Public Document Pack

SOUTH KENT COAST HEALTH AND WELLBEING BOARD

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30 October 2017

Dear Member of the Health and Wellbeing Board

NOTICE IS HEREBY GIVEN THAT a meeting of the **SOUTH KENT COAST HEALTH AND WELLBEING BOARD** will be held in the HMS Brave Room at these Offices on Tuesday 7 November 2017 at 3.00 pm

Members of the public who require further information are asked to contact Rebecca Brough on (01304) 872304 or by e-mail at rebecca.brough@dover.gov.uk.

Yours sincerely

Chief Executive

South Kent Coast Health and Wellbeing Board Membership:

Dr J Chaudhuri (Vice-Chairman)	South Kent Coast Clinical Commissioning Group
Councillor P M Beresford	Dover District Council
Ms K Benbow	South Kent Coast Clinical Commissioning Group
Councillor S S Chandler	Local Childrens Partnership Group Representative
Ms C Fox	Community and Voluntary Sector Representative
Councillor J Hollingsbee	Shepway District Council
Mr S Inett	Healthwatch Kent
Mr M Lobban	Kent County Council
Councillor M Lyons	Shepway District Council
Councillor G Lymer	Kent County Council
Ms J Mookherjee	Kent Public Health, Kent County Council
Vacancy	Dover District Council

AGENDA

1 **ELECTION OF A CHAIRMAN**

To elect a Chairman for the remainder of the municipal year 2017/18 following the resignation of Councillor P A Watkins (Dover District Council).

2 **APOLOGIES**

To receive any apologies for absence.

3 **APPOINTMENT OF SUBSTITUTE MEMBERS**

To note appointments of Substitute Members.

4 **DECLARATIONS OF INTEREST** (Page 4)

To receive any declarations of interest from Members in respect of business to be transacted on the agenda.

5 **MINUTES** (Pages 5 - 8)

To confirm the attached Minutes of the meeting of the Board held on 16 May 2017.

6 **MATTERS RAISED ON NOTICE BY MEMBERS OF THE BOARD**

Any member of the Health and Wellbeing Board may request that an item be included on the agenda subject to it being relevant to the Terms of Reference of the Board and notice being provided to Democratic Services at Dover District Council (democraticservices@dover.gov.uk) at least 9 working days prior to the meeting.

7 **SUSTAINABILITY AND TRANSFORMATION PLAN UPDATE** (Pages 9 - 11)

To receive an update on the Sustainability and Transformation Plan.

Presenter: Karen Benbow, South Kent Coast Clinical Commissioning Group

8 **INTEGRATED ACCOUNTABLE CARE ORGANISATION UPDATE**

To receive an update on the Integrated Accountable Care Organisation.

Presenter: Mark Needham, South Kent Coast Clinical Commissioning Group

9 **INTEGRATED CARE ORGANISATION RESEARCH AND EVALUATION PROJECT**

To receive a presentation on the Integrated Care Organisation Research and Evaluation Projection.

Presenter: Sabrena Jaswal, Centre for Health Services Studies, University of Kent

10 **SOUTH KENT COAST HEALTH AND WELLBEING BOARD: NEXT STEPS** (Pages 12 - 29)

To receive a presentation on the South Kent Coast Health and Wellbeing Board: Next Steps.

Presenter: Michelle Farrow, Dover District Council

11 **URGENT BUSINESS ITEMS**

To consider any other items deemed by the Chairman to be urgent in accordance with the Local Government Act 1972 and the Terms of Reference. In such special cases the Chairman will state the reason for urgency and these will be recorded in the Minutes.

Access to Meetings and Information

- Members of the public are welcome to attend meetings of the Council, its Committees and Sub-Committees. You may remain present throughout them except during the consideration of exempt or confidential information.
- All meetings are held at the Council Offices, Whitfield unless otherwise indicated on the front page of the agenda. There is disabled access via the Council Chamber entrance and a disabled toilet is available in the foyer. In addition, there is a PA system and hearing loop within the Council Chamber.
- Agenda papers are published five clear working days before the meeting. Alternatively, a limited supply of agendas will be available at the meeting, free of charge, and all agendas, reports and minutes can be viewed and downloaded from our website www.dover.gov.uk. Minutes are normally published within five working days of each meeting. All agenda papers and minutes are available for public inspection for a period of six years from the date of the meeting.
- If you require any further information about the contents of this agenda or your right to gain access to information held by the Council please contact Rebecca Brough, Democratic Services Manager, telephone: (01304) 872304 or email: rebecca.brough@dover.gov.uk for details.

Large print copies of this agenda can be supplied on request.

Declarations of Interest

Disclosable Pecuniary Interest (DPI)

Where a Member has a new or registered DPI in a matter under consideration they must disclose that they have an interest and, unless the Monitoring Officer has agreed in advance that the DPI is a 'Sensitive Interest', explain the nature of that interest at the meeting. The Member must withdraw from the meeting at the commencement of the consideration of any matter in which they have declared a DPI and must not participate in any discussion of, or vote taken on, the matter unless they have been granted a dispensation permitting them to do so. If during the consideration of any item a Member becomes aware that they have a DPI in the matter they should declare the interest immediately and, subject to any dispensations, withdraw from the meeting.

Other Significant Interest (OSI)

Where a Member is declaring an OSI they must also disclose the interest and explain the nature of the interest at the meeting. The Member must withdraw from the meeting at the commencement of the consideration of any matter in which they have declared a OSI and must not participate in any discussion of, or vote taken on, the matter unless they have been granted a dispensation to do so or the meeting is one at which members of the public are permitted to speak for the purpose of making representations, answering questions or giving evidence relating to the matter. In the latter case, the Member may only participate on the same basis as a member of the public and cannot participate in any discussion of, or vote taken on, the matter and must withdraw from the meeting in accordance with the Council's procedure rules.

Voluntary Announcement of Other Interests (VAOI)

Where a Member does not have either a DPI or OSI but is of the opinion that for transparency reasons alone s/he should make an announcement in respect of a matter under consideration, they can make a VAOI. A Member declaring a VAOI may still remain at the meeting and vote on the matter under consideration.

Note to the Code:

Situations in which a Member may wish to make a VAOI include membership of outside bodies that have made representations on agenda items; where a Member knows a person involved, but does not have a close association with that person; or where an item would affect the well-being of a Member, relative, close associate, employer, etc. but not his/her financial position. It should be emphasised that an effect on the financial position of a Member, relative, close associate, employer, etc OR an application made by a Member, relative, close associate, employer, etc would both probably constitute either an OSI or in some cases a DPI.

Minutes of the meeting of the **SOUTH KENT COAST HEALTH AND WELLBEING BOARD** held at the Council Offices, Whitfield on Tuesday, 16 May 2017 at 3.02 pm.

