



Date: **5 August 2019**
Our ref: **H&W Cabinet Advisory Group/Agenda**
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HEALTH & WELLBEING CABINET ADVISORY GROUP

14 AUGUST 2019

A meeting of the Health & Wellbeing Cabinet Advisory Group will be held at **12.00 pm on Wednesday, 14 August 2019** in the Business Suite, 1st Floor, Council Offices.

Membership:

Councillors: Game, Farrance, Gregory, Boyd, S Piper and Parsons

AGENDA

Item
No

Subject

1. **ELECTION OF CHAIRMAN**
2. **APOLOGIES FOR ABSENCE**
3. **DECLARATION OF INTERESTS** (Pages 3 - 4)
To receive any declarations of interest. Members are advised to consider the advice contained within the Declaration of Interest advice attached to this Agenda. If a Member declares an interest, they should complete the [Declaration of Interest Form](#)
4. **TERMS OF REFERENCE** (Pages 5 - 10)
5. **CONSULTATION - HELPING LOCAL PEOPLE LIVE THEIR BEST LIFE** (Pages 11 - 66)
[Click here](#) to access the consultation webpage.
6. **MINUTES OF THE HEALTH & WELLBEING PARTNERSHIP** (Pages 67 - 72)
7. **EAST KENT PARTNERSHIP - UPDATE**



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Do I have a Disclosable Pecuniary Interest and if so what action should I take?

Your Disclosable Pecuniary Interests (DPI) are those interests that are, or should be, listed on your Register of Interest Form.

If you are at a meeting and the subject relating to one of your DPIs is to be discussed, in so far as you are aware of the DPI, you **must** declare the existence **and** explain the nature of the DPI during the declarations of interest agenda item, at the commencement of the item under discussion, or when the interest has become apparent

Once you have declared that you have a DPI (unless you have been granted a dispensation by the Standards Committee or the Monitoring Officer, for which you will have applied to the Monitoring Officer prior to the meeting) you **must**:-

1. Not speak or vote on the matter;
2. Withdraw from the meeting room during the consideration of the matter;
3. Not seek to improperly influence the decision on the matter.

Do I have a significant interest and if so what action should I take?

A significant interest is an interest (other than a DPI or an interest in an Authority Function) which:

1. Affects the financial position of yourself and/or an associated person; or
Relates to the determination of your application for any approval, consent, licence, permission or registration made by, or on your behalf of, you and/or an associated person;
2. And which, in either case, a member of the public with knowledge of the relevant facts would reasonably regard as being so significant that it is likely to prejudice your judgment of the public interest.

An associated person is defined as:

- A family member or any other person with whom you have a close association, including your spouse, civil partner, or somebody with whom you are living as a husband or wife, or as if you are civil partners; or
- Any person or body who employs or has appointed such persons, any firm in which they are a partner, or any company of which they are directors; or
- Any person or body in whom such persons have a beneficial interest in a class of securities exceeding the nominal value of £25,000;
- Any body of which you are in a position of general control or management and to which you are appointed or nominated by the Authority; or
- any body in respect of which you are in a position of general control or management and which:
 - exercises functions of a public nature; or
 - is directed to charitable purposes; or
 - has as its principal purpose or one of its principal purposes the influence of public opinion or policy (including any political party or trade union)

An Authority Function is defined as: -

- Housing - where you are a tenant of the Council provided that those functions do not relate particularly to your tenancy or lease; or
- Any allowance, payment or indemnity given to members of the Council;
- Any ceremonial honour given to members of the Council
- Setting the Council Tax or a precept under the Local Government Finance Act 1992



If you are at a meeting and you think that you have a significant interest then you **must** declare the existence **and** nature of the significant interest at the commencement of the matter, or when the interest has become apparent, or the declarations of interest agenda item.

Once you have declared that you have a significant interest (unless you have been granted a dispensation by the Standards Committee or the Monitoring Officer, for which you will have applied to the Monitoring Officer prior to the meeting) you **must:-**

1. Not speak or vote (unless the public have speaking rights, or you are present to make representations, answer questions or to give evidence relating to the business being discussed in which case you can speak only)
2. Withdraw from the meeting during consideration of the matter or immediately after speaking.
3. Not seek to improperly influence the decision.

Gifts, Benefits and Hospitality

Councillors must declare at meetings any gift, benefit or hospitality with an estimated value (or cumulative value if a series of gifts etc.) of £25 or more. You **must**, at the commencement of the meeting or when the interest becomes apparent, disclose the existence and nature of the gift, benefit or hospitality, the identity of the donor and how the business under consideration relates to that person or body. However you can stay in the meeting unless it constitutes a significant interest, in which case it should be declared as outlined above.

What if I am unsure?

If you are in any doubt, Members are strongly advised to seek advice from the Monitoring Officer or the Committee Services Manager well in advance of the meeting.

If you need to declare an interest then please complete the declaration of [interest form](#).

Health & Wellbeing Cabinet Advisory Group - Terms of Reference for 2019/20

Health & Wellbeing Cabinet Advisory Group **14 August 2019**

Report Author **Senior Democratic Services Officer**

Portfolio Holder **Cllr Game, Cabinet Member for Housing & Safer Neighbourhoods**

Status **For Recommendation**

Classification: **Unrestricted**

Key Decision **No**

Ward: **District Wide**

Executive Summary:

The purpose of the report is to introduce and seek Members' views on the terms of reference that were assigned to the Health & Wellbeing Cabinet Advisory Group which are detailed in Annex 1 to the report.

Recommendation(s):

Members' guidance is sought regarding suggestions for amendments to the terms of reference highlighted in Annex 1 to the report.

CORPORATE IMPLICATIONS

Financial and Value for Money	There are no financial implications arising directly from this report
Legal	The cabinet advisory group was set up to consider health and wellbeing issues affecting communities in Thanet area and make recommendations for consideration by the Executive. Cabinet and Leader of Council are entitled to seek advice from amongst fellow councillors on any issues that fall within the executive functions.
Corporate	There are no corporate risks associated with this report. The practice of seeking for suggestions from peers who are not part of the executive is good practice as it contributes to informed policy development.
Equality Act 2010 & Public Sector Equality Duty	Members are reminded of the requirement, under the Public Sector Equality Duty (section 149 of the Equality Act 2010) to have due regard to the aims of the Duty at the time the decision is taken. The aims of the Duty are: (i) eliminate unlawful discrimination, harassment, victimisation and other conduct prohibited by the Act, (ii) advance equality of opportunity between people who share a protected characteristic and people who do not share it, and (iii) foster good relations between people who share a protected characteristic and people who do not share it.

