home First is a multiagency response service that supports hospital discharge for people who are medically stable and have reablement potential. The significant difference with this model is that the assessment and reablement is delivered in the service user’s home setting and not, as has traditionally been done, in a hospital ward or community bed.

Medway’s Home First service has been highlighted at regional and national BCF network events and by the Emergency Care Improvement Pathway (ECIP), which supported its development, as good practice and Medway has been invited to provide presentations of the journey to its creation and delivery as part of the national programme of Masterclasses as well as to information sessions run by the Association of Directors of Adult Social Services (ADASS).

The new Intermediate Care and Reablement Service (IC&RS), which was developed from the learning of the original Home First trial, commenced on 1 October 2016 with Home First as an embedded part. This new service aims to extend the reablement opportunity to people requiring additional non-acute support to get them ready to go home.
Home First provides reablement in people’s own home. There is capacity for up to 35 people a week to go home via this route. The IC&RS is a bed based service. People referred to the IC&RS discharge pathway spend, on average, 21 days receiving support. During this time progress towards independence is constantly monitored and if the multi-disciplinary team providing the reablement identify there is an obvious need for additional on-going support once the person returns home, this is organised while they are still receiving reablement. The average length of stay is around 28 days.

In total over 2500 people have either gone home or had their care transferred earlier through the Home First / Intermediate Care and Reablement pathways since this service was commissioned.

Medway Integrated Community Equipment Service (MICES)

MICES was introduced during 2016 to bring together a number of equipment services into one integrated service. The service now operates from three “satellite” stores and provides quick response times, especially to Home First patients who receive their equipment within 24 hours of it being ordered.

In its first year of operation, June 2016 – June 2017, the new service dealt with 12874 orders, which involved the loan of 31747 pieces of equipment. In that same time-frame 14973 items were recycled back into the system for reuse.

Reducing delays to transfer of care (DTOC)

Even before DTOC was introduced as a National Condition to the BCF programme, Medway had identified, as part of the work with the Emergency Care Improvement Programme (ECIP) that bringing down DTOC numbers and understanding the blockages that led to DTOC was a crucial issue.

When the DTOC work started, the Medway system was ranked in the third quartile for performance and was averaging losses of 774 bed-days each month. In the first quarter of 2017 the bed-days lost averaged 475 and Medway system’s performance is now in the top quartile and almost reaching the stretch target of 2.5%.

Dementia

In the last 2 years there has been a concerted effort across Medway to increase dementia awareness across a range of organisations and the local community, as a way of improving the care and support that people living with Dementia and their carers receive. A number of areas including crisis management, dementia diagnosis, support in care homes and post diagnostic support have been addressed.

Amongst these initiatives has been the introduction of a Dementia Support worker role that has integrated into existing workers role across a number of organisations including Carers First, Alzheimer Society, IMAGO (care navigators), Age UK and is being supported by Admiral Nurses from KMPT and MCH. Practically this means that in addition to Admiral Nurses there a number of dementia trained workers that
can visit individuals in their own homes to provide specific support and advice to them and their carers.

This collaboration has led to the development of multi-disciplinary drop in clinics which run alongside dementia cafes. This increasing cross organisational coordination of support for individuals is leading to increased satisfaction with services and support.

**BCF Plan for 2017-2019**

**Community Discharge Process**

Medway leaders are aware of the plentiful evidence of the benefits for patients, carers staff and organisations of effective hospital discharge planning. Guidance published to date has heavily influenced the work already carried out in the borough and as a result, Medway has seen a change in the number of people who are reported as a delayed transfer of care. This change is sufficiently well documented within the whole system in specific performance reports.

Yet despite the number of “good practice” guides and the demonstrable local achievements, hospital discharge in Medway remains a complex and challenging process for healthcare professionals, patients and their carers. Hospital staff, and therefore their community health and social care partners, remain under constant pressure to discharge patients from the ward as quickly as possible.

A number of proposals and tests will be considered over the coming months in order to develop a new community discharge process in Medway. By January 2018 we will have collated information about the impact from our trials and will be able to implement the agreed approach across Medway.

**Delays to Transfer of Care (DToC)**

A delayed transfer of care (DToC) trajectory has been agreed for Medway in 2017 with 16.56 as the agreed target for daily delays.

Medway will continue to work in a focused, multi-disciplinary way to monitor the system delays, provide solutions to the challenges and deliver the ambitious DToC target.

A separate DToC Plan on a Page is detailed in Appendix 1, and accompanies this BCF plan with specific actions and key performance indicators (KPIs).

**Seven-day services**

Plans to move to 7-day working continue to be developed. Some services, such as Home First, Intermediate Care and Reablement, IDT and the proposed Community Assessment Hub are already focused on 7-day working.
As a restructure of Adult Social Care takes effect from the autumn of 2017, new contracts and rotas for health and social care staff are being drawn up and negotiated. Negotiations will also take place with care providers to assess and restart care at weekends. Hospital departments have plans in place to extend their operational hours into evenings and weekends to enable greater discharge planning over 7 days.