Present:

Chairman: Councillor P A Watkins

Members: Dr J Chaudhuri
Ms S Baldwin
Councillor P M Beresford
Councillor S S Chandler
Councillor J Hollingsbee (Minute Nos 63 and 64 only)
Mr M Lobban
Mr I Rudd

Also present: Ms K Cook (Strategic Policy, Kent County Council)
Ms S Robson (Shepway District Council)

Officers: Leadership Support Officer
Democratic Support Officer

54 ELECTION OF A CHAIRMAN

The Democratic Support Officer called for nominations for a Chairman for 2017/18.

It was proposed by Councillor S S Chandler and duly seconded that Councillor P A Watkins be elected Chairman of the South Kent Coast Health and Wellbeing Board for the Council year 2017/18.

RESOLVED: That Councillor P A Watkins be elected as Chairman of the South Kent Coast Health and Wellbeing Board for the Council year 2017/18.

55 APPOINTMENT OF A VICE-CHAIRMAN

The Democratic Support Officer called for nominations for a Vice-Chairman for 2017/18.

It was proposed by Councillor P A Watkins and duly seconded that Dr J Chaudhuri be appointed Vice-Chairman of the South Kent Coast Health and Wellbeing Board for the Council year 2017/18.

RESOLVED: That Dr J Chaudhuri be appointed as Vice-Chairman of the South Kent Coast Health and Wellbeing Board for the Council year 2017/18.

56 APOLOGIES

Apologies for absence were received from Councillor G Lymer (Kent County Council), Councillor M Lyons (Shepway District Council), Ms K Benbow (South Kent Coast Clinical Commissioning Group), Mr S Inett (Healthwatch Kent) and Ms J Mookherjee (Kent Public Health, Kent County Council).

57 APPOINTMENT OF SUBSTITUTE MEMBERS

It was noted that, in accordance with Council Procedure Rule 4, Ms S Baldwin had been appointed as substitute for Ms K Benbow and Mr I Rudd for Ms J Mookherjee.

58 DECLARATIONS OF INTEREST

Dr J Chaudhuri declared an interest by reason that his GP surgery had been incorporated into Channel Health Alliance, the single legal entity for delivering collective health services.

59 MINUTES

It was agreed that the Minutes of the Board meeting held on 21 March 2017 be approved as a correct record and signed by the Chairman.

60 MATTERS RAISED ON NOTICE BY MEMBERS OF THE BOARD

There were no items raised on notice by members of the Board.

61 KENT SOCIAL CARE TRANSFORMATION UPDATE

The Board received an update from Mr Lobban on the Kent Social Care Transformation strategy. The strategy was a new, outcome-focused model for the delivery of adult social care which would be more responsive to individuals' needs. The draft strategy was due to go to Kent County Council's (KCC) Cabinet Committee for adoption on 21 July 2017, following a 4-week period of consultation.

A number of workshops had been held to consider how different roles within the NHS and KCC, providing similar services, worked together, and whether this relationship could be improved in terms of coordination, accessibility, response, etc. A particular focus had been the role of occupational therapists and social workers in relation to hospital discharges. Pilots in Ashford and Canterbury had examined how services could be brought together and a homecare model which involved nurses rather than social workers overseeing domiciliary care.

Dr J Chaudhuri pointed out that there had been a similar initiative some years previously, and queried opportunities for joint training. Mr Lobban agreed that there was a duplication of roles within KCC and the NHS. It was proposed that specialist staff would be employed by the NHS, with a health and social care workforce employed by KCC. Hours of employment, poor rates of pay and career pathways would need to be addressed.

Ms S Baldwin reported that Medway had also reviewed its domiciliary care workforce. Nurse-led homecare could promote health and wellbeing and was an untapped resource. Mr Lobban commented that nurses were a scarce commodity which was why consideration was being given to having some of their work done by lower-skilled workers, with the appropriate support and supervision. In response to Councillor P A Watkins who queried the division of responsibility within such an arrangement, Mr Lobban clarified that the proposal was very much in the design phase and would need further scoping and discussions with nursing and domiciliary care professionals.

Mr Lobban advised that there were other complications, in that NHS services were free but social care was chargeable for those with means. These issues would need to be worked through. Moreover, whilst coordination and supervision would be crucial, it was recognised that the public sector did not have a good track record in coordinating its services with the independent sector. He reassured the Board

that KCC was not underestimating the demand for these services. In this regard, carrying out frequent reviews could reduce demand and free up capacity.

In response to Councillor S S Chandler, Mr Lobban reported that 40% of the needs of people receiving domiciliary care could be met in another way, potentially through the voluntary sector. KCC believed it could make savings in domiciliary care, but this was likely to require an investment of £2 million in the voluntary sector. Whilst the voluntary sector required continuity and consistency in terms of grant-funding, they also wanted some flexibility in how they approached 'jobs'. KCC was looking at how it could network with the wider voluntary sector through one partner.

RESOLVED: That the update be noted.

62 DRAFT KENT HEALTH AND WELLBEING STRATEGY 2018-2023

Ms K Cook presented the report which outlined the draft Kent Health and Wellbeing Strategy 2018-2023, the development of which was a statutory requirement. The Strategy set out how the Kent Health and Wellbeing Board would operate in the future, and how commissioners could be supported in a different way. It was anticipated that the final Strategy would be presented to the Kent Board in September.

There was discussion around Kent's health priorities. Dr Chaudhuri agreed with the priorities set out in the report, but suggested that comparisons would be beneficial so that performance against previous strategies could be measured. Ms Cook recognised that there was a need for an assurance framework that would provide meaningful information to the Board on outcomes.

RESOLVED: That the report be noted.

63 KENT PUBLIC HEALTH UPDATE

Mr I Rudd advised that, whilst difficult, there was more that could be done to ensure that more people were accessing preventative services earlier.

In response to a question from Councillor P M Beresford, Dr Chaudhuri reported that there was anecdotal evidence to suggest that more people were using e-cigarettes to stop smoking than NHS services. It was also acknowledged that, whilst brief intervention on alcohol could be very effective, healthcare professionals were often reluctant to ask people about their drinking habits. The NHS was at the same point on alcohol as it had been with smoking 20 years ago. There needed to be far greater emphasis on prevention – a matter which a local sub-group was looking at. He remarked that there were a lot of preventative services being provided by a number of organisations. He was keen to see a comprehensive service which covered prevention, wellbeing and rehabilitation.

In response to Councillor Watkins, Ms Cook clarified that there was a new Kent-wide consortium of voluntary sector organisations called Supporting Kent Communities (SKC) whose contract had started in March. It was likely that someone from SKC would act as the voluntary sector's representative on the Board, but she undertook to obtain further information. Councillor Watkins advised that some local access points were likely to close in the coming months, thus reducing the opportunities to disseminate information to communities. The Board would need to decide how it could compensate for these closures.

RESOLVED: That the update be noted.

