**Appendix 1**

# Kent and Medway
# System Transformation Programme

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

# Document Control

## a. Document Identification

| | |
|---|---|
| **Programme** | System Transformation Programme |
| **Author(s)** | M. Ridgwell and I. Chana |
| **Version** | 0.8 |
| **Status** | Draft for discussion |
| **Last updated** | 24/05/19 |
| **Approved by** | Unapproved |

## b. Document History

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

## 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

## 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

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):

| Milestone or Phase | Date |
|---|---|
| All PCNs submit registration information to CCGs | May 2019 |
| Outline support from CCGs to continue to proceed with the establishment of a single CCG as the vehicle for the system commissioner | May 2019 |
| Establish leadership arrangements in transition for the four integrated care partnerships | May 2019 |
| Integrated care partnerships outline development plans in place | May 2019 |
| CCGs confirm PCN coverage and approve GMS/APMS/PMS contract variations | May 2019 |
| Governing Bodies agree Statement of Intent / outline application for CCG merger - to be submitted to NHSE Region for initial review | July 2019 |

| | |
|---|---|
| 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.

| Role | Description | Resource |
|---|---|---|
| Clinical Chair (Bob Bowes, Clinical Chair, West Kent CCG) | Provides clinical leadership, direction and mentorship across the whole programme (including chairing the System Commissioner Steering Group). | Existing CCG<br>0.4 WTE |
| Project Lead Director (Simon Perks, System Commissioner) | 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. | Existing CCG<br>1 WTE |
| Director of Corporate Services, Mike Gilbert, | 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 | Existing CCG<br>0.7 WTE |
| 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:<br>• 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.<br>• 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.<br>• 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<br>1 x AfC 7<br>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<br>- Finance | From STP |

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| operating model | - Digital<br>- Workforce / human resources<br>- Communications and engagement<br>- Business management support<br>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. | |

## 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:

| Risk | Mitigation |
|---|---|
| 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.<br>Robust communications and engagement with key stakeholders – members, governing bodies, provider boards, primary care etc. Development of narrative with consistent messages and tangible benefits<br>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 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. |
| Lack of support of model from CCG member practices | As above |
| Lack of funding and resources for local authorities' impact on ability to support the emerging ICS | Early engagement with local authorities to help shape the direction of travel for the Kent and Medway |

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|---|---|
| | Integrated Care System |
| Lack of support from provider organisations | Demonstrable and targeted programme of clinical and leadership engagement supported by the delivery of effective communications and engagement activities identified in the communications plan. |
| Limited resources to take forward programme including financial and workforce | Progress and risks to delivery to be managed by programme governance and into the STP programme board |
| Maintaining and improving quality and performance of services during a period of uncertainty and change | To be managed locally via statutory bodies |
| Maintaining and improving financial performance during a period of uncertainty and change | To be managed locally and via the STP Finance Group as per existing governance arrangements |
| Overall affordability given the challenged financial positions / the programme of work does not address the financial challenge faced by commissioners and providers | To be managed locally and via the STP Finance Group as per existing governance arrangements |
| Fragility of primary care impacts on delivery of the local care model and primary care network | Interdependency to be managed via existing governance arrangements as well as System Transformation Executive Board |
| Timescales for PCN establishment lead to lack of effective representation of primary care within ICPs in the design phase | To be managed through both the Primary Care Board and the System Transformation Executive |
| 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) | To be managed and worked on through early engagement with regulators and System Transformation Executive Board |
| Significant changes to working assumptions has potential to derail programme delivery in terms of progress against plan, finance and reputation | To be managed and worked on through early engagement with regulators and System Transformation Executive Board |