	<p>Protected characteristics: age, sex, disability, race, sexual orientation, gender reassignment, religion or belief and pregnancy & maternity. Only aim (i) of the Duty applies to Marriage & civil partnership.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">Please indicate which aim is relevant to the report.</td> </tr> <tr> <td>Eliminate unlawful discrimination, harassment, victimisation and other conduct prohibited by the Act,</td> <td style="text-align: center;">✓</td> </tr> <tr> <td>Advance equality of opportunity between people who share a protected characteristic and people who do not share it</td> <td style="text-align: center;">✓</td> </tr> <tr> <td>Foster good relations between people who share a protected characteristic and people who do not share it.</td> <td style="text-align: center;">✓</td> </tr> </table> <p>The report seeks to provide a clearer framework to guide the work of the cabinet advisory group. The group was assigned to investigate key issues affecting the health and wellbeing of the communities in the district.</p> <p>In carrying out its work the group would be mindful of the need to comply with the provisions of the Equality Act 2010 & Public Sector Equality Duty.</p>	Please indicate which aim is relevant to the report.		Eliminate unlawful discrimination, harassment, victimisation and other conduct prohibited by the Act,	✓	Advance equality of opportunity between people who share a protected characteristic and people who do not share it	✓	Foster good relations between people who share a protected characteristic and people who do not share it.	✓
Please indicate which aim is relevant to the report.									
Eliminate unlawful discrimination, harassment, victimisation and other conduct prohibited by the Act,	✓								
Advance equality of opportunity between people who share a protected characteristic and people who do not share it	✓								
Foster good relations between people who share a protected characteristic and people who do not share it.	✓								

CORPORATE PRIORITIES (tick those relevant) ✓	
A clean and welcoming Environment	✓
Promoting inward investment and job creation	
Supporting neighbourhoods	✓

CORPORATE VALUES (tick those relevant) ✓	
Delivering value for money	
Supporting the Workforce	
Promoting open communications	✓

1.0 Introduction and Background

- 1.1 The Leader of Council set up a cabinet advisory group through an individual cabinet member decision published on 27 February 2019.
- 1.2 This group was tasked with investigating certain matters relating to the health and wellbeing of communities in the district as set out in the terms of reference that were published as part of the decision notice.

2.0 The Current Situation

- 2.1 In this report, Members are requested to consider these terms of reference and suggest amendments.

3.0 Options

- 3.1 Members could choose to suggest changes to the current terms of reference highlighted in Annex 1 to the report;

or

- 3.2 The group could opt not to make any amendments to the terms of reference.

4.0 Next Steps

- 4.1 If Members of the cabinet advisory group propose amendments to the terms of reference detailed in Annex 1, such recommendations will need to be forwarded to the Leader of Council for consideration and consent.

Contact Officer:	Charles Hungwe, Senior Democratic Services Officer
Reporting to:	Nick Hughes, Committee Services Manager

Annex List

Annex 1	Health & Wellbeing Cabinet Advisory Group Terms of Reference
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Background Papers

Title	Details of where to access copy
None	N/A

Corporate Consultation

Finance	Matt Sanham, Financial Services Manager
Legal	Colin Evans, Senior Litigation Lawyer

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HEALTH & WELLBEING CABINET ADVISORY GROUP TERMS OF REFERENCE FOR 2019/20

General

A task group of Cabinet is being established to review certain matters relating to the health and wellbeing of the communities in the district.

Membership, Chairmanship and Quorum

Number of Members	Six
Political Composition	3 Conservative; 2 Labour; 1 Thanet Independents.
Co-optees	1 Thanet Health & Wellbeing Partnership member
Substitute Members Permitted	No
Political Balance Rules apply	No
Appointments/Removals from Office	By Cabinet Member for Housing & Safer Neighbourhoods/Leader of Council
Restrictions on Membership	None
Restrictions on Chairmanship	None
Quorum	Three
Number of ordinary meetings per Council Year	Meetings will be called as required

Terms of Reference

1. To have oversight of the Active Thanet Programme;
2. To provide Cabinet with a view on the community impact of major health service change proposals in East Kent;
3. To receive a quarterly update from East Kent Public Health;
4. To receive updates on the progress of the establishment of an East Kent Health and Wellbeing structure.

General

The work of the CAG is restricted to the stated terms of reference highlighted above unless they are reviewed by the Leader.

Notes

This Cabinet Advisory Group was established through terms of reference approved by an Individual Cabinet Member decision made by the Leader of Council on 26 February 2019.

Helping local people live their best life

Improving health and care
in Kent and Medway



Introduction

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

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

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

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

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

Let's
start
well

Where are we starting from?

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

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

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



Why do things need to change?

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

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

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

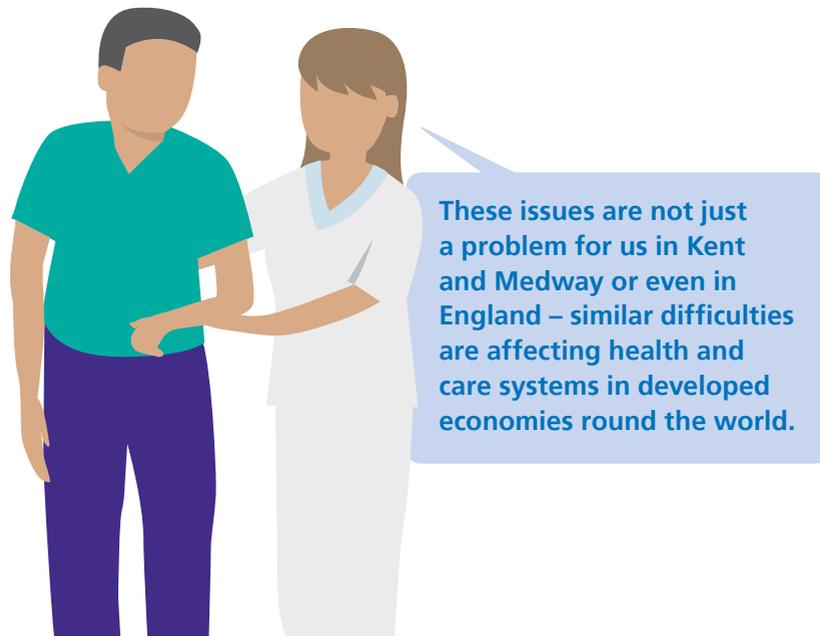
Different health and care organisations have lots of competing priorities, which can sometimes stop them working together in the wider interest of patients.

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

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

Other issues faced by health and care services are:

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



What is the plan?

our local plan



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

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

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

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

What difference will it make?

For people living in Kent and Medway it will mean:



- more support to stay fit and well before things become a problem – including active reminders sent direct to you, and clinical initiatives to, for instance, identify people at higher risk of a stroke
- better access to the care you need, when you need it, in a way that suits you – whether that's in the evenings or at weekends, over the phone, by video link or a standard face-to-face appointment, with a physiotherapist, nurse, clinical pharmacist, GP, or support from a non-medical service
- more focus on your physical AND mental health and wellbeing, recognising that people have different personal aims and needs – we'll respond to what matters to you, not the condition or disease that you may have
- more care out of hospital, with staff working together as a single team to plan and support people with complex health and care needs stay as well as possible and get the care they need when they need it
- better identification of the issues that need tackling and a real focus on quality services, wherever they are provided.

For staff it will mean:

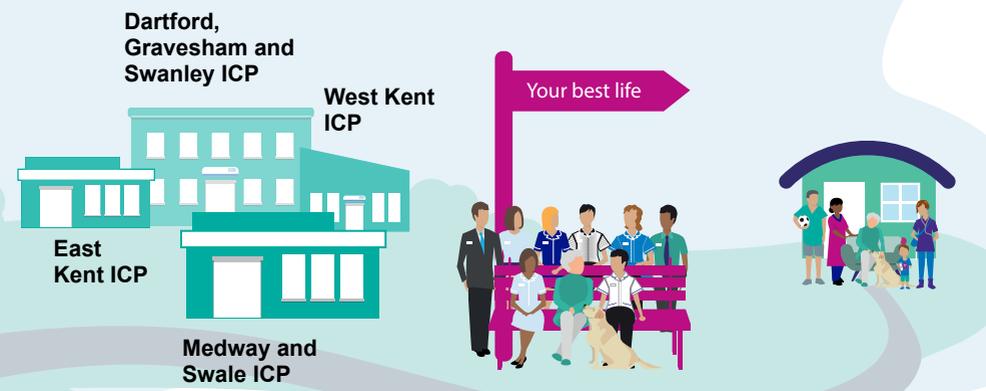


- making a bigger difference to local people – something we all strive to do
- higher job satisfaction and better work/life balance with each professional able to focus on what they do best
- greater resilience for teams and individuals supporting each other
- greater influence on how resources are used to best effect for patients.