64 URGENT BUSINESS ITEMS

There were no items of urgent business.

The meeting ended at 4.39 pm.

East Kent
Programme Board

Update from the meeting of the East Kent Programme Board 12 October 2017

About the East Kent Programme Board
The East Kent Programme Board has been set up by local health and care commissioners to spearhead the drive to determine how best to provide health and care services to the population of east Kent. Its work is part of the wider Sustainability and Transformation Plan (STP) for Kent and Medway.

Comprising all organisations involved in the planning, provision and delivery of health and care services in this area, the Board is an advisory board with a clinical chair. Its membership includes the chief executives and most senior clinicians, practitioners and leaders of east Kent's NHS and care services. The Board oversees a work programme and advises local health and care commissioners whose role it is to plan the future pattern of services across east Kent.

As of 17 November 2016, the East Kent Programme Board has a new and formalised role within the governance structure of the Kent and Medway STP. This allows the Board to build on the work it has done at an east Kent level with colleagues in health and social care across Kent and Medway.

The following update covers the key agenda items discussed at the meeting.

Local care update

All four Clinical Commissioning Groups (CCGs) in east Kent and East Kent Hospitals University Foundation Trust (EKHUFT) have signed a Memorandum of Understanding (MoU) regarding a new system of local care relating to the provision and delivery of some cardiology, respiratory and rheumatology services. A new approach to these three key areas will see more planned care taking place outside of hospital and in a community setting meaning that patients will not need to travel to a hospital for treatment, can receive care closer to home, hospital beds across east Kent will be freed up for more urgent and emergency cases and specialist senior clinical care can be concentrated on treating these cases.

The new approach is being implemented during October and November and all organisations have been asked to share data so that an accurate and timely picture of the status of implementation can be built with the Board receiving regular reports on progress.

The Board also received an update on the implementation of the pneumonia pathway and frailty work that is currently being progressed across east Kent and will receive further updates about this at future meetings.

Stroke

The Board received an update on the Kent and Medway stroke review. The Stroke Programme Board, which is leading the review of acute stroke services on behalf of the Kent and Medway STP, has looked at several possible models and expects to make an announcement on the list of options it will consult on early next year.

This follows a programme of detailed engagement with key stakeholders, in-depth clinical review and evaluation and the consideration of a wide number of options.

The shortlist is likely to include several options involving three specialist hyper acute stroke centres at existing acute hospitals. This shortlist will then be presented to a joint committee of clinical commissioners, independently chaired, who will make the final decision on the shortlist for consultation. Commissioners expect to take these proposals out to a formal public consultation in early Spring 2018.

Workforce update

At STP level, a dedicated workstream is looking at how best to build a sustainable workforce for the future across Kent and Medway. Within east Kent, work has been going on for some time to map current and future demand, identify areas of particular challenge and to develop plans alongside other workstreams to help achieve a sustainable workforce for health and care services.

In east Kent, major workforce challenges have been identified as:

- an ageing population and increased demand for services
- difficulty recruiting and retaining specialist and non-specialist staff i.e. GPs, ED (emergency department) medical staff, nursing, social care workers
- not consistently meeting clinical standards/guidance for workforce levels; and,
- high reliance on temporary staffing at high cost and variability in quality.

The Board received an update on progress to date including a report on the outcomes of a multidisciplinary workshop held at the beginning of October, attended by representatives from all partner organisations across the east Kent health and care economy.

The workshop's main aims were to: recognise the current workforce risks that all partners are managing; identify current and future workforce needs; quantify the gaps between new care models.

Key themes from the workshop included:

- the use of existing skills, capabilities and resources in adopting changes in working practices;
- the need for greater trust and confidence between organisations in the training and competencies of roles shared and working across local care;
- enthusiasm for more shared learning and examples of working differently across East Kent;
- the suggestion of a shared framework that supports changes, promotes localism whilst maintaining an East Kent identity to support future resource and skills development;

- a core set of common competencies that exist across all staff groups supporting the delivery of new models for example leadership skills as part of multi-disciplinary teams;
- the development of a workforce strategy for east Kent;
- greater clarity and the use of a common language across roles and services to support more effective and consistent care navigation.

The Board noted that concerns about the health and care workforce is a key theme that has surfaced during engagement activity, with recent listening events and staff feedback highlighting anxieties about staffing, morale, recruitment and retention.

Whilst there has been a significant amount of work already done to assess the current workforce model and future needs, more work is needed to refine any gaps in capacity and capabilities and a further update on workforce development will be shared at the next meeting in November.

For more information about the work of the East Kent Programme Board visit:
http://kentandmedway.nhs.uk/where-you-live/plans-east-kent/

Ends

Subject:	**FUTURE OF THE SOUTH KENT COAST HEALTH AND WELLBEING BOARD**
Meeting and Date:	**South Kent Coast Health & Wellbeing Board - 7 November 2017**
Report of:	**Michelle Farrow, Head of Leadership Support, Dover District Council**
Classification:	**UNRESTRICTED**

Purpose of the report: To provide a discussion paper and suggested options for the future of the South Kent Coast Health and Wellbeing Board.

The South Kent Coast Health and Wellbeing Board is asked to consider:

a) *The role of the Board and discuss future options;*

- *Remain as is, with 6 meetings per year and a revised workplan*
- *To meet once or twice a year with a revised remit*
- *To dissolve the SKC HWBB*

Recommendation: To move to 1 or 2 set meetings per year. This would enable the partnership working to continue and address any opportunities and challenges as service changes and further integration take place. With the agreement of the Chair and Vice-Chair further meetings could be called as necessary (providing adequate notice is given to all Board members).

1. Summary

The South Kent Coast Health and Wellbeing Board (SKC HWBB) has been operational since 2012, with an agreed Terms of Reference (attached at Appendix 1), in conjunction with the Kent Health and Wellbeing Board.

With the introduction of the Sustainability and Transformation Plans (STP) and local Integrated Accountable Care Structures, and the associated resources involved, it is considered timely to review the role of the SKC HWBB.

The original intention of the Board was to explore and develop integrated ways of working and eventually take on the role of integrated commissioning.

The success of the Board has been in its partnership approach to understanding and supporting each other's agendas and sharing information and working practices that has enabled individual and joint projects to be successful.

There is now far greater collaboration between partners that has a positive impact on the residents and communities of South Kent Coast. The ability to support each other's projects and discuss openly any challenges and opportunities to further integration from a position of trust and mutual understanding, has allowed the Board to move forward.

Integrated commissioning and delivery is now taking place and will be driven and delivered by the Integrated Accountable Care structure. With this and the Sustainability and Transformation Plan, and the roles and capacity of Board

members on these various projects, it is an opportunity to revisit the role of the Board and its capacity and legality to achieve its original aspiration.