# 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).

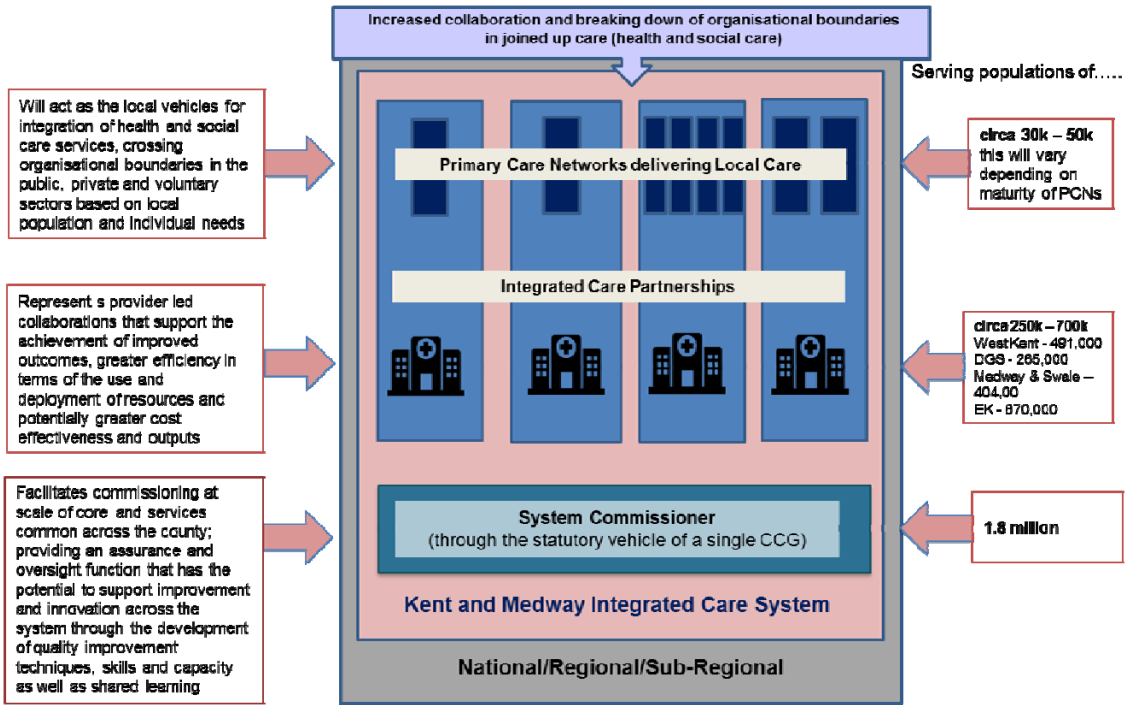
## 2.3 Kent and Medway Integrated Care System model

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 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:

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| 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.<br>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:<br>• Focus on and are responsive to the needs of the population of Kent & Medway<br>• 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<br>• Are forward looking and innovative and make improvement to the operational challenges facing current provision<br>• Champion integration and focus on the patient experience and improved outcomes across health, social care and general wellbeing. |
| Integrated | Integrated Care Partnerships represent a provider led collaborative, operating most effectively |

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| Care Partnerships<br><br>(individual ICP milestones are under development and will presented in their individual plans, which will supplement this document) | 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.<br>Key functions of the place-based Integrated Care Partnerships include:<br>• Accountability for the physical and mental health of their whole population including development and delivery of care and well-being solutions to ensure this<br>• Focus on responding to population health needs and the provision of programmes that promote prevention and address health inequalities and inequality in health outcomes<br>• Ensure a focus on population health; more than the sum of individual care pathways<br>• 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<br>• Support organisational development to enable cultural change and thus deliver integrated working at executive, managerial and practitioner level<br>• Local route for escalation and risk management within the system<br>• Local contract management and the increased use of alternative contract forms to support integrated delivery<br>• 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<br>• 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.<br>• Delivering care within the ICP's capitated budget<br>• Having aligned incentive contracts and sub-contracts which foster collaboration within and outside the ICP.<br>• Monitoring and achieving quality standards with robust measures to address failings<br>• 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:<br>• Defining the needs of the population of Kent and Medway down to a population level of 30-50k<br>• Setting the outcomes to be delivered in addressing those needs, including emphasising prevention and addressing health inequalities and inequality in health outcomes<br>• Allocating capitated budgets within new financial frameworks that encourage Integrated Care Partnerships to focus on population health<br>• Providing oversight and offering strategic solutions to K&M wide functions such as Strategic Estates, Digital, Workforce, and Finance.<br>• Supporting and delivering the organisational development of providers to become members of Integrated Care Partnerships. |

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| | • Giving license to, and receiving assurance from, ICPs on the delivery of outcomes within budget<br>• Acting as the point of escalation of dispute and risk in ICPs<br>• Commissioning core services at scale.<br>• Holding a single contract for larger (K&M) providers, whilst enabling and maintaining local flexibility<br>• Holding contracts for some non-Kent and Medway tertiary and acute providers<br>• Direct commissioning of rare and very expensive services<br>• Providing high quality cost effective commissioning support and back office functions<br>• Developing a Kent & Medway approach to service and quality improvement<br>In addition to the commissioning of physical and mental health services, the establishment of a Kent & Medway system commissioner presents an opportunity to explore the potential for closer alignment or integration of health and social care commissioning in the future. Early conversations have been had with the two upper tier local authorities and there is willingness in principle to align first and explore practical ways of integrating health and social care commissioning. |