How our new system will help you **live** your best **life**



Everyone involved in health and social care will be working together in different, more joined-up ways. From family doctors, to mental health staff, community teams and our major hospitals, we're going to be pooling our resources, skills and expertise to make care and support better for our residents.



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While some of the details of how the new arrangements will work are still being developed, the basics are set out here.

Integrated care system

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

Single clinical commissioning group

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

Four integrated care partnerships (ICP)

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

Primary care networks (PCN)

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

Keeping our population in good health

The new system will support 1.8 million people across Kent and Medway to get better joined-up care and to stay well.

Agenda Item 5

Primary care networks

To improve care for patients, GP practices have been working together and with other teams in local networks across Kent and Medway.

This means patients can access a greater variety of services through their GP practice, sometimes needing to visit other surgeries within their network.

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

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

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

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



Dr Faye Hinsley

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

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

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

"In time, we will be able to partner directly with mental health support providers so that counselling is easier to access. We will be able to bring in nurses with specialist expertise and create opportunities for integrated volunteer support. In this way, the whole community will be able support the health and wellbeing of children and adults."

It's not always about the GP

Not everyone who phones a GP practice for an appointment needs to see a GP.

About 30 per cent of requests are to do with back, neck or joint pain, which might be better seen by a physiotherapist with enhanced skills who can assess and advise you.

Pharmacists can also provide advice and medication for minor ailments.

You might also be seen by a health care assistant, nurse, or stop smoking advisor, for example, depending on what care or advice you need.

The whole you

Sometimes people's health can be best helped by services which are not part of traditional health and social care, such as community groups, or advisors. When GPs or other healthcare professionals refer people to non-medical services, supported by a link worker, this is called 'social prescribing'. It takes care of the whole you.

Integrated care partnerships

One of the common problems people face is dealing with lots of different services provided by different organisations that don't always talk to each other well. It's frustrating for patients, carers and staff, in fact, for all of us.

To solve this, we're creating **integrated care partnerships (ICPs)**, bringing together all the different

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

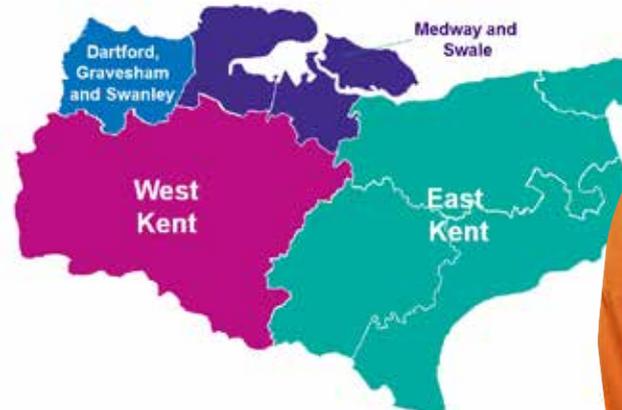
We're in the early stages of working out what our four integrated care partnership will look like and what their role will be but we expect ICPs to:

- free up staff to work in teams based on skills and patient needs, regardless of who they work for (children and young people, and people with long term conditions particularly benefit)
- help local people to support their health and wellbeing, focusing on the areas with greatest need
- reduce unacceptable differences in health and life expectancy by tailoring help to different communities in the way they need support (such as people with severe and enduring mental illness)

- design and deliver the best services to meet the needs of everyone they serve, within the funding available
- achieve the best value for money.

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

We're proposing four integrated care partnerships from April 2020 based on how patients use hospital services: one each for east Kent; Dartford, Gravesham and Swanley; Medway and Swale; and west Kent.



A single clinical commissioning group for Kent and Medway

At the moment, we have eight clinical commissioning groups (CCGs) across Kent and Medway. They are responsible for spending the health budget to meet local people's needs.

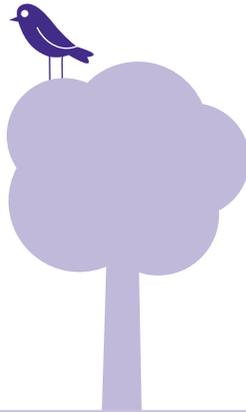
This can mean variation in the services provided across the county and the effect on people's health can be different. Sometimes, this is a good thing, because different populations need different services, but it doesn't always work well and it can lead to increases in health inequalities and differences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

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

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

A Kent and Medway commissioning organisation would take a bird's eye view of challenges across the county and commission some services such as cancer, mental health, children's services and prevention. It would assess the needs of our population and define what the integrated care partnerships must achieve to meet those needs.

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



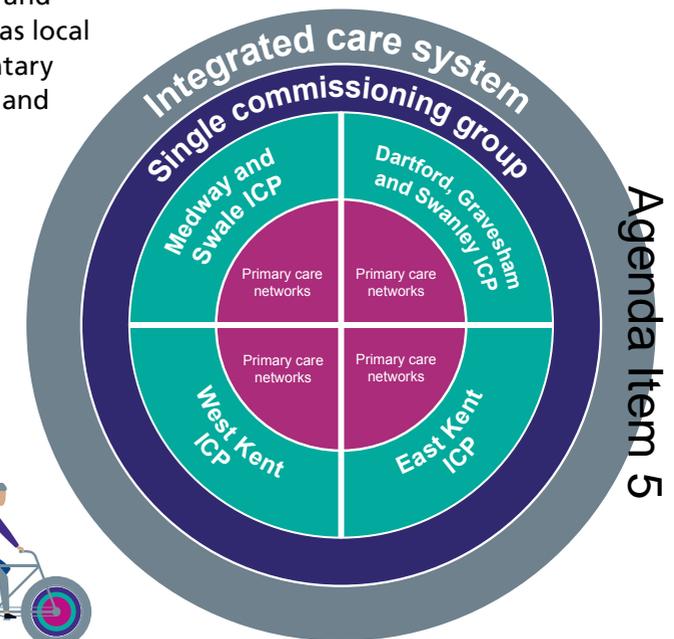
The Kent and Medway integrated care system

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

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

- patient and public representatives so patients help to shape their NHS in the new arrangements
- a clinical and professional board to provide clinical leadership
- formal partnership arrangements with elected members of local authorities through Health and Wellbeing Boards and Health Overview and Scrutiny Committees.

- a partnership board, representing commissioners and providers from across the health and care spectrum, as well as local government, the voluntary and community sector and other stakeholders



What's next?

Over the coming months we will be:

- continuing to develop our plans for the new system including talking to GPs, staff, patients, local authorities, provider trusts, and our independent patient champions Healthwatch Kent and Healthwatch Medway
- launching our people strategy, which sets out how we will support our existing staff and look at ways to attract more health and care professionals to our area
- publishing a five year plan for our area – paying particular attention to children's services, mental health and cancer
- publishing our primary care strategy – which sets out how we will support GPs across Kent and Medway to become networks of practices.



Have your say



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

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

1. Have we explained these plans clearly?

- | | |
|--|---|
| <input type="checkbox"/> Yes it's very clear | <input type="checkbox"/> It could be better explained |
| <input type="checkbox"/> It's fairly clear | <input type="checkbox"/> I don't understand |
| <input type="checkbox"/> Not sure | |

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

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

4. What concerns do you have about the changes?

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



About you

How would you describe your gender?