With all of the above in mind, this discussion paper suggests the HWBB continues to meet as a partnership group, with a reviewed remit and meeting frequency, to ensure collaborative and integrated opportunities are discussed and any challenges are talked through openly. Also, to support and enable integration of health and local development, to support the ongoing development of the IACO structure and as a platform for any potential emerging place based substructures of the STP – all with the aim of continuous improvement of health and care outcomes for the residents and communities served.

2. Introduction and Background

2.1 The SKC HWBB covers the majority of Dover District Council and Shepway District Council, with the exception of two GP practices in the Dover district that falls within the Canterbury and Coastal Clinical Commissioning Group and one GP practice in the Shepway district that fall within the Ashford Clinical Commissioning Group.

2.2 The SKC HWB was established in 2011 as an early-implementer in shadow form and in 2012 as a sub-committee of the Kent HWB. It has its own agreed Terms of Reference and, from the start, has been a board of commissioners, taking forward local projects (such as Healthy Living Pharmacy and Teenage Pregnancy Awareness), and holding workshops to progress issues such as Cardio Vascular Disease and a local Alcohol Strategy. The SKC HWB has a localised Joint Strategic Needs Assessment / Health and Wellbeing Strategy and an Integrated Commissioning Strategy (now superseded).

2.3 Since the commencement of the SKC HWB there have been a number of new developments, including national policy (such as Better Care Fund, NHS Five Year Forward View, Sustainability and Transformation Plans) and local responses to a new way of working (such as Integrated Accountable Care Organisations).

2.4 In early 2016, the SKC HWB secured organisational development support through the Local Government Association. As a result, board members attended a development day in March 2016, with the aim of maturing relationships and to progress developing the SKC HWB into a commissioning board, which would be at the centre of all decision-making concerning health and wellbeing for the residents of the area it serves.

2.5 As agreed at the development day, a working group was set up to continue looking at governance arrangements for the transition to a commissioning board. However, at this time legislation is not in place to enable devolved decision-making powers and funding to the SKC HWB to enable it to function effectively as planned.

2.6 Going forward, if there is agreement to continue with the SKC HWBB, it is necessary to clearly define the purpose of the Board, to ensure it 'adds value' to the existing partner organisations, who are continuing to deliver their core functions.

2.7 Any forward work plan for the SKC HWBB should maintain a focus on the strategic priorities of the Kent Health and Wellbeing Strategy and Joint Strategic Needs Assessment, the Kent and Medway Sustainability and Transformation Plan (STP), and the developing Integrated Accountable Care Structure, to achieve a shared vision for South Kent Coast.

2.8 Should there be agreement to continue with the SKC HWBB (in either a current or reduced meeting format), it is suggested:

There will be a focus on:

a) Reducing health inequalities

b) Creating a high quality health and care system

c) Having a financially sustainable health and care system

This would be achieved through annual (at minimum) updates on the STP, the developments and workstreams of the IACO and SKC CCG and local development plans of the Local Authorities (DDC, SDC and KCC) – to inform any future impacts and influence the direction of health and wellbeing requirements within SKC.

2.9 It is suggested the role of the South Kent Coast Health and Wellbeing Board could be:

a) To enable and facilitate collaborative working across the South Kent Coast

b) To identify, and seek to address, any challenges/obstacles that may hinder delivery of added value, improvements in reducing health inequalities or improvements in health and wellbeing outcomes locally.

c) To review the delivery of local outcomes and priorities contained within the STP, IACO, CCG and Local Authorities and provide support where applicable.

2.10 Currently the SKC Local Children's Partnership Group (LCPG) reports into the SKC HWBB. However, the role of this Board is currently under review. Members on the HWBB will be able to ensure links are maintained between the current and new arrangements.

2.11 The Kent HWBB has also been going through a period of review (report attached at Appendix 2) and notes that not all local HWBBs are adding value, or continuing to meet. Through consultation it is noted the link between the Kent board and local Boards has been 'weak' and the 'issue of lack of decision-making powers at the main Board was replicated in the local Boards'. The Kent HWBB report sought to;

a) Agree that the Board should seek a role within the governance arrangements of the Kent and Medway STP

b) Agree to explore the creation of a joint Board with Medway Council to support the above recommendation

2.12 Depending on the outcome of the review of the Kent HWBB, there may be a further requirement to re-visit the decisions taken in this paper and consider the sub-committee role of any redefined Kent Board.

3. Identification of Options

3.1 To continue with Board as it currently is with 6 meetings per year. This option may require a further review of the Boards role and membership, plus the agreement of a work plan to ensure the Board does not become a 'talking shop' delivering no clear actions and outcomes.

3.2 To move to 1 or 2 set meetings per year. This would enable the partnership working to continue and address any opportunities and challenges as service changes and further integration take place. With the agreement of the Chair and Vice-Chair further

meetings could be called as necessary (providing adequate notice is given to all Board members).

3.3 To dissolve the SKC HWBB. This option would mean no meetings would take place and any partnership discussions would need to be held at alternative meetings.

4.1 **Resource Implications**

There are no direct resource / management implications arising from this report. Dover District Council will continue to administer the Board, subject to the discussion/agreements of this report.

4. Appendices

Appendix 1 – South Kent Coast HWBB Governance arrangements

Appendix 2 – Kent Health and Wellbeing Board - future direction and fitness for purpose

South Kent Coast CCG Health and Wellbeing Board

Governance Arrangements

The Kent Health and Wellbeing Board (HWB) leads and advises on work to improve the health and wellbeing of the people of Kent through joined up commissioning across the NHS, social care, public health and other services (that the HWB agrees are directly related to health and wellbeing) in order to:

- secure better health and wellbeing outcomes in Kent
- reduce health inequalities and
- ensure better quality of care for all patients and care users.

The HWB has a primary responsibility to make sure that health care services paid for by public monies are provided in a cost-effective manner. It is supported in this work by a series of sub committees referred to as CCG level Health and Wellbeing Boards.

Role of the CCG level Health and Wellbeing Board

The CCG level Health and Wellbeing Board (HWB) will lead and advise on the development of CCG level Integrated Commissioning Strategy and Plan; ensure effective local engagement and monitor local outcomes. It will focus on improving the health and wellbeing of the people living in their CCG area through joined up commissioning across the NHS, social care, district councils, public health and other services (that the HWB agrees are directly related to health and wellbeing,) in order to secure better health and wellbeing outcomes in their area and better quality of care for all patients and care users.

Terms of Reference:

The CCG level HWB will:

1. Be appointed and act as a sub committee of the Kent Health and Wellbeing Board (a committee of Kent County Council).

2. Develop and deliver a CCG level Integrated Commissioning Strategy and Plan, based on the Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and partners Commissioning Plans. This will be approved by the Kent Health and Wellbeing Board.

3. Consider the totality of the resources in the CCG area for health and wellbeing and consider how and where investment in health improvement and prevention services could (overall) improve the health and wellbeing of local residents.