**Trusted assessments**
Medway plans to roll out a single assessment process through the Community Discharge process. The service is being developed around the principle that people will receive one assessment which is accepted across the health and social care system.

We will ensure people are upskilled to undertake an appropriate level of assessments as part of the Three Conversation’s model. Once the reorganisation of Adult Social Care is embedded in the third and fourth quarters of 2017/18, we will move away from making long term decisions in a crisis situation.

KPIs will be developed with social care to ensure progress is maintained and can be documented.

**Focus on choice**
Admission advice and information leaflets are now available for patients. We aim to increase the visibility of information about the "patient pathway" through the hospital and increase the understanding of the "choice" policy. This is being monitored through the A&E Delivery Board.

We will continue to monitor choice as a component of DToC. The DToC categories are reported to the Urgent Care Organisational Group as a regular item and the DToC plan contains KPIs relating to maintaining momentum and reducing those categories, like Patient Choice, which impact on the DToC performance.

**iBCF Funding**
The following diagram demonstrates our intended approach in relation to the management of iBCF funding. This additional funding will be used for addressing demand on social care; facilitating hospital discharge; stabilising the social care market and enhancing integration. Although the iBCF is reported separately, the funds will be incorporated into the overall Section 75 which covers BCF.
**Risk and performance monitoring**

The Risk Register detailed below for the Medway Better Care Fund provides an overview of the top risks identified for 2017-18. The risks will be reviewed on a monthly basis by the BCF Programme Lead, with oversight by the Joint Commissioning Management Group on a quarterly basis through a performance dashboard.

### Key:

- **JCMG**: Joint Commissioning Management Group
- **AEDB**: A&E Delivery Board
- **UCOG**: Urgent Care operational Group
- **APC**: Adults’ Partnership Commissioning
- **ASC**: Adult Social Care
- **CCG**: Clinical Commissioning Group

### There is a risk that:

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Potential impact</th>
<th>Overall risk factor</th>
<th>Mitigating Actions</th>
<th>Ownership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakdown in partnership working results in an inability</td>
<td>2</td>
<td>4</td>
<td>8</td>
<td>Robust partnership governance arrangements via JCMG</td>
</tr>
</tbody>
</table>
to co-ordinate and integrate health and social care services, reducing the collective impact on improving outcomes for vulnerable residents.

<table>
<thead>
<tr>
<th>MFT is unable to reduce overheads linked to a reduction in activity from BCF impact, compromising their financial position</th>
<th>3 3 9</th>
<th>• CCG and MFT are working closely together to ensure detail of plans aligned and impact understood. Annual review of target involving commissioners and provider(s).</th>
<th>AEDB</th>
</tr>
</thead>
</table>
| Shifting of resources to fund new joint interventions and services will destabilise current providers across the health and social care system | 3 4 12 | • Review individual risk assessments ensuring intended as well as potential consequences are assessed
• Contingency plans put in place | JCMG |
| Day-to-day operational pressures on providers prevents them from making the required changes to develop a long-term integrated vision | 3 3 9 | • Commissioners will work closely with providers throughout the process and ensure that they have the necessary support and resources to deliver the required changes in the timeframe required | APC
JCMG |
| Inability within the timeframe required to address the cultural and competency requirements across the whole workforce to enable integrated working to be successful | 4 3 12 | • Through engagement with service providers we will ensure diverse staff groups are brought together to build a new integrated professional identity reinforced by physical co-location, joint management structures and shared training | SRG
JCMG |
| Preventative services will fail to translate into the necessary | 3 4 12 | • Partnership Commissioning will ensure that activity is monitored | APC
JCMG |
reductions in acute, nursing home/residential care home activity, impacting the overall funding available to support core services and future schemes and report any deviation from planned trajectory to the Joint Commissioning Management Group who will put in place remedial action in a timely fashion. Contingency plans inline with risk sharing agreement in s75

<table>
<thead>
<tr>
<th>Sustainability of financial planning assumptions</th>
<th>3</th>
<th>4</th>
<th>12</th>
<th>• Close monitoring against the Better Care Fund metric to secure shift in patient flows out of hospital. To continue to review financial planning assumptions against progress and adjust plans accordingly.</th>
<th>JCMG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better Care Fund schemes will increase demand for community based services, which could lead to higher waiting times for community care assessment.</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>• Commissioners will work closely with providers to ensure appropriate monitoring tools are in place to manage any increase in demand. • Contingency plans put in place including further investment of community services.</td>
<td>APC, JCMG</td>
</tr>
<tr>
<td>Scheduling of change is complex with risk of potential gaps if acute services are reduced before community capacity is in place</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>• Transition planning and co-design will be critical. Close transition management and creative contract negotiation processes underpin better planning and commissioning.</td>
<td>JCMG</td>
</tr>
</tbody>
</table>

The majority of services within the BCF Plan are currently operational, and the risks already assessed and owned. In the case of new services or major variations to existing services, business cases will be developed to ensure that they are fully costed, outcomes clearly stated and risks fully assessed. Business plans and Project Initiation Documents (PIDs) will be agreed by the Joint Commissioning Management Group. These plans will include robust mobilisation plans for each project, including key milestones, impacts and risks.