- Male Female
Other Prefer not to say

What is your date of birth?

____ / ____ / ____

Do you consider yourself to have a disability or long-term health condition?

(e.g. diabetes, asthma, epilepsy, mental health condition)

- Yes No Prefer not to say

How would you describe your ethnicity?

- | | |
|---|---|
| <input type="checkbox"/> White British | <input type="checkbox"/> Any other Asian background
(Please specify below) |
| <input type="checkbox"/> White Irish | <input type="checkbox"/> Black or Black British Caribbean |
| <input type="checkbox"/> Any other White background
(Please specify below) | <input type="checkbox"/> Black or Black British African |
| <input type="checkbox"/> Mixed White and Black Caribbean | <input type="checkbox"/> Any other Black Background |
| <input type="checkbox"/> Mixed White and Black African | <input type="checkbox"/> (Please specify below) |
| <input type="checkbox"/> Mixed White Asian | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Any other mixed background
(Please specify below) | Any other ethnic group
(please specify) |
| <input type="checkbox"/> Asian or Asian British Indian | <input type="checkbox"/> Prefer not to say |
| <input type="checkbox"/> Asian or Asian British Pakistani | |
| <input type="checkbox"/> Asian or Asian British | |
| <input type="checkbox"/> Bangladeshi | |

Send this page to:

Freepost KENT & MEDWAY
NHS, New Hythe Lane,
Aylesford, Kent ME20 6WT

Alternatively, you can fill in our survey online at www.kentandmedway.nhs.uk/ics or email us at comms.kentandmedway@nhs.net

The deadline for responses is Friday, 16 August.

What town/city do you live in?

Frequently asked questions

Does this mean that local practices will close and people will be forced to travel long distances to big 'hubs' to seek advice and care?

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

How will ICPs work across Kent and Medway?

ICPs are alliances of health and care organisations who will

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

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

When will the ICS come into being?

We will be working as an ICS by April 2021 although we anticipate much closer working across the health and care system in advance of that date, with a single CCG being established as part of this from April 2020.

You can read more frequently asked questions on our website at www.kentandmedway.nhs.uk/ics



Our vision is for everyone in Kent and Medway to have a great quality of life by giving them high-quality care.

Quality of life, quality of care

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**Kent and Medway
System Transformation Programme**

Programme Initiation Document (PID)

24/06/19

Document Control

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0.9	24/06/19	Draft	M. Ridgwell / I. Chana	Final review following STP Programme Board

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.

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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

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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 be 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. The development of a range of expected outcomes for health and social care in order to move away from activity based accounting
- vi. Identification of current commissioning functions and an outline assessment of where these will be delivered within the future system architecture
- vii. A robust communications and engagement plan (covering all key stakeholders but particularly NHS boards, CCG governing bodies, GP member practices and local authorities)
- viii. Development of the draft constitution
- ix. A review of resource allocation to address inequalities and the wider determinants of health

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 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 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 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: <ul style="list-style-type: none"> • 2 x Programme Manager (Band 8a). Responsible for day to day co-ordination of the underpinning work streams, programme reporting, over-sight of programme risk management and co-ordination of core programme resourcing. • Business Support Manager – 1 wte (Band 7). Day to day support to System Commissioner Programme. The BSO will provide support to ensuring the programme's rigour, through monitoring and reporting of progress and overseeing all aspects of business support. • Administrative support – 1 wte (band 4). Provides dedicated day to day support of system commissioner programme including formal and informal reporting, diary management and support to the Steering Group and Joint Committee 	2 x AfC 8a 1 x AfC 7 1 x AfC 4
Overarching system transformation programme, and interim ICS 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 <ul style="list-style-type: none"> - Finance - Digital 	From STP

	<ul style="list-style-type: none"> - Workforce / human resources - Communications and engagement - Business management support <p>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.</p>	
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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	<p>Development of a robust JSNA for Kent and Medway, which identifies the key priorities and actions required to effect population health and wellbeing improvement. JSNA to inform resource prioritisation and integration of physical and mental health, primary and secondary and health and social care.</p> <p>Robust communications and engagement with key stakeholders – members, governing bodies, provider boards, primary care etc. Development of narrative with consistent messages and tangible benefits</p> <p>Demonstrable programme of clinical and leadership engagement, supported by communications and engagement, with key stakeholders and audience groups</p>
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 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, primary care networks and thus the viability of the ICPs	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

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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

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the benefit of non-recurrent support from the commissioner support fund and provider support fund, which reduces this overspend to circa £46m.

- **Services could be run more productively:** Around £190m of savings could be made if services were run as efficiently as top performing areas in England.

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

2.3 Kent and Medway Integrated Care System model

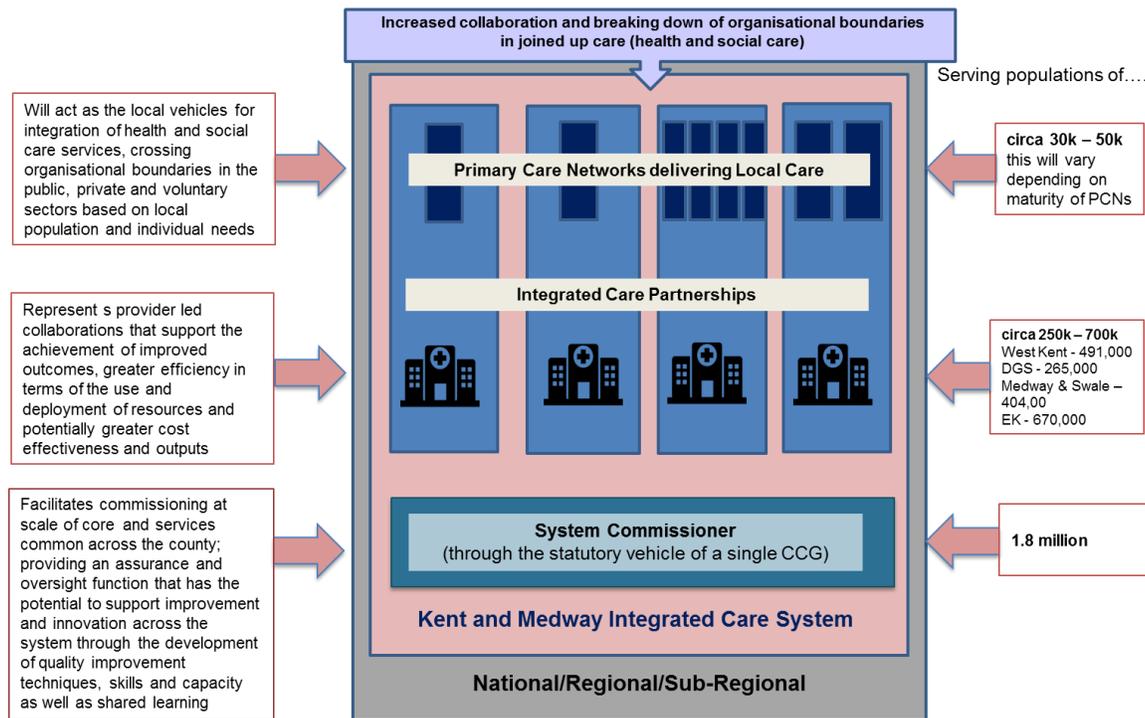
This section details the overall ambition for the Kent and Medway Integrated Care System model that we are working to deliver. It does not cover the interim operating model which is detailed in Section 2.4

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

- **Primary care networks**, serving populations of 30,000 to 50,000, as outlined in the NHS Long Term Plan and enabled through the new GP contract, which support delivery of primary care at scale
- **Four place-based integrated care partnerships**, that determine and secure the delivery of care through integrated working, operating across populations of around 250,000 to 700,000 (individual ICP milestones are under development and will be presented in their individual plans, which will supplement this document):
 - East Kent Integrated Care Partnership
 - Dartford, Gravesham and Swanley Integrated Care Partnership
 - Medway and Swale Integrated Care Partnership
 - West Kent Integrated Care Partnership
- **A single system commissioner**, delivered through the establishment of a single Kent and Medway CCG covering our population of circa 1.8 million (i.e. the number of people registered with our GP practices). The new single CCG would not simply be a coming together of the current CCGs with the same responsibilities. Its focus would be on a much wider population needs basis as outlined in the table below.

