Transforming health and social care in Kent and Medway

NHS

Frequently asked questions (FAQs) on Integrated Care System progress in Kent and Medway

1. What is an Integrated Care System?

The NHS Long Term Plan makes it clear that every part of the country is expected to have an Integrated Care System (ICS) by April 2021, growing out of current Sustainability and Transformation Partnerships (STPs). Fourteen of the 44 STPs are already working towards becoming integrated care systems.

Building on the foundations of STPs, NHS England has defined that an ICS brings together local organisations, to redesign care and improve population health, creating shared leadership and action. They will deliver the 'triple integration' of primary and specialist care, physical and mental health services, and wider health with social care.

Each ICS will serve a population of more than one million people and it is currently planned that **Kent and Medway will become an ICS**.

ICSs will improve people's health and care by:

- Ensuring a greater focus on improving the health of a population and preventing ill health.
- Incentivising local systems to work together to improve quality of care and health outcomes for local people, making most effective use of their collective resource.
- Supporting the coordination of services, with a proactive focus on those at risk of developing acute illness and being hospitalised.
- Providing more care in a community and home-based setting, including in partnership with council social care, and the voluntary and community sector.

ICSs will work at a 'place based' level, rather than through individual health and care organisations. Commissioners will make shared decisions with partners including providers, on how to best use resources, design services and improve population health.

In developing the ICS, local leaders will need to carefully balance the need 'to commission services once, at scale' verses addressing local needs across the county: quite a few commissioning decisions will not be suitable for all and local needs will still need to be taken into account.

Advanced ICSs could also include delegated commissioning for social care services from the local authorities.

2. How will the ICS work?

An ICS is not a statutory organisation. It is a partnership of all health and social care organisations responsible for developing and overseeing delivery of the strategy that improves the health and well-being of a local population and improves the quality of care and outcomes for those people who need our services.

Every ICS will have:

- **A Clinical Commissioning Group (CCG)** that will act as the statutory body for commissioning health care services. The NHS Long Term Plan recommends that each ICS will have a single CCG covering the same geographical area. However, the range of responsibilities of the CCG is likely to be streamlined, allowing local areas within an ICS (through Integrated Care Partnerships – see further below) to determine how services should be provided for their immediate population.

- **A partnership board**, drawn from and representing commissioners, NHS trusts, primary care networks, and – with the clear expectation that they will wish to participate - local authorities, the voluntary and community sector and other partners;

- Sufficient clinical and management capacity drawn from across their constituent organisations to enable them to implement agreed system-wide changes. This could be through a **clinical and professional** board or similar group;

- Full engagement with primary care, including through an officially appointed Clinical Director of each **Primary Care Network** (see below);

- **Formal partnership arrangements** with elected members of **local authorities**, through Health and Wellbeing Boards and Health Overview and Scrutiny Committees

Advanced ICSs could also include delegated commissioning for social care services from the local authorities.

3. What is an Integrated Care Partnership (ICP)?

Within an ICS, providers will be required to collectively contribute to the system goals and performance, to support improved services, use of resources and better patient outcomes and experience. This will be supported by longer-term NHS contracts with all providers or groups of providers through **Integrated Care Partnerships (ICPs)**.

The ambition is to have health and social care providers working in a seamless way together through local ICPs. An ICP will generally serve between 250,000 and 500,000 people.

Integrated Care Partnerships are likely to include a combination of GPs, GP Primary Care Networks, GP Federations; mental health, social care and community services; acute hospitals; district and borough councils; and voluntary sector partners.

Organisations within each ICP will have greater freedom to work together to determine how services should be provided. Each ICP will have one or more contracts with the ICS which will be based on the delivery of specific outcomes that address the needs of the population. The organisations within an ICP will be able to determine how this is achieved and where resources are best focused. They will be required to work in partnership rather than competing with each other.

The form of ICPs can be various, from joint partnership agreements, through to more formal joint ventures and potentially merger of providers.

4. What is a Primary Care Network?

Primary care will continue to be the cornerstone of healthcare delivery. GPs will continue to be critical leaders within the ICS and ICPs. The CCG will continue to be led by primary care clinicians and locally, new formal **Primary Care Networks** (PCNs), made up of groups of GP practices serving populations of circa 30,000 to 50,000 will co-ordinate the delivery of local and community care provision.

Primary Care Networks will retain the very best of how primary care currently operates, whilst finding improved ways to deliver care that continues to meet patients' needs with support of the wider health and care system; helps GPs and other professionals manage workloads and critically attract and retain staff.

Additional funding for primary care recently announced through the new GP contract will be made available directly through PCNs, encouraging partnership working across groups of practices which in turn should help primary care become more sustainable over the longer term.

For some element of their work, Primary Care Networks may decide to work together through GP Federations or other partnerships, potentially providing a greater collective voice within their ICP.