Performance monitoring will take place quarterly at the Joint Commissioning Management Group, on an agreed set of metrics which will evidence the impact of BCF implementation in Medway.
National Conditions

National condition 1: jointly agreed plan

The diagram below describes Medway governance processes:

The Joint Commissioning Management Group (JCMG) which was established to lead on all elements of joint commissioning, including BCF has enabled us to share our learning to inform local plans across the system, providing us with the flexibility to adapt to changes in need, performance or circumstance.

Meeting every six weeks, the JCMG has enabled us to ensure the separate CCG and Council governance processes are fully informed e.g. the Health and Wellbeing Board, Medway CCG’s Governing Body, Medway Council’s Overview and Scrutiny Committee and Cabinet.

The overall BCF fund for 2017 – 2018 is £22,677,366.00 and for 2018 – 2019 is £24,350,408.00 with the existing Section 75 agreement covering the governance and joint working. The funding includes provision for a joint commissioning team.

The BCF pooled budget includes the iBCF allocations for both years, which are £3,962,308.00 for 2017 – 2018 and £5,151,562.00 for 2018 – 2019. The BCF budget will also include the funding for the Transforming Care Programme once this has been finalised. All of these elements will be covered by one Section 75 agreement.

The BCF expenditure and narrative plan has been approved by the Joint Commissioning Management Group which represents the Council and CCG, and will be taken to the meeting of the Medway Health and Wellbeing Board on 12 September 2017 for endorsement.
National condition 2: social care maintenance

We have created a monthly provider forum in Medway, which has had good representation from our residential/ nursing homes as well as home care providers. We have invited guest speakers and have had themed and solution focused discussions, resulting in an action plan for improvement. Updates on progress are given at each provider forum and sent out electronically. The provider forum has representation from Medway Clinical Commissioning Group, GPs, NHS Medway Foundation Trust and all other health partner agencies and is led by Medway Council.

In order to stabilise the local care market our iBCF will focus on:

Fair cost of care fee uplifts:
It is recognised that in Medway care providers have seen very little in the way of uplifts over a number of years. Medway has one of the lowest unit costs for residential and domiciliary care provision in the South East and this is a contributing factor to many struggling to deliver the level of service expected by the Council.

There is agreement across the health and social care system that an amount of £962,000.00 will be allocated from the iBCF funds in 2017 – 2018 and increased further in 2018 – 2019. This is reported in the NHSE BCF planning template.

Pathway redesign:
We are redesigning our care pathways to reduce hand overs, improve information and advice, improve use of reablement, reduce long-term care packages, increase take-up of direct payments, introduce a strength based approach to social care and implement a ‘Three conversations approach’ to social care delivery.

Our trial of the ‘Three Conversation Model’ in Medway has shown some improvements to client satisfaction and outcomes and we intend to roll this approach out across our social care teams. Through this, we will remove the traditional ‘assessment for services’ approach and create a new culture where practice is based on three conversations. We are currently concluding a staff reorganisation to better support and implement the new model.

Strategic planning and programme support:
Medway CCG and Medway Council have very close working relationships including a joint partnership commissioning team. The co-terminosity with Medway Council and its Unitary Authority status provide a real advantage in the commissioning of services for Medway residents. Medway Council and CCG will continue to develop and embed its partnership commissioning arrangements through the BCF. Funding has been allocated through iBCF to increase dedicated finance support for the BCF programme in 2017/18.

Micro-commissioning:
This project is about developing and embedding streamlined decision making, placement finding and payment pathways to achieve tighter controls on spend. It will also develop a strong and efficient Access to Resources team whose remit will be to
source better value from all residential, nursing, supporting living, extra care and homecare provision.

**National condition 3: NHS commissioned out-of-hospital services**

Medway CCG, Medway Council and Medway NHS Foundation Trust are developing an action plan to implement the High Impact Change Model. We have previously worked with ECIP on our BCF programme and we are keen to identify and implement best practice models. We are also looking at fast track assessments for CHC to ensure that at least 85% of CHC assessments are undertaken outside of the acute setting.

Key areas of development include: the new Community Discharge process, the commissioning of nine assessment beds in the community and the commissioning of an intermediate care and reablement service.

Through the [High Impact Change Model](#) self-assessment we have identified key areas for improvement. These relate primarily to integrated assessment and budgets and this will largely be addressed through the creation of a new community discharge process, remodelling assessment beds so that we will be able to ensure that at least 85% of CHC assessments are eventually undertaken outside of the acute setting.