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The following diagram outlines the future Kent & Medway Integrated Care System architecture:



More information on these key building blocks is detailed below:

<p>Primary Care Networks</p>	<p>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. PCNs are a group of practices working together locally in partnership with community services, social care, and other providers of health and care services which provides services that meets the needs of a neighbourhood with a population of 30k – 50k.</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> • Focus on and are responsive to the needs of the population of Kent & Medway • Seek to be sustainable in their delivery considering key factors such as workforce, standards of care, co-ordination of health and social care needs and financial affordability • Are forward looking and innovative and make improvement to the operational challenges facing current provision • Champion integration and focus on the patient experience and improved outcomes across health, social care and general wellbeing.
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<p>Integrated Care Partnerships</p> <p>(individual ICP milestones are under development and will be presented in their individual plans, which will supplement this document)</p>	<p>Integrated Care Partnerships represent a provider led collaborative, operating most effectively 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.</p> <p>Key functions of the place-based Integrated Care Partnerships include:</p> <ul style="list-style-type: none"> • Accountability for the physical and mental health of their whole population including development and delivery of care and well-being solutions to ensure this • Focus on responding to population health needs and the provision of programmes that promote prevention and address health inequalities and inequality in health outcomes • Ensure a focus on population health; more than the sum of individual care pathways • Assure and oversee the quality of services and care provided. This assurance role will need further scoping in line with changes in NHS England and Improvement • Support organisational development to enable cultural change and thus deliver integrated working at executive, managerial and practitioner level • Local route for escalation and risk management within the system • Local contract management and the increased use of alternative contract forms to support integrated delivery • Taking account of and addressing the needs of their population, particularly in order to address the wider determinants of health, improve prevention and reduce health inequalities • Designing pathways that both deliver the required outcomes and can be delivered within the particular ICP’s circumstances. This design will be clinically and professionally led within the ICP and be able to demonstrate compliance with best practice and wide clinical, public and political engagement. • Delivering care within the ICP’s capitated budget • Having aligned incentive contracts and sub-contracts which foster collaboration within and outside the ICP. • Monitoring and achieving quality standards with robust measures to address failings • Monitoring the care delivered and reporting on performance (including patient experience) compared to design.
<p>The Kent and Medway System Commissioner</p>	<p>A single Clinical Commissioning Group (CCG) will be responsible for delivering a number of functions. As a system commissioner, it will be responsible for:</p> <ul style="list-style-type: none"> • Defining the needs of the population of Kent and Medway down to a population level of 30-50k • Setting the outcomes to be delivered in addressing those needs, including emphasising prevention and addressing health inequalities and inequality in health outcomes • Allocating capitated budgets within new financial frameworks that encourage Integrated Care Partnerships to focus on population health • Providing oversight and offering strategic solutions to K&M wide functions such as Strategic Estates, Digital, Workforce, and Finance. • Supporting and delivering the organisational development of providers to become members of

	<p>Integrated Care Partnerships.</p> <ul style="list-style-type: none"> • Giving license to, and receiving assurance from, ICPs on the delivery of outcomes within budget • Acting as the point of escalation of dispute and risk in ICPs • Commissioning core services at scale. • Holding a single contract for larger (K&M) providers, whilst enabling and maintaining local flexibility • Holding contracts for some non-Kent and Medway tertiary and acute providers • Direct commissioning of rare and very expensive services • Providing high quality cost effective commissioning support and back office functions • Developing a Kent & Medway approach to service and quality improvement <p>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.</p>
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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)

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- 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 that 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 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. 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: <ul style="list-style-type: none"> • CCCs (potentially in due course) - CCG functions other than those listed below • STP / ICS - Functions delegated or directed by NHS England (e.g. assurance, resilience planning) • STP / ICS - Over-arching strategic and programme planning