5. What is happening about creating an Integrated Care System in Kent and Medway?

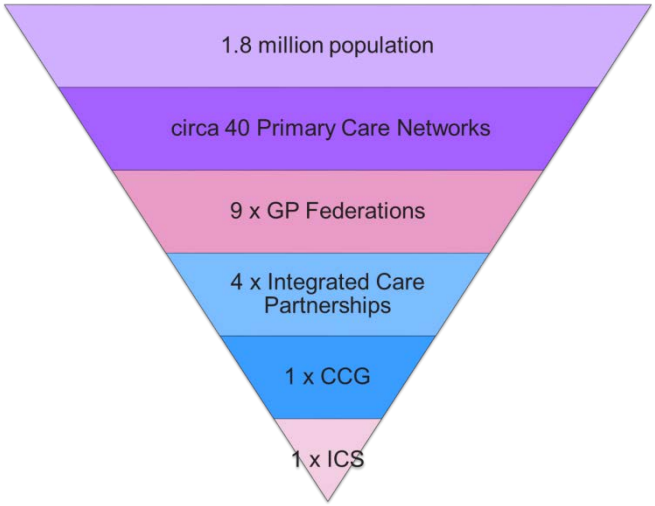
The Kent and Medway CCGs have been working with partners to consider future functions and form as part of developing a more effective commissioning and provider landscape. Current plans are focusing on a single Kent and Medway ICS with the same boundaries as a single CCG and a small number of ICPs (possibly four) based around specific health economy areas.

As part of this, the CCG's System Commissioning Steering Group, primarily made up of the CCG clinical chairs, have been thinking about which services should be commissioned at a county wide level - for example ambulance and stroke services - and what should stay at a more local level, commissioned and delivered through Integrated Care Partnerships (ICPs). While considerable work is still required on this, it is likely that much of what CCGs do today could be done within ICPs, or indeed Primary Care Networks.

Whilst this is our shared ambition across all eight CCGs, we haven't yet formally approved any detailed plans or agreed the proposed change, which will be subject to due process, including GP membership and NHS England approval.

There are currently nine GP federations and around 40 'groups' of GP practices across the county working under the various guises of clusters, localities, hubs, MDTs, etc. We recognise that across Kent and Medway, as GPs and primary care teams have looked at how they can work more effectively together and provide services at scale over the past few years, different names have been attributed to this work. Under the guidance of the NHS Long Term Plan it would make sense to unify the way we describe and refer to these. These could well develop in to the Primary Care Networks across the county as described above.

Potential new health and care framework across Kent and Medway



6. How does this sit with the single strategic commissioning function we have heard about?

The local term 'strategic commissioner' has been succeeded by 'system commissioner', which in essence means the CCG. The CCG will remain the statutory health commissioner across Kent and Medway. It may also take on additional commissioning responsibilities currently held by from NHS England. Some decisions about how local services are resourced and delivered are likely to be delegated to the ICPs through a contract with the ICS.

7. Will the ICS be a statutory body with authority to spend money and take decisions?

The ICS will not be a statutory body. It will be the system partnership responsible for determining the health and care priorities for Kent and Medway's population. The single CCG will be the statutory commissioning body for healthcare, responsible for contracting service and care delivery.

Advanced ICSs could also include delegated commissioning for social care services, whereby the CCG and local authorities have formal joint commissioning arrangements in place.

8. How many integrated care partnerships will there be across Kent and Medway and what will they do? Also, how will the new system ensure local issues are properly considered – how do we get bigger, without losing the clear local focus of CCGs?

No decisions have been made yet, but current planning assumptions are for a small number of ICPs, possibly four, linked to the established NHS geographical areas, for example east Kent.

The ICPs will be local groups of health and care organisations, including we anticipate, borough councils and voluntary/community sector members. Each ICP would be expected to develop its own priorities and models of care, reflecting the different needs of their local populations, and thinking about how they will work differently in the future. Common themes are emerging from the early discussions, with more emphasis on wellbeing and prevention and on breaking down the barriers between organisations.

Across each of these local partnerships we are starting to think about new and different ways of designing services so we can look after people's whole needs. From April 2020 we want to start working in a new way and, while it's unlikely that patients and the public will see any immediate big changes, we know that in the long run there will be significant benefits for local people. For example, better integrated services for children and young people and fully integrated health and care planning for people with long term conditions or who are vulnerable.

ICPs collaborative arrangements could be in various forms, including local 'alliance' contracts with a number of providers; giving one provider 'lead' contractual responsibility with them sub-contracting with partners; or the forming of joint venture companies for example.

9. What impact will this have on CCG staff?

We do not yet know the full answer to this, and what the implications will be for individuals and their roles – we are at a very early stage of discussion and exploration, and that level of detail is some way off. However, we know that our staff are our most important and valued resource. Staff at all levels have a wealth of professional knowledge and expertise that we strongly believe should help shape the future commissioning and care landscape.

The CCG leadership teams are absolutely committed and actively seeking to encourage all staff have a meaningful say in how Kent and Medway responds to this national policy direction, and how we can make our services better for the people of Kent and Medway.

We need to recognise the significant task we currently have to deliver existing priorities and ensure our patients continue to experience high quality, timely services that secure the most effective outcome. We cannot take our eye off this.