In partnership with Kent, Medway has established a 24/7 Crisis Resolution Home Treatment Team (CRHTT). CRHTT is made up of Psychiatrists, Psychiatric Nurses, Pharmacists, Social Workers, Occupational Therapists and Support Workers, all of whom work together to resolve the mental health crisis. The service was set up to respond to and support adults who are experiencing a severe mental health problem which could otherwise lead to an inpatient admission to a psychiatric hospital. The main aims are to help someone manage and resolve a crisis through assessment and treatment in their home environment as an alternative to going into hospital. They also support people being discharged from psychiatric hospital, enabling them to continue recovery at home.

The Medway Liaison Psychiatry Service aims to provide mental health support to people admitted to Medway Maritime Hospital. The service works very closely with staff at Medway Maritime Hospital to allow patients' mental health to be treated effectively alongside any physical health problems. The service is available to anyone over the age of 18, regardless of address, who attends an emergency department or is an inpatient at Medway Maritime Hospital and needs advice, assistance or a mental health assessment.

Kent and Medway STP plans have highlighted a range of actions relating to mental health, acknowledging that mental health is as important as physical health and planning a range of actions:

- Work to deliver integrated mental and physical health services
- Deliver rapid access to individuals and their families to give expert advice, guidance and support during their first episode of psychosis
• Implement a CORE 24 model of liaison psychiatry in all acute emergency departments

• Transform children’s emotional and wellbeing services and improve transition between children’s and adult services

• Improve prevention and early intervention, help and support

• Deliver screening, assessment, intervention, training and support across the physical and mental health journey for women, babies and families.

We have already:

• Reduced our use of private beds to zero
• Secured funding for a Core 24 Liaison Service
• Developed and implemented a Peer Supported Open Dialogue service
• Secured additional funding and procured a provider for mother and infant mental health services
• Launched two new Street Triage services in Thanet and Medway.

In addition to the cross-organisational dementia work highlighted earlier in this report, a project funded by the BCF in 2017 will be extending our work with care homes in order to improve staff knowledge, understanding and support for those people with Dementia. Clinical staff will visit care homes to undertake initial assessments of clients who are as yet undiagnosed but displaying symptoms. This increased diagnosis then leads to improvements in care as detailed in current research and best practice. Dementia crisis management is also being addressed through work with Med OCC and MCH on developing pathways to manage and avert carer breakdown as reported through the dedicated helpline.

Along with other systems we are embracing the challenge provided by 7-day working and it is a feature that all future BCF initiatives will be delivered across 7 days. We have plans in place to meet our targets in this area, however this is an area that will require specific focus over the next year alongside the development of demand and capacity plans.

Finally, Medway CCG and Council have expressed an interest in BCF Graduation for 2017/18 and we await the result of this submission. We are moving towards a mature BCF, and the Council and CCG share a vision to create one commissioning organisation, with shared provision. In the year ahead we, therefore, need to make plans that move us towards realising this vision, focussing on developing people as well as systems and processes.

**National Condition 4: Managing Transfers of Care**

In relation to reducing delayed transfers of care, we have committed to the following actions:

- We will review and amend patient pathways to reach our targets around delayed transfers of care.
- We will develop a Community Discharge process which will be delivered as a test for change from October 2017, as well as establish 9 assessment beds which are already operational

- We will increase the availability of clinical support available to care homes to reduce transfers to hospital and hospital admissions. This will be supported in part through the creation of a community paramedic scheme

- We will focus on the patient journey and flow through the system, reducing transfers of care and improving the patient experience. We have funded additional assessment beds to improve the patient experience, and enable the ongoing assessments of people with complex care needs following hospital discharge

- We will make reablement available to all those who can benefit from it and monitor effectiveness, particularly for those with complex needs

- We will invest in dementia care, to increase the availability of EMI beds and reduce out of area placements

- We will work with providers to build changes into the local market which will deliver savings and improvements in service delivery. We will provide an uplift in fees in order to achieve this

- We will invest in Extra Care housing to reduce our existing block contracts and reduce residential care costs in the longer term

- We will fund a complex care coordinator and project officer support for our Transforming Care Programme

The Medway and Swale Health and Social Care Economy A&E Delivery provides whole system oversight and leadership to drive improvement in A&E performance, and ensure high quality Urgent Care Pathways for patients in the context of the Sustainability and Transformation Plan (STP). Every statutory body has a seat on the A&E Delivery Board and is represented at executive level with the authority to commit to decisions on behalf of their organisation.

The A&E Delivery Board is responsible for leading recovery of performance against the national standard that 95% of patients will be seen and discharged within 4 hours of arrival at A&E at Medway NHS Foundation Trust. The A&E Delivery Board will also oversee the strategic direction and delivery of Unplanned Care as defined by the STP and the outcome of the Urgent and Emergency Care Review.

**Overview of funding contributions**

Funding contributions for Medway’s BCF have been agreed and confirmed, including agreement on identification of funds for Care Act duties, reablement and carer breaks from the CCG minimum.
A pooled budget for the Better Care Fund is administered in accordance with a Section 75 agreement between the CCG and the Council. For 2017–2018 the proposed BCF budget is £22,677,366.00 and the proposed pooled BCF budget for 2018–19 is £24,350,408.00.