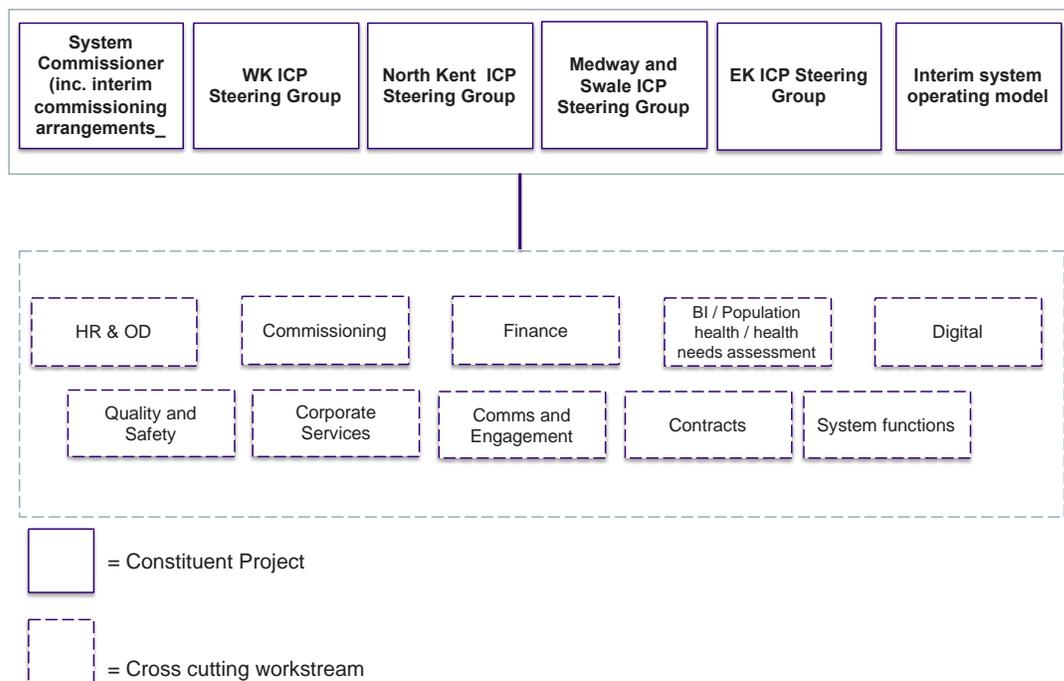
3 PROGRAMME GOVERNANCE

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

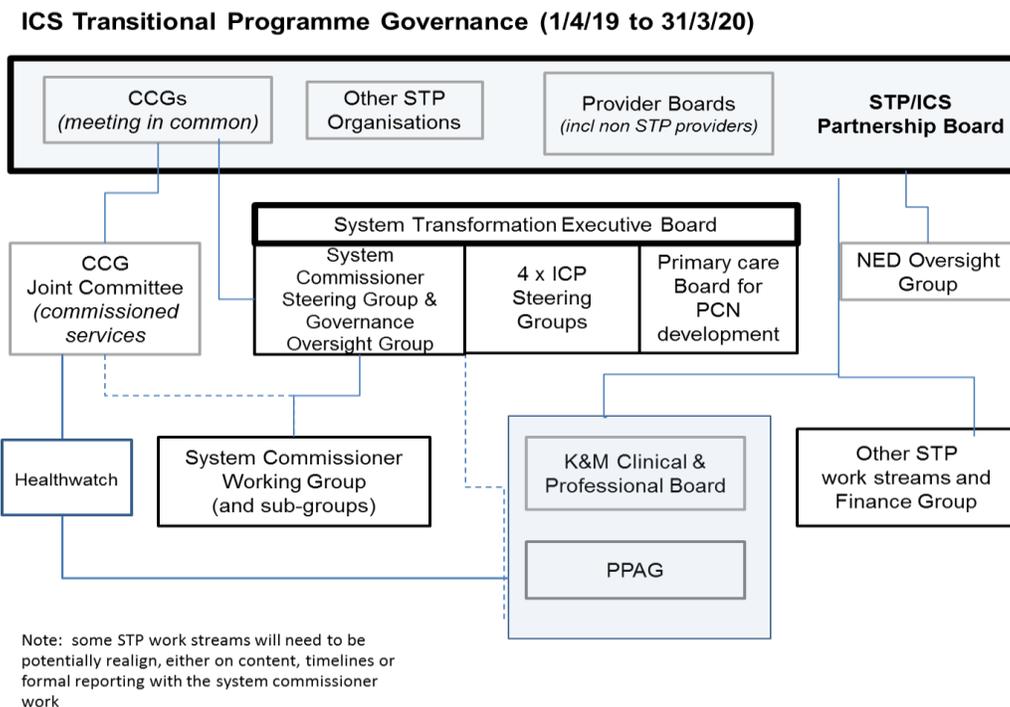
The core constituent projects and cross-cutting workstreams, that sit within the programme, are outlined in the diagram below:



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.



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

Group	Role	Frequency	Chair	Membership
STP Programme Board <i>(The renaming of this group to the ICS Partnership Board will be considered as part of the programme)</i>	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.	Bi-monthly	STP Chief Executive	Representation from all STP core partner organisations (see Section 12.3 for list)

Non-Executive Director (NED) Oversight Group	Provides independent scrutiny and oversight of the STP Partnership Board and its programmes of work, including development of the Integrated Care System.	Monthly	STP Chair	STP Chair, 2 x Provider NEDs, 2 x CCG independent members, 2 x Upper Tier LA elected Members
CCG Joint Committee(s)	<ul style="list-style-type: none"> Delegated Authority from CCG governing bodies for a range of commissioning responsibilities (e.g. Stroke, Cancer and in due course: Children’s services, Mental Health etc...) Responsible for determining joint commissioning agenda and priorities 	Monthly	Stroke: Independent Chair K&M Joint Committee - CCG Clinical Chair East Kent: Independent Chair	Representatives from each CCG Governing Body (incl AO, MDs, Clinical Chairs and independent lay members)
System Transformation Executive Board	<ul style="list-style-type: none"> Responsible for the monitoring delivery of overall programme objectives Designs principles and coordinates and supports the ICS development (spanning both the ICP and system commissioner development) Ensures consistency of approach whilst also supporting local flexibility and autonomy Provides senior executive leadership Framework for ICP development Development of an assurance and regulatory framework 	Monthly	STP CEO / AO	STP CEO / CCG single accountable officer – Chair, STP Deputy CEO Senior sponsor, Chair of SCOG, senior sponsors for four ICP Steering Groups, CEO, KMPT Kent County Council lead director Medway County Council lead director Co-chair of Primary Care Board
System Commissioner Steering Group	Responsible for delivery of project objectives that include but not limited to: <ul style="list-style-type: none"> Commissioning transformation and development of the System Commissioner Merger of eight CCGs to form the single, Kent and Medway CCG as the system commissioner Provides clinical leadership and endorsement of ICS development 	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	To provide providing scrutiny, advice and guidance to the System Commissioner Steering Group	Monthly	Mike Gilbert, Director of Corporate	CCG Lay member (Governance Leads) and CCG Company

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Oversight Group			Affairs	Secretary
ICP Steering Groups x 4 (place-based)	<ul style="list-style-type: none"> Responsible for delivery of the ICPs and delivery of agreed system and local objectives PCN development (working with the Primary Care Board) Identification of priorities 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 	As per local agreement	WK: Mile Scott, CEO MTW EK: Paul Bentley, CEO KCHFT North Kent: Louise Ashley, CEO, DGT Medway and Swale: James Devine, CEO, MFT	To be identified through individual ICP project plans (and recommended to include LMC representation to facilitate representation of general practice)
K&M Clinical and Professional Board	<ul style="list-style-type: none"> Advises the STP Programme Board and CCG's Joint Committee on all clinically and professionally related matters Provides collective clinical and professional leadership to the Kent and Medway system Leads the development of the clinical and professional content of Kent and Medway level strategies 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)	<ul style="list-style-type: none"> Provides strategic leadership to the Primary Care workstream Ensures that the programme delivers its milestones and outcomes on time and to budget (based on agreed plan TBD) Ensures that risks to implementation are identified and effectively managed Ensures that the programme engages effectively with all necessary stakeholder groups in the development of proposals, including championing the programme across 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	Reports to System Commissioner Steering Group Responsible for developing and overseeing implementation of future	Monthly	System commissioner lead director	CCG Senior Managers and Subject Matter Experts

and work streams	<p>system commissioner functions.</p> <p>10 x cross cutting work streams:</p> <ul style="list-style-type: none"> • Commissioning • Primary Care • Comms and Engagement • Contracting, performance management and business intelligence • Corporate Services/Governance • Digital • Finance • HR and Workforce and OD • Quality and Safety, safeguarding and CHC • population health management 			SC Programme Director to chair work stream groups as appropriate
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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	<ul style="list-style-type: none"> • Develop an HR Framework for bringing together commissioners and, in due course, any changes to providers around the development of ICPs and will see the transition of workforce from 8 existing CCGs into 4 ICPs and a single K&M CCG • Develop a programme that guides leadership development of ICPs and PCNs with a focus on population health (at all management and clinical levels) • Develop the OD programme for the ICS (all components) that promotes learning organisations / collaborations and recognises the evolutionary nature of system transformation • Design of the human resources function across the system • Design of the workforce planning function across the system
Commissioning	SC	Adam Wickings, Chief Operating Officer, West Kent / Lorraine	<ul style="list-style-type: none"> • Description of commissioning functions in each part of the new system model* • Identify areas of commissioning that need to be

		Goodsell, Deputy Managing Director, East Kent	<p>undertaken jointly between health and local authorities (public health and social care)</p> <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Description of commissioning functions in each part of the new system model* • Development of capitated (or other) budgetary framework • 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	<ul style="list-style-type: none"> • Develop needs assessment framework, including identifying wider determinants of health • Launch the analytics strategy and put in place resourcing and governance to ensure delivery • Describe and make available population down to PCN level • Define relationship and put on a more formal basis relationship between SC and HWBBs • Define outcomes based on identified priorities, including emphasising prevention and health inequalities • outcomes framework (including to support benefits realisation)
Digital	ICS / SC / ICP / PCN	Andrew Brownless, Chief Information Officer	<ul style="list-style-type: none"> • Digital strategy • Network model • Identify core systems / Integration / standardisation of core systems • At individual practitioner level provide tools to risk stratify and cohort patients • Link with Local Authorities digital strategies to create an integrated approach • Digital innovation approach through Innovation Collaborative
Communications and engagement	ICS / SC / ICP / PCN	Julia Rogers, K&M Director of Communications and Engagement	<ul style="list-style-type: none"> • System Transformation Communications and Engagement Plan including proactive approach to engagement with key audiences and stakeholders • Reactive responses against plan to media enquiries • Staff and stakeholder briefings • Design and implement effective strategic and operational communications and engagement function across the