4. Works with existing partnership arrangements, e.g. children's commissioning, safeguarding and community safety, to ensure that the

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most appropriate mechanism is used to deliver service improvement in health, care and health inequalities.

5. Endorse and secure joint arrangements where agreed and appropriate; including the use of pooled budgets for joint commissioning (s75), the development of appropriate partnership agreements for service integration, and the associated financial protocols and monitoring arrangements, making full use of the powers identified in all relevant NHS and local government legislation.

6. Undertake monitoring of local outcomes.

7. Ensure effective local engagement on health and care issues, using existing engagement mechanisms where necessary and linking in to any county level engagement work where established.

8. Provide advice (as and when requested) to the Kent Health and Wellbeing Board on local service reconfigurations that may be subject to referral to the Kent County Council Health Overview and Scrutiny Committee or the Secretary of State on resolution by KCC HOSC.

9. Be the focal point for joint working in the CCG area to ensure facilities and accessibility, in order to enhance service integration.

10. Report to the Kent Health and Wellbeing Board on an annual basis on its activity and progress against the milestones set out in the Integrated Commissioning Strategy and any established work plan.

11. Responsible for overseeing local project resource to facilitate local pathway redesign, as appropriate

12. Provide recommendations how and where investment, resources and improvements can be made within the South Kent Coast CCG area.

13. Identify how to make the best use of the flexibilities at the Board's disposal, such as devolved/pooled budgets.

Membership:

The Chairman will be elected by the CCG level HWB.

DDC: Cllr Paul Watkins, Leader

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DDC: Cllr Pauline Beresford, Portfolio Holder for Housing, Health, and Well-Being
SDC: Cllr Jenny Hollinsgbee, (SDC)
SDC: Cllr Michael Lyons, (SDC)
SKC CCG: Karen Benbow, Chief Operating Officer
SKC CCG: Dr Joe Chaudhuri (Deputy Clinical Chair)
KCC: Geoff Lymer, Deputy Cabinet Member
KCC: Mark Lobban, Director of Strategic Commissioning Families and Social Care
Public Health: Jess Mookherjee, Consultant in Public Health
Voluntary and Community Sector: Jan Perfect (CaseKent)
Health Watch: Steve Inett
Local Children's Partnership Group: Cllr Sue Chandler

The administering Local Authority is Dover District Council.

Chair – Cllr Paul Watkins, DDC
Vice-Chair – Dr Joe Chaudhuri, SKC CCG

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Procedure Rules

1. **Conduct.** Members[1] of the HWB are expected to subscribe to and comply with the Kent County Council Code of Conduct. Non-elected representatives on the HWB (e.g. GPs and officers) will be co-opted members and, as such, covered by the Kent Code of Conduct for Members for any business they conduct as a member of the HWB.

2. **Declaration of Disclosable Pecuniary Interests.** Section 31(4) of the Localism Act 2011 (disclosable pecuniary interests in matters considered at meetings or by a single member) applies to the HWB and any sub committee of it. A register of disclosable pecuniary interests is held by the Clerk to the HWB, but HWB members do not have to leave the meeting once a disclosable pecuniary interest is declared, however they cannot have a vote on that matter.

3. **Frequency of Meetings**. The HWB meets at least quarterly. The date, time and venue of meetings is fixed in advance by the HWB in order to coincide with the key decision-points and the Forthcoming Decision List.

4. **Meeting Administration.**
   - HWB meetings are advertised and held in public and administered by the nominated District/Borough/City Council.
   - The HWB may consider matters submitted to it by local partners.
   - The administering Council gives at least five clear working days' notice in writing to each member of every ordinary meeting of the HWB, to include any agenda of the business to be transacted at the meeting.
   - Papers for each HWB meeting are sent out at least five clear working days in advance.
   - Late papers may be sent out or tabled only in exceptional circumstances.
   - The HWB holds meetings in private session when deemed appropriate in view of the nature of business to be discussed.
   - The HWB meetings will be web cast where the facilities are in place
   - The Chairman's decision on all procedural matters is final.

5. **Meeting Administration of Sub Committees**. HWB sub-committees are administered by a principal local authority, in the case of the Clinical Commissioning Group level HWBs, by a District Council in that area. They will be subject to the provisions stated in these Procedure Rules.

6. **Special Meetings.** The Chairman may convene special meetings of the HWB at short notice to consider matters of urgency. The notice convening such meetings shall state the particular business to be transacted and no other business will be transacted at such meeting.

[1] 'Member's meaning membership of the HWBB

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The Chairman is required to convene a special meeting of the HWB if they are in receipt of a written requisition to do so signed by no less than three members of the HWB. Such requisition shall specify the business to be transacted and no other business shall be transacted at such a meeting. The meeting must be held within five clear working days of the Chairman's receipt of the requisition.

7. **Minutes.** Minutes of all of HWB meetings are prepared recording:

   - the names of all members present at a meeting and of those in attendance
   - apologies
   - details of all proceedings, decisions and resolutions of the meeting

   Minutes are printed and circulated to each member before the next meeting of the HWB, when they are submitted for approval by the HWB and are signed by the Chairman.

8. **Agenda.** The agenda for each meeting normally includes:

   - Minutes of the previous meeting for approval and signing
   - Reports seeking a decision from the HWB
   - Any item which a member of the HWB wishes included on the agenda, provided it is relevant to the terms of reference of the HWB and notice has been give to the Clerk at least nine working days before the meeting.

   The Chairman may decide that there are special circumstances that justify an item of business, not included in the agenda, being considered as a matter of urgency. He must state these reasons at the meeting and the Clerk shall record them in the minutes.

9. **Chairman and Vice Chairman's Term of Office.** The Chairman and Vice Chairman's term of office terminates on 1 April each year, when they are either reappointed or replaced by another member, according to the decision of the HWB, at the first meeting of the HWB succeeding that date.

10. **Absence of Members and of the Chairman.** If a member is unable to attend a meeting, then they may provide an appropriate alternate person to attend in their place, subject to them being of sufficient seniority to agree and discharge decisions of the Board within and for their own organisation. The Clerk of the meeting should be notified of any absence and/or substitution at least five working days prior to the meeting. The Chairman presides at HWB meetings if they are present. In their absence the Vice-Chairman presides. If both are absent, the HWB appoints from amongst its members an Acting Chairman for the meeting in question.

11. **Voting.** The HWB should operate on a consensus basis. Where consensus cannot be achieved the matter is put to a vote. The HWB decides all such

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matters by a simple majority of the members present. In the case of an equality of votes, the Chairman shall have a second or casting vote. All votes shall be taken by a show of hands unless decided otherwise by the Chairman.