The BCF pooled budget includes the iBCF allocations for both years, which are £3,962,308.00 for 2017 – 2018 and £5,151,562.00 for 2018 – 2019. iBCF funding is allocated to the following areas:

<table>
<thead>
<tr>
<th>Stabilising the Care Market</th>
<th>Developing community infrastructure</th>
<th>Managing demand on social care</th>
<th>Facilitating hospital discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fair cost of care fee uplifts</td>
<td>Extra care GP support in care homes Community paramedic scheme</td>
<td>Dementia care Transforming Care / complex care coordination Placements Transitions - improving the seamless approach to transitions and the outcomes for individuals and their families</td>
<td>Additional assessment beds commissioned to improve patient flow Integrated community discharge process is being developed to improve discharge</td>
</tr>
</tbody>
</table>

Our BCF expenditure plan is summarised in the following table and detailed fully in the BCF Planning Template, submitted separately:

<table>
<thead>
<tr>
<th>No.</th>
<th>Scheme name</th>
<th>2017/18 expenditure</th>
<th>2018/19 expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Joint commissioning infrastructure / programme support</td>
<td>£835,000</td>
<td>£835,000</td>
</tr>
<tr>
<td>2</td>
<td>Telecare</td>
<td>£80,000</td>
<td>£80,000</td>
</tr>
<tr>
<td>3</td>
<td>Intermediate care and reablement service</td>
<td>£3,955,515</td>
<td>£3,955,515</td>
</tr>
<tr>
<td>4</td>
<td>Carers support services</td>
<td>£879,335</td>
<td>£879,335</td>
</tr>
<tr>
<td>5</td>
<td>Dementia services</td>
<td>£202,032</td>
<td>£202,032</td>
</tr>
<tr>
<td>6</td>
<td>Maintaining social care &amp; managing demand including. community paramedic scheme</td>
<td>£3,612,815</td>
<td>£3,732,815</td>
</tr>
<tr>
<td>7</td>
<td>Care home support</td>
<td>£550,930</td>
<td>£550,930</td>
</tr>
<tr>
<td>8</td>
<td>Care Navigator Scheme</td>
<td>£224,886</td>
<td>£224,886</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Amount 2017</td>
<td>Amount 2018</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>9</td>
<td>Facilitating hospital discharge including new community discharge process</td>
<td>£1,635,114</td>
<td>£1,835,465</td>
</tr>
<tr>
<td>10</td>
<td>Medway Integrated Equipment Service</td>
<td>£2,200,000</td>
<td>£2,200,000</td>
</tr>
<tr>
<td>11</td>
<td>Disabled facilities grant</td>
<td>£1,854,496</td>
<td>£2,017,933</td>
</tr>
<tr>
<td>12</td>
<td>Transforming care programme</td>
<td>£387,350</td>
<td>£387,350</td>
</tr>
<tr>
<td>13</td>
<td>Stabilising the care market, including care home placements, extra care, and fair cost of care fee uplifts</td>
<td>£1,808,129</td>
<td>£2,997,383</td>
</tr>
<tr>
<td>14</td>
<td>Community nursing</td>
<td>£4,451,764</td>
<td>£4,451,764</td>
</tr>
<tr>
<td></td>
<td><strong>TOTAL</strong></td>
<td><strong>£22,677,366</strong></td>
<td><strong>£24,350,408</strong></td>
</tr>
</tbody>
</table>