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:

| Assumption | Description |
|---|---|
| Support from CCGs and membership | Assumes there will be support for the proposed system model as outlined in this document |
| Support from Provider Organisations | Assumes there will be support for the proposed system model as outlined in this document |
| Support from NHS E / I | Assumes NHS England will support the development of a single CCG through their mandated process |
| Implementation timing | Assumes a single CCG will be implemented by April 2020.<br>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 |
| Collaborative versus organisational focus | 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 |
| Supporting from local authorities | Assuming LAs will support, including in relation to a Medway and Swale ICP |
| Delegation of function from NHS England | Assuming NHS E / I functions around local assurance and EPRR will be delegated to ICSs |
| The STP / ICS working alongside the CCC(s) during transition but acknowledge these functions are likely to come together as the ICS arrangements mature | 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:<br>• CCCs (potentially in due course) - CCG functions other than those listed below<br>• STP / ICS - Functions delegated or directed by NHS England (e.g. assurance, resilience planning)<br>• STP / ICS - Over-arching strategic and programme planning |

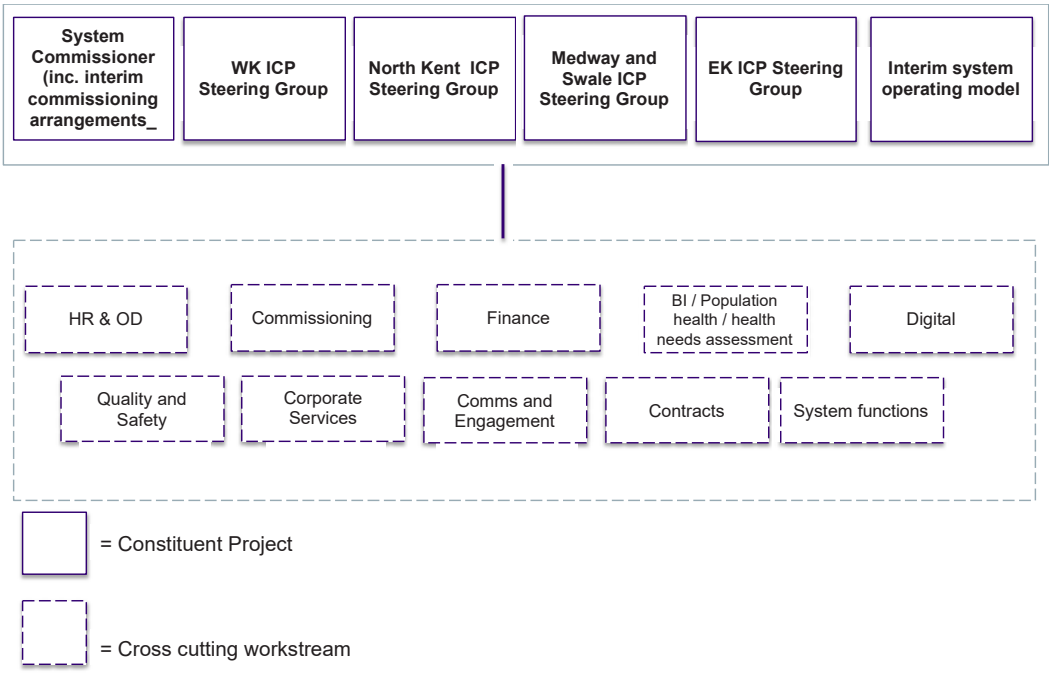
# 3 PROGRAMME GOVERNANCE

## 3.1 High-level Programme Structure

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:

| Term | Definition |
|---|---|
| Programme | A group of related projects and change management activities that together achieve beneficial change for an organisation. |
| Project | 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 |
| Workstream | Thematic portfolio of programmes or projects and processes that are strategically selected and managed to advance business goals |