12. **Quorum.** A third of members of the Board form a quorum for HWB meetings. No business requiring a decision shall be transacted at any meeting of the HWB which is inquorate. If it arises during the course of a meeting that a quorum is no longer present, the Chairman either suspends business until a quorum is re-established or declares the meeting at an end.

13. **Adjournments.** By the decision of the Chairman**, or** by the decision of a majority of those members present, meetings of the HWB may be adjourned at any time to be reconvened at any other day, hour and place, as the HWB decides.

14. **Order at Meetings.** At all meetings of the HWB it is the duty of the Chairman to preserve order and to ensure that all members are treated fairly. They decide all questions of order that may arise.

15. **Suspension/disqualification of Members.** Any body with a representative on the HWB will be asked to reconsider the position of their nominee if they fail to attend two or more consecutive meetings without good reason or without the prior consent of the Chairman.

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From:	Peter Oakford, Deputy Leader, Cabinet Member for Strategic Commissioning & Public Health and Chairman of the Kent Health and Wellbeing Board David Whittle, Director Strategy, Policy, Relationships and Corporate Assurance
To:	Health and Wellbeing Board – 20 September 2017
Subject:	Health and Wellbeing Board – future direction and fitness for purpose
Classification:	Unrestricted

Summary: This paper reports the findings of the review undertaken by the Chairman into the fitness for purpose and future focus of the Board in light of the development of the Kent and Medway STP.

Recommendations:

The Board is asked to:

a) **Note** findings of the review;
b) **Agree** that the Board should seek a role within the governance arrangements of the Kent and Medway STP;
c) **Agree** that the Chairman explore the creation of a joint Board with Medway Council to support the above recommendation.

1. Introduction:

1.1 At the last meeting of the Board it was agreed that the Chairman would undertake a review of the fitness for purpose and future direction of the Kent Health and Wellbeing Board (the Board) in light of the development of the Kent and Medway Sustainability and Transformation Plan (STP) and its impact. The Chairman agreed to visit/discuss the issue with each member of the Board to gauge their views and report back with findings and options. These visits/discussions took place throughout late July and August, and a list of those consulted is in Appendix A. This included current Board members, former Board members and other interested organisations/partners.

1.2 This report summarises the key issues raised during those discussions and sets out options for the Board to consider before agreeing next steps.

2. Background:

2.1 The Board is a formal committee of the County Council required by S.194 of the Health and Social Care Act 2012. The Board existed in shadow status from the summer of 2011, following Kent being given early implementer status by the Department of Health, and became fully operational on the 1st April 2013. The Act denotes the number of statutory members of the HWBB as:

- The Leader of the Council and/or their nominee
- Director of Adult Social Services for the local authority
- Director of Children's Services for the local authority
- Director of Public Health for the local authority
- A representative of the Local Healthwatch organisation
- A representative of each clinical commissioning group
- A general power of the local authority to appoint other persons as appropriate

2.2 S.197-199 establishes the Board as a forum for leaders from the local health and care system to jointly work to improve the health and well-being of the people in their area; reduce health inequalities, and promote the integration of services. It has a statutory duty to ensure the production of a joint strategic needs assessment and a joint health and wellbeing strategy, setting out priorities for local commissioning. It also needs to ensure the production of a Pharmaceutical Needs Assessment. These priorities then inform local authority and CCG commissioning plans.

2.3 Health and Wellbeing Boards have limited formal powers and were constituted as a partnership forum rather than an executive decision-making body, with executive authority for health and social care commissioning remaining with the CCG governing body or the local authority Cabinet. This reflects the intention of the Health and Social Care Act 2012 to create CCGs as the statutory vehicle for the commissioning of health services for their local population, and a clear statutory demarcation between commissioning and service provision within the health system. In only a limited number of examples, usually smaller unitary/metropolitan council area has a local authority Cabinet delegated executive decision-making authority to a Health and Wellbeing Board.

2.4 In Kent, the Board also created local Health and Wellbeing Boards (following Clinical Commissioning Group boundaries) as sub-committees of the main Board. This followed the Department of Health giving both the County Council and Dover District Council early implementer status in 2011 (although district councils held no formal role under the Act) and there was an appetite across CCGs and the District Councils for local Boards to support local planning, integration and engagement. It is worth noting that the other two-tier authorities given early implementer status (Hertfordshire & St Albans and Suffolk & Great Yarmouth) did not follow through to create a local Board structure. It was also agreed that three representatives from District Councils, nominated by the Kent Council Leaders group, would sit as members of the Board.

2.5 In March 2014, the Board also agreed to establish a Children's Health and Wellbeing Board as an informal working group reporting to the Board. The aim of the Children's Board is to ensure a clear link between the commissioning of children's services and the priorities set out in JSNA and the Health and Wellbeing Strategy as required under S.7 of the Children and Families Act 2014. It also supports the general duty on all partners for inter-agency cooperation to improve the welfare of children as set out in S.10 of the Children Act 2004.

2.6 It should be noted that while the statutory requirements as to membership and purpose of the Board is set out in the statute, there was an expectation from the Government that Health and Wellbeing Boards would develop beyond this limited statutory role as new partnership arrangements matured. As such, there is scope for variability in the focus and operation of the Board while still complying with the statutory limitations of the 2012 Act.

3. The development and focus of the Board

3.1 Many of those interviewed commented on the success of the previous Chairman in personally driving the development of the Board from the early implementer stage. In particular, there was a consensus that this had allowed members to forge cross-sector relationships that had not previously existed, and develop a pan-Kent view of the health and social care system. There was agreement that these 'softer' benefits should neither be underplayed nor lost in any reforms, as effective relationships across the different sectors are critical.

3.2 In particular, the advantage of the Board was particularly felt by clinical leads who found its broader consideration of health and well-being to be important. Discussions on the wider determinants of health such as social care, public health, housing, leisure etc. were seen as critical to supporting primary care, given the increasing demand for primary care can only be met through greater social prescribing and signposting to services provided by wider public services.

3.3 However, there was a broad degree of frustration from Board members regarding its limited role and in particular its lack of decision-making powers (beyond approving the JSNA, HWB

Strategy and PNA). There was agreement that this led to items being 'show and tell' narratives, where different partners in the system would inform other partners of their plans and strategies but with only limited reference to the wider pan-Kent issues, and limited scope for board members to influence those plans and activities. As such, members felt the Board wasn't adding value in the way it could or should do. Non-members interviewed expressed frustration that the influence of the Board wasn't felt across the wider health and social care system or the wider Kent public service landscape.

3.4 Some interviewees expressed the view that the Health and Wellbeing Board should be a mechanism for collectively holding the health and social care system to account for delivery. However, a counter view put forward by some was that as a committee of the County Council, which is meeting in public and with elected politicians as members, such collective peer challenge was unrealistic. They feel the Board is not a suitable forum for 'difficult discussions' on system performance, and that such conversations take place through better alternative forums.