Approval and sign off

This plan has been jointly agreed by Medway Council and Medway CCG. The plan will be presented to the Medway Health and Wellbeing Board at its meeting on 12 September 2017.
<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>Action</th>
<th>Outcome</th>
<th>KPI</th>
<th>Lead</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>VOLUNTARY AND COMMUNITY SECTOR</td>
<td>REVIEW AND BUILD CAPACITY OF VOLUNTARY SECTOR ORGANISATIONS TO ENGAGE IN DISCHARGE TEAMS TO SUPPORT PEOPLE HOME FROM HOSPITAL</td>
<td>REDUCTION IN SOCIAL ISOLATION AND COMMUNITY RESILIENCE</td>
<td>REVIEW TARGETS FOR 2017/18 PR</td>
<td>PROGRAMME LEAD ADULTS' COMMISSIONING / PUBLIC HEALTH</td>
<td>MARCH 18</td>
</tr>
<tr>
<td></td>
<td>SUPPORT COMMUNITY INITIATIVES (SUCH AS DERIC / MEGAN) TO BECOME INTEGRATED WITHIN THE DEVELOPMENT OF A NEW HEALTH AND SOCIAL CARE MODEL</td>
<td>VOLUNTARY SECTOR FULLY INTEGRATED AS PART OF THE HEALTH AND SOCIAL CARE TEAM BOTH WITHIN THE ACUTE TRUST AND IN THE COMMUNITY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHOICE</td>
<td>IMPLEMENT THE NEW NATIONAL GUIDANCE ON PATIENT AND FAMILY CHOICE</td>
<td>REDUCTION IN DTOC DAYS RELATING TO CHOICE IN LINE WITH ACTION PLAN</td>
<td>REDUCTION IN NUMBER OF PEOPLE / BED DAY DELAYS ON CHOICE</td>
<td>PROGRAMME LEAD ADULTS' COMMISSIONING</td>
<td>MARCH 2017</td>
</tr>
<tr>
<td></td>
<td>IMPLEMENT A TRIAL TO PROVIDE TAILORED INFORMATION, ADVICE AND GUIDANCE FOR THOSE IDENTIFIED AS REQUIRING SUPPORT</td>
<td>INCREASED SUPPORT FOR PEOPLE ON CHOICE</td>
<td>ACHIEVE 5.5% REDUCTION AND LESS THAN 6 BED DAYS LOST DUE TO SOCIAL CARE</td>
<td>PROGRAMME LEAD ADULTS' COMMISSIONING / HEAD OF SERVICE SOCIAL CARE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CHOICE PROTOCOL USED PROACTIVELY TO CHALLENGE PEOPLE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIGITAL ROAD MAP</td>
<td>DEVELOPMENT OF STRATA WITH SYSTEM PARTNERS</td>
<td>INCREASED INTEROPERABILITY</td>
<td>INCREASED USAGE OF TECHNOLOGY ENABLED CARE SERVICES (TECS)</td>
<td>PROGRAMME LEAD ADULTS' COMMISSIONING</td>
<td>MARCH 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BETTER UTILISATION OF TECS AS BOTH A PREVENTATIVE MEASURE AND DISCHARGE FACILITATION</td>
<td></td>
<td>PROGRAMME LEAD ADULTS' COMMISSIONING</td>
<td></td>
</tr>
</tbody>
</table>
1 Medway’s Market Position Statements
<table>
<thead>
<tr>
<th>Description</th>
<th>Length of funding</th>
<th>Investment</th>
<th>Indicative savings / quality impacts</th>
</tr>
</thead>
</table>
| A. Commission a 24 Hour Home Care Pilot – to deliver wrap around 72 hour nurse-led care at home and needs-led support for up to 11 further days to support complex assessments to take place outside of the hospital. This is to support our strategic aims to prevent hospital admissions and readmissions. | 3-6 month pilot to commence Q3 | Based on costs of E Kent Model ‘Home to Decide’:  
• £1420 for 72 hour wrap around service and assessment  
• £180/£290/£395 per day for recovery / moderate/ intensive support for up to 11 days  
• Estimate total investment to support 20 patients in pilot **£100k** (average £4,600 per patient) | This pilot aims to expand on the established Discharge to Assess model to support more complex assessments outside of the acute and reduce transfers from hospital to long-term residential or nursing care.  
There is potential for reduction in the cost of long-term placement or care package – supports a period of ‘settlement’ prior to assessment for more complex patients / those with mild dementia.  
Early discussions with another provider indicates an opportunity to reduce these costs through a tender process to around £1000 per week. |
**BCF Plan 19/20 (JCMG approved projects)**

| B. | Expansion of non-weight bearing (NWB) pathway. To include those with restricted movement. £55k additional funding requested (for £165k total investment in 19/20) | 2019-20 | £55k  
Additional investment provides care for up to 18 additional patients based on current NWB average pathway costs of £3k per patient (average length of care 6.1 weeks at £500 per week)  
Estimated system savings of £122k a week based on comparing cost of acute care @ £1610 a week.  
£9821 (cost of acute care over 6.1 weeks) with £3000 (NWB cost) = £6821 saved per patient supported (x18) = £122k | This builds on the existing successes of NWB Pathway. This will support earlier discharge of patients from the hospital and potential reductions in delayed transfers to care. |

**APPENDIX B**
<table>
<thead>
<tr>
<th></th>
<th>C. Medway Council already purchases a portal for the purpose of trading with schools. This proposal is to purchase a second portal as a provider portal. The portal would give all Council and CCG teams a presence, and would list key information and could go as far as embedding social media and YouTube videos.</th>
<th>Two year pilot</th>
<th>£1000. With the aim to be self-funded by end of year 3</th>
<th>Providers have previously raised communications as an issue, in terms of being able contact the correct team/person and outflow of emails from Council and CCG. The portal would enable providers to come together to realise cost savings through greater purchasing power. Further functionality is a newsreel, training booking, communication forums, survey capability, and an opportunity for third parties/external agencies to advertise.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>D. PCN social prescribing overhead and support funding The PCNs are utilising the new NHS funding Link Worker roles for individual settings. However the funding is post only and no allocation for backroom activity or opportunities to collaborate.</td>
<td>annual</td>
<td>£35k</td>
<td>This investment will ensure the potential 7 new service providers of social prescribing do not unintentionally destabilise the exiting social prescribing services, such as care navigators. Supporting the PCNs will also ensure a close linkage with existing activities such as patient activation and ensure a robust evaluation process will be in place to track progress against Medway’s 5 year social prescribing plan.</td>
</tr>
<tr>
<td>Total</td>
<td><strong>£191k</strong> JCMG will be offered additional options to spend against the currently unallocated funds.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BCF Plan 19/20 (JCMG approved projects)**

**APPENDIX B**
HEALTH AND WELLBEING BOARD

10 SEPTEMBER 2019

WORK PROGRAMME

Report from: Neil Davies, Chief Executive
Author: Jade Milnes, Democratic Services Officer

Summary

The report advises the Board of the forward work programme for discussion in the light of latest priorities, issues and circumstances. It gives the Board an opportunity to shape and direct the Board’s activities.