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

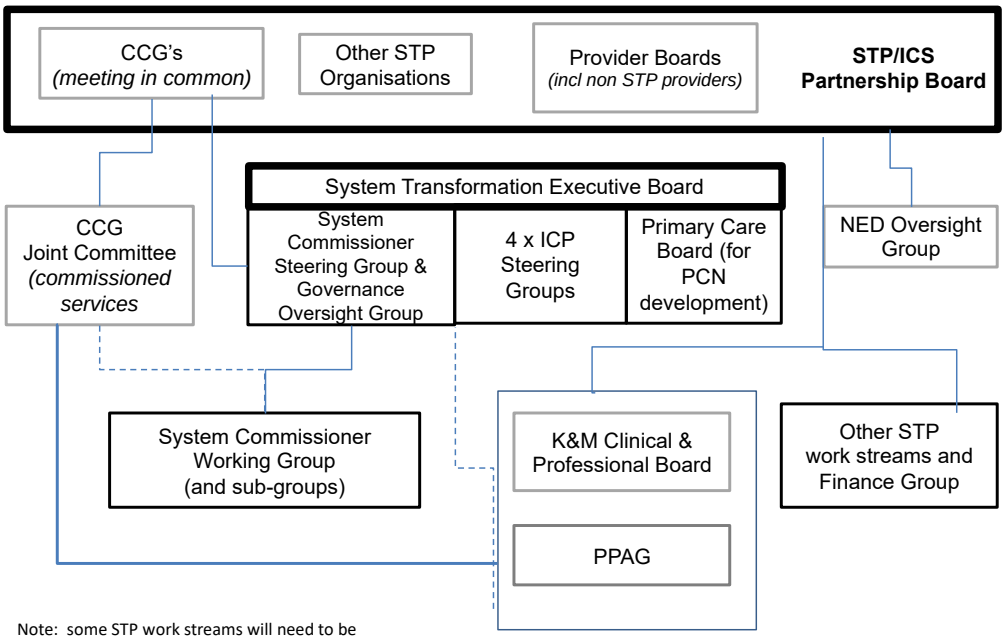



The core constituent projects, as detailed above, will each require their own project plans, which will be developed alongside this document. These will be agreed, managed and coordinated through the programme governance structure detailed later in this document.

## 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)**




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:

| Group | Role | Frequency | Chair | Membership |
|---|---|---|---|---|
| STP Programme Board *(The renaming of this group to the ICS Partnership Board will be considered as part of the programme)* | 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. | Monthly | STP Chief Executive | Representation from all STP core partner organisations (see Section 12.3 for list) |
| Non-Executive Director (NED) | Provides independent scrutiny and oversight of the STP Partnership Board | Monthly | STP Chair | STP Chair, 2 x Provider NEDs, |

| | | | | |
|---|---|---|---|---|
| Oversight Group | and its programmes of work, including development of the Integrated Care System. | | | 2 x CCG independent members,<br>2 x Upper Tier LA elected Members |
| 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…)<br>• Responsible for determining joint commissioning agenda and priorities | Monthly | Stroke: Independent Chair<br><br>K&M Joint Committee - CCG Clinical Chair<br><br>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<br>• Principles and Coordinates and supports the ICS development (spanning both the ICP and system commissioner development)<br>• Ensures consistency of approach whilst also supporting local flexibility and autonomy<br>• Provides senior executive leadership<br>• Framework for ICP development<br>• Development of an assurance and regulatory framework | Monthly | STP CEO / AO | STP CEO / CCG single accountable officer – Chair,<br>STP Deputy CEO Senior sponsor,<br>Chair of SCOG,<br>senior sponsors for four ICP Steering Groups,<br>CEO, KMPT<br>Kent County Council lead director<br>Medway County Council lead director<br>Co-chair of Primary Care Board |
| System Commissioner Steering Group | Responsible for delivery of project objectives that include but not limited to:<br>• Commissioning transformation and development of the System Commissioner<br>• 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 |
| ICP Steering | • Responsible for delivery of the ICPs | As per | WK: Mile Scott, | To be identified |

| | | | | |
|---|---|---|---|---|
| Groups x 4 (place-based) | and delivery of agreed system and local objectives<br>• PCN development (working with the Primary Care Board)<br>• Identification of priorities<br>• 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 | local agreement | CEO MTW<br>EK: Paul Bentley, CEO KCHFT<br>North Kent: Louise Ashley, CEO, DGT<br>Medway and Swale: James Devine, CEO, MFT | through individual ICP project plans (and recommended to include LMC representation to facilitate representation of general practice) |
| K&M Clinical and Professional Board | • Advises the STP Programme Board and CCG's Joint Committee on all clinically and professionally related matters<br>• Provides collective clinical and professional leadership to the Kent and Medway system<br>• Leads the development of the clinical and professional content of Kent and Medway level strategies<br>• Oversee the work of the clinical and innovation workstreams | Monthly | CCG Clinical Chair / Provider Medical Director | Representation from all STP core partner organisations (see Section 8) |
| Primary Care Board (PCN Development) | • Provides strategic leadership to the Primary Care workstream<br>• Ensures that the programme delivers its milestones and outcomes on time and to budget (based on agreed plan TBD)<br>• Ensures that risks to implementation are identified and effectively managed<br>• Ensures that the programme engages effectively with all necessary stakeholder groups in the development of proposals, including championing the programme acro**ss** Kent and Medway | Monthly | Joint Chairs: one CCG Clinical Chair and one LMC Member | CCG, LMC, GP Federations, PCCCs, mental health, PPAG, NHSE |
| System Commissioner / Future Functions Working Group and work streams | Reports to System Commissioner Steering Group<br><br>Responsible for developing and overseeing implementation of future system commissioner functions. | Monthly | System commissioner lead director | CCG Senior Managers and Subject Matter Experts<br><br>SC Programme Director to chair |