			<p>system (including co-production)</p> <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Development of outcome-based contracts, including performance management and escalation framework • ICP MOU / contractual framework that focuses on wider determinants of health, prevention and outcomes framework, including framework for approval of sub-contacting that foster collaboration within and without of the ICP
Corporate services	ICS / SC / ICP / PCN	Mike Gilbert, STP / DGS CCG, Director of Corporate Services	<ul style="list-style-type: none"> • Describe corporate risk identification and escalation process • 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	<ul style="list-style-type: none"> • Best practice framework – process that drives optimum and innovative outcomes • Quality framework, including metrics and governance structure for oversight and route for clinical risk identification and risk escalation
System functions	ICS / SC	Michael Ridgwell, STP Deputy CEO	<ul style="list-style-type: none"> • Planning (including major service reconfigurations) • Resilience • Performance / assurance (including in relations to effectiveness of outcomes-based commissioning, and oversight of the best value test) • Assurance and license of system commissioner, ICPs and other constituent bodies • Service / System Improvement • Direct commissioned services and identify list of service that should be commissioned at a Kent and Medway level

3.4 Role descriptions

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

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 Director	Responsible for the day-to-day delivery of their core constituent project or work area they are 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	<ul style="list-style-type: none"> Glenn Douglas, STP Chief Executive / CCG Accountable Officer
System Commissioner (including interim CCG operating model)	<ul style="list-style-type: none"> Senior sponsor: Dr Bob Bowes, Clinical Chair, WK CCG Project Lead Director: Simon Perks, Director of System Transformation
West Kent ICP	<ul style="list-style-type: none"> Senior sponsor: Miles Scott, Chief Executive, Maidstone and Tunbridge Wells NHS Trust ICP GP lead: Dr Sanjay Singh ICP non-executive lead: John Goulston, Chairman, Kent Community Health NHS Foundation Trust Project lead director: Amanjit Jhund, Director of Strategy, Planning and Partnerships, Maidstone and Tunbridge Wells NHS Trust
East Kent ICP	<ul style="list-style-type: none"> Senior sponsor: Paul Bentley, Chief Executive, Kent Community Health NHS Foundation Trust ICP GP lead: Dr Sadia Rashid ICP non-executive lead: Stephen Smith, Chairman, East Kent Hospitals University NHS Trust Project lead director: Tbc
DGS ICP	<ul style="list-style-type: none"> Senior sponsor: Louise Ashley, Chief Executive, Dartford, Gravesham and Swanley NHS Foundation Trust ICP GP lead: Tbc ICP non-executive lead: Tbc Project lead director: Sue Braysher, Director of System Transformation, Dartford, Gravesham and Swanley NHS Foundation Trust / Dartford, Gravesham and Swanley CCG

Medway and Swale ICP	<ul style="list-style-type: none"> • Senior sponsor: James Devine, Chief Executive, Medway Foundation NHS Trust / Martin Riley, Chief Executive, Medway Community Healthcare • ICP GP lead: Tbc • ICP non-executive lead: Tbc • Project lead director: James Lowell, Director of Planning and Partnerships, Medway Foundation NHS Trust
Interim ICS operating model	<ul style="list-style-type: none"> • Senior sponsor: Michael Ridgwell, Deputy STP Chief Executive • Project lead director: Ravi Baghirathan

4 HIGH LEVEL PROGRAMME PLAN

For the System Commissioner and Primary Care Network projects, the following high-level milestones will be kept under review (individual ICP milestones are under development and will be 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	October / November

conditions)	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

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 0.4 wte

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<p>Project Lead Director (Simon Perks, System Commissioner)</p>	<p>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.</p>	<p>Existing CCG 1 wte</p>
<p>Mike Gilbert, Director of Corporate Services</p>	<p>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</p>	<p>Existing CCG 0.7 wte</p>
<p>System commissioner (including potential merger of the CCGs)</p>	<p>In recognition of the complexity and scale of the programme, additional programme management resources will also be required from CCGs:</p> <ul style="list-style-type: none"> • 2 x Programme Manager (Band 8a). Responsible for day to day co-ordination of the underpinning work streams, programme reporting, over-sight of programme risk management and co-ordination of core programme resourcing. • Business Support Manager – 1 wte (Band 7). Day to day support to System Commissioner Programme. The BSO will provide support to ensuring the programme's rigour, through monitoring and reporting of progress and overseeing all aspects of business support. • Administrative support – 1 wte (band 4). Provides dedicated day to day support of system commissioner programme including formal and informal reporting, diary management and support to the Steering Group and Joint Committee 	<p>2 x AfC8a 1 x AfC7 1 x AfC4</p>
<p>Overarching system transformation programme, and interim ICS operating model</p>	<p>Where appropriate existing programme management resources will be aligned from the STP to support the system transformation programme across the different core projects, including</p> <ul style="list-style-type: none"> - Finance - Digital - Workforce / human resources - Communications and engagement - Business management support <p>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.</p>	<p>From STP</p>
<p>Patient involvement volunteers</p>	<p>Input from patient members of the Patient and Public Advisory Group including attendance at system transformation meetings and discussions within the main PPAG meetings</p>	

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 to whom 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	<ul style="list-style-type: none"> • Improved outcomes against a range of indicators as outlined in the joint strategic needs assessment (JSNA) • Improved performance against NHS Constitution targets • Improved performance against NHS Long Term Plan priorities (recognising these include indicators within the JSNA and NHS Constitution target) • Improved self-management and prevention 	Patient and local populations	Outcomes framework to be developed not only as part of the system transformation programme but linked to the long term plan and the JSNA
Deliver Improved use of available resources (both financial and staffing)	<ul style="list-style-type: none"> • Delivery of nationally mandated 20% reduction in management costs • Financial performance within the agreed system control total • Development of new workforce models to: <ul style="list-style-type: none"> - address workforce shortages - meet increasing demand - support staff - support service innovations 	Organisations Patients and public Staff	Outcomes frameworks to be delivered in relation to: <ul style="list-style-type: none"> • Finance (as part of the long term plan) • Patient experience • Staff experience (e.g. as measured through staff surveys)

Alongside identifying the benefits of any proposed options, the cost of proposals will need to be quantified as part of a detailed options appraisal. Not only will the return on investment of any proposals need to be quantified but proposals will need to deliver the mandated management savings that CCGs and NHS England need to deliver, in order to increase investment in frontline services.