1. **Budget and Policy Framework**

   1.1 The Health and Social Care Act 2012 places a duty on local authorities to establish a Health and Wellbeing Board for their area.

   1.2 On 25 April 2013, the Council established the Board for Medway and agreed its terms of reference.

2. **Background**

   2.1 The work programme is set out at Appendix 1 to the report. It should be noted that the work programme is likely to be subject to frequent changes and additions throughout the year and is for guidance only.

   2.2 A pre-agenda meeting was held on 15 August 2019. At this meeting it was recommended that at each meeting of the Board, Members consider how they could support progress within each theme of the Joint Health and Wellbeing Strategy (JHWS). The first theme, ‘Giving every child a good start’, is included within the agenda, item 5 refers.

   2.3 It was also recommended that the progress report on the Transforming Care (TC) Plan be deferred from 10 September 2019 and be considered by the Board on 18 February 2020. This would enable the Board to consider in more detail the outcomes of the TC programme. It was noted that the Board would be considering the Learning Disabilities Strategy at their meeting in November. The work of the TC programme is integral to this Strategy.

   2.4 Following the pre-agenda meeting, it was recommended that a report on establishing a single Clinical Commissioning Group (CCG) be added to the agenda on 10 September 2019; agenda item 8 refers. This report will be accompanied by a presentation on the wider health and care system
transformation and a presentation on the development of the Integrated Care Partnership (ICP).

2.5 In July 2019, the Government published the Prevention Green Paper, which may be found here: https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document. This Paper sets out how the Government plans to embed the principle ‘prevention is better than a cure’ across wider society. It is recommended that the Board add a briefing on the Prevention Green Paper to their work programme for 5 November 2019.

2.6 The Draft Medway Children and Young People's Plan 2019-2024 was scheduled to be included on this Agenda (10 September 2019). However, a request was made at the Children and Young People Overview and Scrutiny Committee on 25 July 2019 that more measurable data be included within the Plan. In addition, consultation has been ongoing with various groups of young people and there has been a request that the design of the Plan be improved to be more appealing to young people. To facilitate these additional requirements, it is expected that this report will now be presented to the Board on 5 November 2019.

2.7 Finally, officers have confirmed that the update on the outcome of the Section 136 ‘deep dive' which is listed on the work programme with a date to be determined could be presented to the Board on 18 February 2020 following completion of the deep dive in December 2019. This would align with Mental Health Crisis Care Concordat Annual Report. It is therefore recommended that the report be added to the Board’s Work Programme for this date.

2.8 By way of a further update on the evaluation of the Suicide Prevention Programme also listed on the work programme with a date to be determined, The National Evaluation Team has confirmed the final evaluation will be presented in 2020 at the end of the transformation programme. Members of the Board will be apprised on progress.

3. 2019/20 Audit and Counter Fraud Planned Work

3.1 The Internal Audit Team has commenced an audit of the Joint Health and Wellbeing Strategy. The review will consider the following Risk Management Objectives:

3.1.1 RMO1 - The council are compliant with the legislation set out in the Health and Social Care Act 2012 regarding sections 192, 193 and 194.
3.1.2 RMO2 - The Joint Health & Wellbeing Strategy in place is compliant with the legislation.
3.1.3 RMO3 - There are controls in place to ensure the Strategy is being followed and the outcomes monitored.

3.2 The outcome of the audit will be presented to the Board in due course.
4. **Community Pharmacy Contractual Framework: 2019 to 2024**


4.2 When the Pharmaceutical Needs Assessment (PNA) is next reviewed, officers will evaluate the impact of the new Framework on pharmacy provision in Medway.

5. **The Kent and Medway Joint Health and Wellbeing Board**

5.1 The last meeting of the Kent and Medway Joint Health and Wellbeing Board was held on 25 June 2019.

5.2 At this meeting the Joint Board considered:
- a ‘deep dive’ into physical activity;
- an overview of learning disability annual health checks and over 75 eligibility;
- a progress update on the local care workstream; and
- an update on creating a new commissioning landscape in Kent and Medway.

5.3 The Joint Board received a presentation on ‘Creating a new commissioning landscape in Kent and Medway.’ This included an update on the development of Primary Care Networks, Integrated Care Partnerships and movement towards a single Clinical Commissioning Group across Kent and Medway.