| | | | | |
|---|---|---|---|---|
| | 10 x cross cutting work streams:<br>• Commissioning<br>• Primary Care<br>• Comms and Engagement<br>• Contracting, performance management and business intelligence<br>• Corporate Services/Governance<br>• Digital<br>• Finance<br>• HR and Workforce and OD<br>• Quality and Safety, safeguarding and CHC<br>• population health management | | | work stream groups as appropriate |

## 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.

| **Cross cutting workstream** | **ICS / SC / ICP / PCN** | **Lead** | **Deliverables** |
|---|---|---|---|
| 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<br>• Develop a programme that guides leadership development of ICPs and PCNs with a focus on population health (at all management and clinical levels)<br>• Develop the OD programme for the ICS (all components) that promotes learning organisations / collaborations and recognises the evolutionary nature of system transformation<br>• Design of the human resources function across the system<br>• 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*<br>• Identify areas of commissioning that need to be undertaken jointly between health and local authorities (public health and social care) |

| | | | |
|---|---|---|---|
| | | Kent | • Identify mechanisms for health and social care integrations and resource implications |
| Finance (via the existing K&M Finance Group) | SC | Reg Middleton, WK Director of Finance | • Description of commissioning functions in each part of the new system model*<br>• Development of capitated (or other) budgetary framework<br>• Framework that incentivises collaboration and is outcome focused with a shift to improving population health outcomes and improving inequalities (including to support benefits realisation) |
| Business Intelligence / Population segmentation / population health management / Health needs assessment | ICS / SC / ICP / PCN | Ivor Duffy, EK Director of Finance | • Develop needs assessment framework, including identifying wider determinants of health<br>• Launch the analytics strategy and put in place resourcing and governance to ensure delivery<br>• Describe and make available population down to PCN level<br>• Define relationship and put on a more formal basis relationship between SC and HWBBs<br>• Define outcomes based on identified priorities, including emphasising prevention and health inequalities<br>• outcomes framework (including to support benefits realisation) |
| Digital | ICS / SC / ICP / PCN | Andrew Brownless, Chief Information Officer | • Digital strategy<br>• Network model<br>• Identify core systems / Integration / standardisation of core systems<br>• At individual practitioner level provide tools to risk stratify and cohort patients<br>• Link with Local Authorities digital strategies to create an integrated approach<br>• Digital innovation approach through Innovation Collaborative |
| Communications and engagement | ICS / SC / ICP / PCN | Julia Rogers, K&M Director of Communications and Engagement | • System Transformation Communications and Engagement Plan including proactive approach to engagement with key audiences and stakeholders<br>• Reactive responses against plan to media enquiries<br>• Staff and stakeholder briefings<br>• Design and implement effective strategic and operational communications and engagement function across the system (including co-production)<br>• Working with the existing Patient and Public Advisory |

| | | | |
|---|---|---|---|
| | | | Group to co-design the new model of patient engagement across all levels of the future system architecture. |
| Contracts | ICS / SC / ICP / PCN | TBC | • Development of outcome-based contracts, including performance management and escalation framework<br>• 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 |
| Corporate services | ICS / SC / ICP / PCN | Mike Gilbert, STP / DGS CCG, Director of Corporate Services | • Describe corporate risk identification and escalation process<br>• Indemnity framework, recognising the collaborative framework in which ICPs and PCNs will operate |
| Quality and safety | ICS / SC / ICP / PCN | Paula Wilkins, Director of Nursing, West Kent / Sarah Vaux, Director of Nursing, East Kent | • Best practice framework – process that drives optimum and innovative outcomes<br>• Quality framework, including metrics and governance structure for oversight and route for clinical risk identification and risk escalation |
| System functions | ICS / SC | Michael Ridgwell, STP Deputy CEO | • Planning (including major service reconfigurations)<br>• Resilience<br>• Performance / assurance (including in relations to effectiveness of outcomes-based commissioning, and oversight of the best value test)<br>• Assurance and license of system commissioner, ICPs and other constituent bodies<br>• Service / System Improvement<br>• 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:

| Role | Responsibility |
|---|---|
| Senior sponsor | 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. |
| Project Lead | Responsible for the day-to-day delivery of their core constituent project or work area they are |

| | |
|---|---|
| Director | supporting, including achievement of key deliverables within the specified timeline |
| ICP GP Lead | 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. |
| ICP non-executive lead | 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. |
| Workstream Lead | 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. |