3.5 There is consensus from all Board members that the emergence of the STP is a game changer. At a practical level, the STP governance arrangements and programme delivery are now driving the day-to-day activity of Board members, both CCG and KCC, as well as a requiring a significant degree of capacity and capability of the resources from their respective organisations. As a consequence, this is leading to meeting fatigue and prioritisation of effort more carefully. Given this, many Board members feel that they cannot prioritise engagement with the Health and Wellbeing Board while the STP is so resource intensive.

3.6 Moreover, in responding to the policy direction set by NHS England through the *Five Year Forward View,* the STP is blurring the demarcation between health commissioners and providers in favour of an integrated planning framework across the health and social care system. As such, the operating environment set for the Board through the 2012 Act is being radically transformed, even if the legal framework lags behind. It is felt that the Board must respond to this changing operating environment if it is to remain relevant.

3.7 There was broad agreement that it was the right time to review the role and fitness for the purpose of the Board. However, given the fluid nature of the health and social care system as a result of the STP, it was felt that any new arrangements would need to be revisited again in 18-24 months to ensure that they were still appropriate.

4. The role of the Board vis-à-vis the STP

4.1 Given the current prominence of the STP, there was agreement that its successful development and delivery is the short-term (1-2 years) priority for the health and social care system in Kent. There was also agreement that as a statutory committee with a remit covering health and social care, a membership drawn from across both sectors and a role in promoting integration, that the Board should play a significant role within the STP. There was also a strong view expressed by the majority of interviewees that if the HWBB were to have a more formal role within the STP, then it should be at a Kent and Medway geography, as this is the spatial scale of the STP. This would require the creation of a joint Health and Wellbeing Board between KCC and Medway Council.

4.2 The difficulty is that while there was a substantial degree of consensus that the Board *should* have a role within the STP, there was limited clarity about *what* that role should be and how it could be discharged in practice. Presuming that a joint Kent and Medway joint Board is possible, options put forward included:

a) **Strategic oversight:** Given national political and media interest in STP development, and the requirement of NHS England for all STPs to have local public and partner support, some interviewees suggested that the Board could have a strategic oversight role over STP development and delivery. As such, the Board might consider the STP a 'third pillar' of its responsibilities alongside the JSNA and the Health and Wellbeing Strategy. This was particularly

supported by those who expressed concern about the opaque and unclear accountability arrangements for the STP. However, it can be argued that given the number of STP updates considered by the Board already this year, it already acts as a form of strategic oversight. Moreover, this option is limited by the fact that even within the STP, there is no single decision-making authority and any proposals for change currently require sign off by each CCG governing body and, if necessary, local authority Cabinet. Without knowing what strategic oversight means beyond what the Board is already doing, this option risks the new joint Board with Medway merely becoming a talking shop sitting above the STP. Also, as some decisions emanating from the STP will likely be significant service changes, there is a risk that a 'strategic oversight' role duplicates the statutory role of Health Overview and Scrutiny Committees in considering service reconfiguration proposals.

b) **Act as the STP Programme Board:** Some suggested that given many members on the Board also sit on the STP Programme Board, the Health and Wellbeing Board could take on that responsibility. While possible, it needs to be remembered that there are organisations on the Programme Board that are not on the Health and Wellbeing Board, in particular, some health providers and other representative bodies (such as the Local Medical Committee). There is also the added complexity that the Programme Board is in the process of recruiting an independent Chairman, and is supported by external consultancy given the demands of the STP and the need for frequent Programme Board meetings. Transposing Programme Board responsibilities to a joint Health and Wellbeing Board is not straightforward.

c) **Work stream lead responsibility:** Another option suggested by a number of interviewees was that a joint Board should take a greater responsibility and accountability for the development of specific work streams within the STP, in particular, those work streams where local government and social care have a particular interest because of the potential impact on local authority social care and public health budgets, staffing and commissioning arrangements. The two work streams most frequently suggested where the 'Local Care' and 'Prevention'. It was broadly felt that while these were essential to the delivery of a new health and social care model, the STPs immediate focus on acute service sustainability meant they are not as prominent in the STP as they could be. It was felt that placing them under the auspices of a joint Board would give them the necessary ownership to be developed at a greater pace.

4.3 It was widely recognised that if there was an appetite for a greater role within the STP, then this would drive business and agenda in the short-term bar any continued statutory responsibilities for the JSNA, Strategy and Pharmaceutical Needs Assessment. This did raise some words of caution, particularly from clinicians, that the important focus on the wider determinants of health should not be lost given that post-STP, these issues will still be fundamental to dealing with future demand pressures.

4.4 Indeed, when asked what the Board should focus on if it were *not* able to integrate with the STP or form a joint Board with Medway, the majority of interviewees suggested that a sharper focus on the wider determinants of health, particularly on a smaller number of priorities identified through the forthcoming refresh of the Health and Wellbeing Strategy. This would, however, have to be achieved through fewer Board meetings as the resource demands of the STP would remain.

5. Membership

5.1 The issue of the membership of the Board was the area of least agreement amongst those interviewed. Whilst there was an acceptance that if the Board took on a formal role in the STP its membership would have to change to discharge that role, on the general principle of membership there was little agreement, and a general concern that changing the membership of the Board would change the nature of discussions and detrimentally impact on meeting management.

5.2 Although the Kent Board chose to establish itself as a board of commissioners, there are a number of examples of Health and Wellbeing Boards including health providers on the Board itself

(normally as non-voting members) or creating specific mechanisms to engage health providers. Some interviewees expressed support for inviting representatives from acute, primary and community providers in Kent onto the Board on the basis that the STP and wider policy agenda for health is removing the absolute demarcation between commissioning and provision, and there was no logic for the Board in keeping it. Others expressed sympathy for this view but were concerned about the practical implications of inviting more members onto a Board that already has a large membership.

5.3 Others thought that inviting providers onto the Board was not only impractical but would have unintended consequences. In particular, there was concern that a focus from providers on short-term delivery would skew discussions away from the strategic issues that is the remit of the Board. Unsurprisingly, the providers interviewed thought that they should be represented on the Board, as the Board is better served by having as much input from clinicians as possible, and provider organisations were more clinically focussed. In particular, they argued they would be able to support the delivery of the Boards objectives more directly by being members, and that the Board would provide an appropriate vehicle currently for providers to engage in strategic planning conversations.

5.4 The issue of broadening the membership to wider public service partners was also considered during interviews. Whilst it was felt that this would not be appropriate if the Board was focussed on a role within the STP, if focussed on wider determinants, there was general agreement that would be beneficial, although some concern as to the impact on the management of the meetings. The Police and Crime Commissioner would like to be included as a member of the Board, given the strong link between demand on police services and mental health.