6.2 Programme Impact Assessment

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

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	<p>Development of a robust JSNA for Kent and Medway, which identifies the key priorities and actions required to effect population health and wellbeing improvement. JSNA to inform resource prioritisation and integration of physical and mental health, primary and secondary and health and social care.</p> <p>Robust communications and engagement with key stakeholders – members, governing bodies, provider boards, primary care etc. Development of narrative with consistent messages and tangible benefits</p> <p>Demonstrable programme of clinical and leadership engagement, supported by communications and engagement, with key stakeholders and audience groups</p>
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

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	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 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, primary care networks and thus the viability of the ICP	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

	<p>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.</p> <p>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.</p> <p>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.</p>
<p>Staff across all commissioner and provider organisations including those outside of the traditional health economy in LAs, VCSE and private providers</p>	<p>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’.</p> <p>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.</p> <p>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.</p> <p>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.</p>
<p>GP members</p>	<p>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.</p> <p>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.</p>
<p>Decision-makers</p>	<p>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</p>
<p>Politicians and elected representatives</p>	<p>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.</p>

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

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

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	Non-Executive Director (NED) Oversight Group	STP CEO
	CCGs Joint Committee	STP Deputy CEO
Maidstone and Tunbridge Wells NHS Trust	STP Partnership Board	CEO
	West Kent ICP	CEO
	Clinical and Professional Board	Trust Medical Director
	Non-Executive Director (NED) Oversight Group	Trust Chair
Medway Local Authority	STP Partnership Board	Leader of the Council
	Medway and Swale ICP	Tbc
	Clinical and Professional Board	Tbc
	Non-Executive Director (NED) Oversight Group	Elected Member of the Council
Medway NHS Foundation Trust	STP Partnership Board	CEO
	Medway & Swale ICP	Director of Strategy
	Clinical and Professional Board	Joint Chair - Trust Medical Director
NHS England / Improvement	STP Partnership Board	Dir of Strategy and Partnerships
	CCGs Joint Committee	NHSE Rep and Specialist Commissioning Rep
South East Coast Ambulance NHS Foundation Trust	STP Partnership Board	CEO
	Clinical and Professional Board	Trust Medical Director
Medway Community Healthcare	STP Partnership Board	CEO
	Medway ICP	CEO
	Clinical and Professional Board	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 our websites in the interest of transparency. This has worked well during the stroke review and our work in east Kent, where we have also used various web presences to inform local audiences and stakeholders about forthcoming events and engagement opportunities and to host surveys and other feedback mechanisms.
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. 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			
Name:		Date:	
Signature:			

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

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

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

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

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

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

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

NAME OF ORGANISATION: Kent and Medway NHS and Social Care Partnership Trust			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: Maidstone and Tunbridge Wells NHS Trust			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: Medway Community Healthcare			
Name:		Date:	
Signature:			

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NAME OF ORGANISATION: Medway CCG			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: Medway Council			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: Medway Foundation NHS Trust			
Name:		Date:	
Signature:			

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

NAME OF ORGANISATION: South Kent Coast CCG			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: Swale CCG			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: Thanet CCG			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: West Kent CCG			
Name:		Date:	
Signature:			

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Gravesham Borough Council – Decisions taken by the Thanet Health and Wellbeing Partnership on Thursday, 18 July 2019

Agenda Item No	Topic	Decision
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Part A – Items considered in public

A1	Minutes from the Summit Meeting	The minutes were agreed - the meeting took place between TDC, CCG and Voluntary sector.
A2	To Agree the Amended Terms of Reference for the THWP	<p>Terms of reference Madeline Homer made a point that the objectives are significant and group needs to be focussed and its programme of work moving forward will need to works towards these objectives rather than trying to resolve each of them.</p> <p>Funding had been received from NHS England - for Lightfoot to come to work in East Kent. They are bringing in New Zealand experience - important that we are data driven in order to deliver the best service - Dr Peshen outlined.</p> <p>Focus next steps - to give an overview - need to identify topics we need them to focus on.</p> <p>Membership expectations: Madeline Homer stressed the importance of a need for a general consensus of commitment by all members to the partnership, particularly as regards Partnership attending meetings.</p> <p>Action Members need to send a substitute.</p> <p>Structure of the meeting Attendees: There was a general consensus that the public and other councillors not on the body be allowed to attend and observe. Madeline Homer was going to seek the view of the Leader of Council for a final position.</p> <p>The meeting approach could be to break down into two parts for observers:</p> <p>First part: Public session; Second part: Private session where observers with expertise could listen in and participate on</p>

Gravesham Borough Council – Decisions taken by the Thanet Health and Wellbeing Partnership on Thursday, 18 July 2019

Agenda Item No	Topic	Decision
		<p>invitation.</p> <p>There is a need for those intending to attend to give the Chairman 24 hour notice of their intention to attend.</p>
A3	An Update on Care Navigations Mapping in Thanet	<p>Action Faye Hames informed the group that a national campaign Every Mind Matters - 7 October National Campaign run by Public Health - Karen Sharpe to bring details back on 5 September meeting.</p> <p>Action Agencies need to explore if they are delivering any Services that could fall within the scope of Social Prescribing and feedback at the next meeting.</p> <p>Action Share outcomes of the searches with the Partnership and present to the rest of the PLT.</p> <p>Chairman - next stage is to work out how we bring the services together so that they can be accessed. How does the health service work alongside the Voluntary sector.</p> <p>Connect Well with EK database is being developed which will be publically developed.</p> <p>Action There is a need to explore how employers can connect into this service in order to engage and reference into the service to keep employees in the workplace and reduce absence due to sickness.</p> <p>Action Consideration needs to be given to determine a way to measure the impact to see if any of this is working. It might be that there is a need to identify cohorts of patients from the GPs whose</p>

Gravesham Borough Council – Decisions taken by the Thanet Health and Wellbeing Partnership on Thursday, 18 July 2019

Agenda Item No	Topic	Decision
		<p>information is anonymised and used for measuring the success of the approach.</p> <p>Alistair Lyndsey Identify cohort for parents -Lightfoot system and data could be used. Look at working age adults in the Margate area. Target the patient cohort initially.</p> <p>Action How do we get employers to be engaged with social prescribing? There is a need to explore how employers can engage social prescribing.</p> <p>Mental health service should use population management system and the data generated by that system.</p> <p>Action Bring back to the next meeting an update on Mental Health element of the Care Navigation Mapping</p> <ul style="list-style-type: none"> • The Scope; • The Solutions options. <p>Action Respiratory problems (COPD) are a big issue in Thanet for Older People -</p> <ul style="list-style-type: none"> • Conduct a scoping exercise with support from Lightfoot. <p>Faye Hames to provide a similar presentation at the PLT in order to promote the Care Navigation Mapping to GPs and Practice Managers.</p>
A4	SEND rebuilding trust with our families	<p>A damning report about the local SEND service delivery was produced by the inspectors.</p> <p>Special Educational Needs (SEND) also covers child's mental health.</p>

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Agenda Item No	Topic	Decision
		<p>Big issue for Thanet is speech and language and that there is a shortage of speech and language experts. Children Centre waiting list for speech & language therapy was 13 months.</p> <p>For Thanet, the current system disadvantages non wealthy parents as they cannot afford to pay for the appeals process to get tribunal hearings.</p> <p>This affects a large cohort of children - many local parents are unhappy with the system.</p> <p>It was agreed that this is a systemic failure.</p> <p>Action Can the Thanet Health & Wellbeing Partnership help facilitate a change to the SEND systems and help build the local offer that would work for thanet which could include working with GP's and schools.</p> <p>How can we help - work with the Kent Pact locally and link to health.</p> <p>Action Sharon to speak at next PLT.</p> <p>Action Can the Thanet Health & Wellbeing Partnership help iron out the gaps in the pathways. Once a plan has been devised, share that with GPs.</p> <p>Need to connect into a local resource to develop a better local offer around SEND.</p> <p>Action Sharon to present a 2-3 case study at a future meeting to enable partners to see what role they can play in the process. Case studies would help partners have a better understanding as they</p>

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		<p>will highlight the gaps and the Partnership can work through how they can support or fill the gaps in the care navigation.</p> <p>Action Carol Cook to Invite Sue Mullins and Sharon McLaughlin to the next meeting to give an update on work being done around the deficits of work and support for families and speak after the SEND case studies presentation.</p>
A5	Items for Consideration at the Next Meeting	<u>05 September 2019</u>

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