## 3.5 Key roles

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

| Role | Lead |
|---|---|
| Overall senior sponsor for System Transformation Programme | • Glenn Douglas, STP Chief Executive / CCG Accountable Officer |
| System Commissioner (including interim CCG operating model) | • Senior sponsor: Dr Bob Bowes, Clinical Chair, WK CCG<br>• Project Lead Director: Simon Perks, Director of System Transformation |
| West Kent ICP | • Senior sponsor: Miles Scott, Chief Executive, Maidstone and Tunbridge Wells NHS Trust<br>• ICP GP lead: Dr Sanjay Singh<br>• ICP non-executive lead: John Goulston, Chairman, Kent Community Health NHS Foundation Trust<br>• 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<br>• ICP GP lead: Dr Sadia Rashid<br>• ICP non-executive lead: Stephen Smith, Chairman, East Kent Hospitals University NHS Trust<br>• Project lead director: Tbc |
| North Kent ICP | • Senior sponsor: Louise Ashley, Chief Executive, Dartford, Gravesham and Swanley NHS Foundation Trust<br>• ICP GP lead: Tbc<br>• ICP non-executive lead: Tbc<br>• 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<br>• ICP non-executive lead: Tbc<br>• 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<br>• 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):

| **Milestone or Phase** | **Date** |
|---|---|
| All PCNs submit registration information to CCGs | May 2019 |
| Outline support from CCGs to continue to proceed with the establishment of a single CCG as the vehicle for the system commissioner | May 2019 |
| Establish leadership arrangements in transition for the four integrated care partnerships | May 2019 |
| Integrated care partnerships outline development plans in place | May 2019 |
| CCGs confirm PCN coverage and approve GMS/APMS/PMS contract variations | May 2019 |
| Governing Bodies agree Statement of Intent / outline application for CCG merger - to be submitted to NHSE Region for initial review | July 2019 |
| 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 at 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 | January 2020 |

| | |
|---|---|
| change submitted | |
| New system commissioner arrangements come into force | April 2020 |
| National primary care network services start | April 2020 |

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.

| Role | Description | Resource |
|---|---|---|
| Clinical Chair (Bob Bowes, Clinical Chair, West Kent CCG) | Provides clinical leadership, direction and mentorship across the whole programme (including chairing the System Commissioner Steering Group). | Existing CCG<br>0.4 wte |

| | | |
|---|---|---|
| Project Lead Director (Simon Perks, System Commissioner ) | 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. | Existing CCG<br>1 wte |
| Mike Gilbert, Director of Corporate Services | 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 | Existing CCG<br>0.7 wte |
| 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:<br>• 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.<br>• 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.<br>• 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<br>1 x AfC7<br>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<br>- Finance<br>- Digital<br>- Workforce / human resources<br>- Communications and engagement<br>- Business management support<br>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:

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

b. 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:

| **Objective** | **Benefit** (note this is not an exhaustive list and will be updated as the programme progresses) | **Beneficiary** | **Measured through** |
|---|---|---|---|
| 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)<br>• Improved performance against NHS Constitution targets<br>• Improved performance against NHS Long Term Plan priorities (recognising these include indicators within the JSNA and NHS Constitution target)<br>• 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<br>• Financial performance within the agreed system control total<br>• Development of new workforce models to:<br>- address workforce shortages<br>- meet increasing demand<br>- support staff<br>- support service innovations | Organisations<br>Patients and public<br>Staff | Outcomes frameworks to be delivered in relation to:<br>• Finance (as part of the long term plan)<br>• Patient experience<br>• 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:

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

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:

**Risk score = Impact x Likelihood**

| | Likelihood | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Impact | Rare | Unlikely | Possible | Likely | Almost certain |
| 5 Catastrophic | 5 | 10 | 15 | 20 | 25 |
| 4 Major | 4 | 8 | 12 | 16 | 20 |
| 3 Moderate | 3 | 6 | 9 | 12 | 15 |
| 2 Minor | 2 | 4 | 6 | 8 | 10 |
| 1 Negligible | 1 | 2 | 3 | 4 | 5 |

**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.

| Risk | Mitigation |
|---|---|
| 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.<br><br>Robust communications and engagement with key stakeholders – members, governing bodies, provider boards, primary care etc. Development of narrative with consistent messages and tangible benefits<br><br>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 |