We know from staff surveys and feedback that resource is stretched and while we are grateful for your huge commitment, we must not and will not take that for granted. The CCG leadership will work with everyone to try and balance today's priorities, prepare staff for future opportunities and give them the chance to get involved in designing the new organisational forms.

10. Will there be redundancies? Will teams have to move site? What support will there be for staff?

As we have not yet got into any detailed planning, we do not know the answers to the first two of these questions yet. But we can say that there will be support for staff as we go through these proposed changes.

You might be asked to work in different locations or for different NHS organisations in the future, but it is far too early for any detailed plans or proposals and any proposal would be subject to staff engagement and consultation as appropriate.

With regard to support, the CCGs are increasing investment in individual and organisational development to ensure everyone is best placed and equipped for the future. We are currently reviewing key staff policies across Kent and Medway to ensure all staff are treated equally and we will continue to ensure informal and formal support is available throughout all our organisations.

11. If acute trusts are taking the decisions on spending, won't they suck even more money in from the system, depleting primary and community care?

The Long Term Plan for the NHS and new contract for primary care proposes the opposite. There is a clear expectation (likely to be supported with direct central allocations) that much of the new additional funding will go to primary care, through Primary Care Networks; community services; children's and mental services and so on, with less going to the acute sector than previously.

Of course this will require wholesale change to the way services are planned and delivered – so that we can be sure that patients are treated by the most appropriate team and service along each patient pathway. We aim to achieve this through integrated partnership working and this is where the ICS, ICPs and PCNs will play their part.

12. Are we just going back to having a Kent and Medway regional health authority again?

No. The previous regional health authorities, strategic health authorities and primary care trusts were predominantly management-led organisations. There is no change in primary legislation which means clinically-led CCGs and, over time, a clinically-led CCG for Kent and Medway, will still be the statutory commissioning organisations.

Integrated Care Systems will include the proposed single CCG alongside a whole system Partnership Board and clinical and professional body, and will have to be closely aligned with the local authorities. The NHS Long Term Plan and new GP contract will put significant additional funding into primary care directly through Primary Care Networks (PCNs). This is very different from ways of working we have seen before.

13. How will back office functions such as finance, HR and corporate services be embedded in the new organisations?

As with other CCG functions, back-office teams such as the finance, HR, corporate services functions remain a critical part of the current organisations. This will not change in the future in terms of all statutory organisations needing strong and effective support services. How this will look going forward is not yet known. Work has just started with a small number of senior managers to think about future function and form. Discussion with members of staff in the various teams will be important to ensure the totality of each function and individual roles both now and in the future are fully understood.

14. When will this happen?

The NHS Long Term Plan states that all areas of the country should have moved to have an ICS by April 2021. It does not say anything more than this, although the (unwritten) expectation is that CCG transformation should probably have taken place by this time too. ICP development and maturity of new ways of working will likely take longer.

In Kent and Medway current thinking is for the ICS and CCG establishment to take place from April 2020. This is ambitious but would potentially shorten the period of uncertainty for staff and support important care transformation and sustainability. It is likely that ICPs will develop at varying rates and will take longer than the ICS/CCG transition. If this is the case, the CCG would retain commissioning functions until each ICP is mature enough to take on these responsibilities. Many

people would probably need to work in the ICS until ICPs take on these responsibilities and then would likely transition to the ICPs.

15. Some CCGs have already merged with councils – is that happening here?

Some of the early adopter systems have agreed to jointly commission health and social care from within a single organisation through pooled funding or similar arrangements. This is currently being explored within Kent and Medway, but no decisions have yet been made.

16. What is the remit of the STP?

The STP remains the lead Partnership Board for Kent and Medway system transformation. It is made up of all key stakeholder organisations from across the county. There are a number of critical work streams that are being led by the STP, including productivity, prevention, local and primary care development, and workforce planning.

The STP has no statutory authority. It works on mutual partnership and the authority vested in the representatives of all the different organisations which comprise it. The STP is financed by each of the stakeholder organisations and the annual budget is approved by each organisation's Board or Governing Body.

The System Commissioner work stream remains part of the STP, but is overseen by the System Commissioner Steering Group which is chaired and primarily run by the eight CCG clinical chairs, along with the Accountable Officer, Glenn Douglas and Managing Directors, Ian Ayres and Caroline Selkirk. This work stream is focussing on the future function and form of the CCG(s).

It is expected that the STP will transition with some review and refresh into the ICS framework, possibly through the new Partnership Board.

17. Have any decisions been made about the CSU and in-housing of CCG services?

No. A lot more work needs to be undertaken to think about where future functions will sit and what the organisational form might look like. As part of this, consideration will need to be given to all services that are currently out-sourced and whether this is the most effective and efficient use of resource.

18. Is there going to be a recruitment freeze to help with the 20% management cost savings?

No, this is not currently planned, although CCG running costs are always kept under review.

CCGs across Kent and Medway have agreed to appoint new staff on a fixed term basis unless there are exceptional circumstances that require the appointment of a permanent member of staff. This is to safeguard existing posts and ensure CCG are able to deliver management cost savings in 2020/21.