5.4 The agenda and webcast may be viewed online: [https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=911&MId=8310&Ver=4](https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=911&MId=8310&Ver=4)

5.5 Table 1 sets out the future meeting dates and associated agenda despatch dates.

<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Agenda Despatch</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 December 2019</td>
<td>2 December 2019</td>
</tr>
<tr>
<td>17 March 2020</td>
<td>9 March 2020</td>
</tr>
</tbody>
</table>

Table 1

5.6 Meetings within this municipal year are held at Kent County Council, Sessions House, County Hall, Maidstone, Kent ME14 1XQ.

5.7 The meeting of the Joint Board scheduled for September 2019 has been withdrawn and instead Members will hold a development session.

6. **Risk implications**

6.1 There are no specific risk implications connected with this report.
7. Financial and legal implications

7.1 There are no specific financial implications arising from this report.

7.2 In the event of there being any recommendations relating to commissioning these will need to be referred to the Council’s Cabinet and/or NHS Medway Clinical Commissioning Group.

8. Recommendations

8.1 The Health and Wellbeing Board is asked to agree the work programme attached at Appendix 1 to the report, subject to:

i) the addition of an item to consider the advancement of a theme of the Joint Health and Wellbeing Strategy (JHWS) to each meeting of the Board as follows:
   a. ‘Enabling our older population to live independently and well’ (5 November 2019);
   b. ‘Preventing early death and increase years of healthy life’ (18 February 2020);
   c. ‘Improving physical and mental health and well-being’ (14 April 2020); and
   d. ‘Reducing health inequalities’ (2020 TBC).

ii) the addition of a briefing on the Prevention Green Paper to 5 November meeting of the Board;

iii) the provisional addition of the Draft Medway Children and Young People’s Plan 2019-2024 to 5 November meeting of the Board;

iv) the addition of the update on the outcome of the Section 136 ‘deep dive’ to 5 November meeting of the Board; and

v) the deferral of the Transforming Care Update to 18 February 2020.

8.2 The Health and Wellbeing Board is asked to consider whether any further changes need to be made.

Lead officer contact
Jade Milnes, Democratic Services Officer
Telephone: 01634 332008 Email: jade.milnes@medway.gov.uk

Appendices
Appendix 1 - Health and Wellbeing Board Work Programme

Background papers
None
MEDWAY HEALTH AND WELLBEING BOARD WORK PROGRAMME

Notes:

The Independent Chairs of the two Safeguarding Boards (Between September and December each year) and the Corporate Parenting Board (in April each year) will present to the Health and Wellbeing Board (HWB) and Community Safety Partnership (CSP) their Annual Reports outlining performance against Business Plan objectives in the previous financial year.

Between October and February each year the HWB will present to the Safeguarding Boards the review of the JHWS, refreshed JSNA and the proposed priorities and objectives for the refreshed JHWS to enable the Safeguarding Boards to hold to account and challenge performance of the HWB and ensure that their refreshed Business Plans appropriately reflect relevant priorities set in the refreshed JHWS and related commissioning strategies.

Between December and April each year, the CSP Chair will present to the HWB and Safeguarding Boards the CSP Strategic Assessment and the proposed CSP priorities and plans.

<table>
<thead>
<tr>
<th>Meeting Date (despatch date)</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 November 2019</td>
<td>Annual Public Health Report</td>
</tr>
<tr>
<td></td>
<td>Kent and Medway Adult Safeguarding Annual Report</td>
</tr>
<tr>
<td></td>
<td>Learning Disability Strategy</td>
</tr>
<tr>
<td></td>
<td>Medway Safeguarding Children Board Annual Report</td>
</tr>
<tr>
<td></td>
<td>NHS Local Five Year Plan</td>
</tr>
<tr>
<td></td>
<td>SEND Strategy</td>
</tr>
<tr>
<td>18 February 2020</td>
<td>Update on activity of the NHS Medway CCG Primary Care Commissioning Committee</td>
</tr>
<tr>
<td>(10 February 2020)</td>
<td>Contribution of NHS Medway CCG to the Delivery of the Joint Health and Wellbeing Strategy</td>
</tr>
<tr>
<td></td>
<td>CSP Strategic Assessment and Community Safety Plan</td>
</tr>
<tr>
<td></td>
<td>Mental Health Crisis Care Concordat Annual Report</td>
</tr>
<tr>
<td>14 April 2020</td>
<td>Medway Corporate Parenting Board Annual Report</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>(2 April 2020)</td>
<td>Medway Safeguarding Children Partnership Action Plan</td>
</tr>
<tr>
<td><strong>Dates to be confirmed</strong></td>
<td>Evaluation of the Suicide Prevention Programme</td>
</tr>
<tr>
<td></td>
<td>Update on the Outcome of the Section 136 ‘Deep Dive’</td>
</tr>
<tr>
<td></td>
<td>Update on the “Involving Medway”</td>
</tr>
<tr>
<td></td>
<td>Update on the work of the Patient Experience and Public and Patient Engagement (PEPPE) group</td>
</tr>
</tbody>
</table>