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

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

# 8 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:

| **Key audience/stakeholder group** | **Rationale for engagement** |
|---|---|
| Patients and the public | 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 |

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| | 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.<br><br>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.<br><br>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'.<br><br>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.<br><br>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.<br><br>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.<br><br>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. |

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| 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;

| ORGANISATION | ROLES | KEY ROLES FILLED BY |
|---|---|---|
| PPAG and local patient groups | STP Programme Board<br>Non-Executive Director (NED) Oversight Group<br>System Commissioner Steering Group Members<br>Joint Committees<br>Clinical and Professional Board<br>East Kent ICP<br>West Kent ICP<br>DGS ICP<br>Medway / Swale ICP | Nominated PPAG representatives |
| Dartford and Gravesham NHS Trust | STP Partnership Board<br><br>DGS ICP<br><br>Clinical and Professional Board | CEO<br><br>Director of Transformation<br><br>Trust Medical Director |
| East Kent Hospitals University NHS Foundation Trust | STP Partnership Board<br><br>East Kent ICP<br><br>Clinical and Professional Board | CEO<br><br>Trust Chair<br><br>Trust Medical Director |
| Kent County Council | STP Partnership Board<br><br><br><br><br><br>System Commissioner Steering Group | Leader of the Council<br>Cabinet Member for Social Care and Public Health<br>Corporate Director Adult Social Care and Health<br>Director of Public Health<br><br>Corporate Director Adult Social Care and Health<br>Director Strategic Commissioning |

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| | Clinical and Professional Board<br><br>Non-Executive Director (NED) Oversight Group<br><br>Population Health Outcomes, Case for Change (JSNA) and Prevention workstream | Directors of Partnerships, Adult Social Care and Health Corporate Director Elected Member of the Council<br><br>Director Public Health and Deputy Director Public Health |
| Kent and Medway CCGs | STP Programme Board<br><br>Non-Executive Director (NED) Oversight Group<br><br>System Commissioner Steering Group Members<br><br>System Commissioner Governance Oversight Group<br><br>Joint Committees<br><br>Clinical and Professional Board<br><br>East Kent ICP<br>West Kent ICP<br>DGS ICP<br>Medway / Swale ICP | AO, MDs (Members)<br><br>2 x Independent Members<br><br>CCG Chaired, 8 x CCG Clinical Chairs, 3 x Independent Members, AO and MDs<br>CCG Chaired, 8 x CCG Lay Members for Governance<br><br>CCG Chaired, 8 x CCG Clinical Chairs, AO, MDs and other CCG Governing Body Members<br><br>CCG Joint Chaired, 8 x CCG Clinical Chairs<br><br>CCG Joint Chaired, 8 x CCG Clinical Chairs<br><br>GP Representative<br>GP Representative<br>GP Representative<br>GP Representative |
| Kent and Medway Community NHS Foundation Trust | STP Partnership Board<br><br>East Kent ICP<br><br>West Kent ICP<br><br>Clinical and Professional Board | CEO<br><br>CEO<br><br>Trust Chair<br><br>Trust Medical Director |
| Kent and Medway NHS and Social Care Partnership Trust | STP Partnership Board<br><br>Clinical and Professional Board<br><br>Non-Executive Director (NED) Oversight Group | CEO<br><br>Trust Medical Director<br><br>Chair – Trust Chair |
| Kent and Medway Sustainability and Transformation Partnership | STP Partnership Board<br><br>System Transformation Executive Steering Group | Chair - STP CEO<br><br>Chair STP CEO/AO |

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| | Non-Executive Director (NED) Oversight Group<br><br>CCGs Joint Committee | STP CEO<br><br>STP Deputy CEO |
| Maidstone and Tunbridge Wells NHS Trust | STP Partnership Board<br><br>West Kent ICP<br><br>Clinical and Professional Board<br><br>Non-Executive Director (NED) Oversight Group | CEO<br><br>CEO<br><br>Trust Medical Director<br><br>Trust Chair |
| Medway Local Authority | STP Partnership Board<br><br>Medway and Swale ICP<br><br>Clinical and Professional Board<br><br>Non-Executive Director (NED) Oversight Group | Leader of the Council<br><br>Tbc<br><br>Tbc<br><br>Elected Member of the Council |
| Medway NHS Foundation Trust | STP Partnership Board<br><br>Medway & Swale ICP<br><br>Clinical and Professional Board | CEO<br><br>Director of Strategy<br><br>Joint Chair - Trust Medical Director |
| NHS England / Improvement | STP Partnership Board<br><br>CCGs Joint Committee | Dir of Strategy and Partnerships<br><br>NHSE Rep and Specialist Commissioning Rep |
| South East Coast Ambulance NHS Foundation Trust | STP Partnership Board<br><br>Clinical and Professional Board | CEO<br><br>Trust Medical Director |
| Medway Community Healthcare | STP Partnership Board<br><br>Medway ICP<br><br>Clinical and Professional Board | CEO<br><br>CEO<br><br>MD |
| Virgin Healthcare | North Kent ICP | Tbc |
| 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:

| Tool | Frequency | Responsible | Audience |
|---|---|---|---|
| Meeting minutes | Every decision making meeting | Meeting Lead | Working group members |
| Newsletters | Monthly | Communications and engagement | All stakeholders |
| Meeting Packs | Monthly | Meeting Lead | Steering Committee members |
| CCG AO report | Monthly | Meeting Lead | CCG Governing Bodies and members |
| **Existing channels/tools/activity** | | | |
| Web – partner organisations websites and the well-established STP website. | Ongoing – scheduled activity in response to specific announcements, plans and on a reactive basis. | Communications and engagement | All stakeholders – we aim to publish as much material as possible on out 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. |
| 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. | Ongoing – scheduled activity in response to specific announcements, plans and on a reactive basis. | Communications and engagement | 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. |
| STP stakeholder Bulletin | Monthly | CCGs | 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. |

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| CCG websites and social media channels | Ongoing – scheduled activity in response to specific announcements, plans and on a reactive basis. | CCGs | All stakeholders. |
| Local and trade media | Ongoing – scheduled activity in response to specific announcements, plans and on a reactive basis. | Communications and engagement | 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.<br>We will also continue to seek opportunities for proactive work with trade and professional media outlets (HSJ, Municipal Journal, Pulse etc). |
| Face to face briefings and meetings within individual organisations | Tbc | Programme team and communications and engagement | Staff – we will harness established meetings and briefing sessions to engage with staff about developing plans. |
| Development and implementation of new visual identity to support ICS | In development | Communications and engagement | All stakeholders – although recommend that implementation is low key |
| Ensure that key messages are included in communications and engagement work relating to the 19/20 Operational Plan and five year plan engagement | Ongoing | Communications and engagement | All stakeholders as appropriate. |
| Development of FAQs for different stakeholder audiences | Ongoing | Communications and engagement with input from programme team | All stakeholders as appropriate. |
| Briefing materials including PowerPoint slides, core content and graphics, targeted updates for different stakeholder groups | Ongoing | Communications and engagement with input from programme team | All stakeholders as appropriate. |
| **Potential new channels/tools/activity** | | | |

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| 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 | | | |
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| Name: | | Date: | |
| Signature: | | | |

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

| NAME OF ORGANISATION: Dartford, Gravesham and Swanley CCG | | | |
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| Name: | | Date: | |
| Signature: | | | |

| NAME OF ORGANISATION: Dartford and Gravesham NHS Trust | | | |
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| Name: | | Date: | |
| Signature: | | | |

| NAME OF ORGANISATION: East Kent Hospitals University NHS Foundation Trust | | | |
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| Name: | | Date: | |
| Signature: | | | |

| NAME OF ORGANISATION: Kent Community Healthcare Foundation Trust | | | |
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| Name: | | Date: | |
| Signature: | | | |

| NAME OF ORGANISATION: Kent County Council | | | |
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| Name: | | Date: | |
| Signature: | | | |

| NAME OF ORGANISATION: Kent Community Healthcare Foundation Trust | | | |
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| Name: | | Date: | |
| Signature: | | | |

| NAME OF ORGANISATION: Kent and Medway NHS and Social Care Partnership Trust | | | |
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| Name: | | Date: | |
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| NAME OF ORGANISATION: Maidstone and Tunbridge Wells NHS Trust | | | |
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| NAME OF ORGANISATION: Medway Community Healthcare | | | |
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| NAME OF ORGANISATION: Medway CCG | | | |
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| NAME OF ORGANISATION: Medway Council | | | |
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| NAME OF ORGANISATION: Medway Foundation NHS Trust | | | |
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| Name: | | Date: | |
| Signature: | | | |

| NAME OF ORGANISATION: South East Coast Ambulance Service NHS Foundation Trust | | | |
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| Name: | | Date: | |
| Signature: | | | |

| NAME OF ORGANISATION: South Kent Coast CCG | | | |
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| Name: | | Date: | |
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| NAME OF ORGANISATION: Swale CCG | | | |
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| Name: | | Date: | |
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| NAME OF ORGANISATION: Thanet CCG | | | |
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| Name: | | Date: | |
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| NAME OF ORGANISATION: West Kent CCG | | | |
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