5.5 Repeatedly throughout the review process, Board members thought a representative from the state education sector would be a positive step given the importance of schools, education and training to the future health and wellbeing of the population and reducing health inequalities. It was suggested that the Association of Kent Head teachers might be appropriate to become a member of the Board. Alongside education, the most frequently referenced wider public sector partner whom it was felt should be represented on the Board was housing. This representative could come from one of the housing associations operating in Kent or a representative from the Kent Housing Group, the officer group of district council housing officers that acts as a pan-Kent coordinating body.

6. Agenda planning and meeting management

6.1 Another issue that was frequently referenced by those interviewed were concerns about meeting management. In particular, numerous interviewees raised concerns that the Board frequently has too many agenda items to discharge, and that there was a tendency for the time available in meetings to be focussed on just a single (and often the first substantive) item, with other items having to effectively be rushed through without appropriate consideration.

6.2 It was generally recognised that this was a consequence of the Board having too greater scope and not focussing on more specific objectives and priorities. There has become a tendency to treat the Boards consideration of an item as a 'tick box' exercise that was adding unnecessary items to the agenda. Some health members felt that they had not done enough to support the local authority in developing an appropriate forward plan and ensure appropriate agendas were set for the Board.

7. Meeting arrangements

7.1 There was some concern about the meeting arrangements of the Board including the bi-monthly meeting schedule and timing the start of meetings in the early evenings. This is difficult for members who have to travel long distances home in the late evening from Maidstone. The meeting schedule necessary to support the STP has compounded this matter for some Board members.

7.2 The rationale for the evening meetings lies in the initial establishment of the Board at early implementer stage in 2011. At the time, clinical leads were combining their new CCG leadership roles with GP surgeries, and evening meetings were deemed the best way to allow clinical leads to attend. The bi-monthly meeting frequency was, again, set at early implementer stage as this was necessary to discharge the business of the Board. However, it is worth noting that the terms of reference for the Board only require it to meet quarterly.

8. Local Health and Wellbeing Boards

8.1 As noted in paragraph 2.4 the Board established local Health and Wellbeing Boards as a response to the concurrent early implementer status given to both KCC and Dover District Council in 2011. From the interviewees who had experience of local Boards (not all did) there were very mixed views about them. In some CCG areas the local Boards had found a niche role, and promoted wider engagement with partners at a local level, and as such were valued. In other areas, the Boards have fallen away and were no longer meeting. All respondents felt that the links between the main Board and the local Boards were weak, and the issue of lack of decision-making powers at the main Board was replicated in local Boards.

8.2 A number of respondents made the point that the future of local Boards couldn't be separated from the STP, as they also contributed to the feeling of meeting overload, but also because there is an emerging place based sub-structure for delivery of the STP. There is also widespread expectation that whatever new integrated health and social care arrangements might be created through the STP, these will have a local footprint (most likely through Accountable Care Systems) that would inevitably further challenge the purpose and role of local Boards.

8.3 It was broadly felt that trying to 'sort out' local Boards and bring them back to having some uniform, standardised role with stronger links back to the countywide Board would be both impractical and should not be an immediate priority given other pressures.

9. Children's Health and Wellbeing Board

9.1 Not all those interviewed as part of the review had experience of the Children's Health and Wellbeing Board. There was as mixed response about whether it should continue to sit as a informal subcommittee of the main Board. On the one hand, there was a strong view from some interviewees that if the aim of the Board was to impact on the wider determinants of health, such longitudinal change must start by a focus on children as part of the preventative agenda, and therefore children's issues should be a core focus of the main Board.

9.2 Conversely there was also a view put forward that the integration of health and children's social care in Kent is lagging behind the progress made in other areas of the country, and as such, a separate Children's Health and Wellbeing Board can provide a vehicle for progressing that agenda more quickly given it provides an appropriate, and specific, engagement vehicle. In the future, should the integration of children's health and social care progress, it was suggested that the Children's Board could exist as a decision-making committee in its own right. It was certainly felt by a number of interviewees that the current lack of a focus on children's issues in the STP made having a specific vehicle for engaging on children's issues necessary.

10. Discussion and next steps

10.1 If we accept that form should follow function, then the fundamental decision, from which other issues and decisions (e.g. membership, agenda planning, sub-board arrangements) will flow, is what role, if any, the Board should seek to have within the STP?

10.2 It is important to recognise that the Board cannot unilaterally decide to integrate itself into the STP governance arrangements. The STP is a separate entity. It is developing its own governance and support arrangements. As a change programme it needs to be flexible and adaptable to both

local and national requirements. Its membership is broader than the Board's. If the Board does feel it should have a role within the STP, this needs to be negotiated and there must be consensus about what the role is to be, and how it should be discharged.

10.3 Moreover, if the Board is to have a role in the STP, the consensus is that it must operate at a Kent and Medway. The Kent Board cannot do this unilaterally as it would require the creation of a Joint Health and Wellbeing Board between Medway Council and Kent County Council. Both Councils would formally have to agree, and Medway Council are under no requirement or obligation to do so. If Medway Council did agree, then the Kent Board would likely need to delegate much of its functions to the new joint Board for the period it is in place.

10.4 If Medway Council does not agree, then we should not expend time and resource seeking to persuade. Instead, we should default to the option identified in para 4.4 and on which there was broad agreement through the review, to refocus the Kent Board on the wider determinants of health, agree fewer specific and actionable objectives, and pare down the forward agenda and meeting requirements accordingly.

10.5 Initial conversations with Medway Council leadership have taken place about the appetite to create a joint Health and Wellbeing Board. Medway Council are willing to explore the creation of a joint Board, on a without prejudice basis, and KCC and Medway officers have been tasked to prepare reports on the options and practicalities for the operation of a joint Board, to be considered by both Councils' senior leadership later this month. An update on those discussions will be provided to the next Board meeting.

11. Recommendations:

11.1 The Board is asked to:

a) Note findings of the review;
b) Agree that the Board should seek a role within the governance arrangements of the Kent and Medway STP;
c) Agree to explore the creation of a joint Board with Medway Council to support the above recommendation.

Background Documents:

- Terms of reference and governance arrangements for the Kent Health and Wellbeing Board, Kent County Council, 28 March 2013 available at: https://democracy.kent.gov.uk/documents/s38976/Appendix%20A%20-%20Delivering%20Better%20Healthcare%20for%20Kent.pdf

Appendix:

- Appendix 1: Persons consulted as part of the review

REPORT AUTHOR:

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Appendix A: Interviewees as part of the review:

- Felicity Cox, Director Commissioning Operations South (South East), NHS England
- Dr Fiona Armstrong, Swale CCG Chair
- Dr Elizabeth Lunt, Clinical Chair for Dartford, Gravesham & Swanley CCG
- Patricia Davies, Accountable Officer, Dartford, Gravesham & Swanley CCG and Swale CCG
- Simon Perks, Accountable Officer, Ashford CCG and Canterbury & Coastal CCG
- Simon Dunn, Clinical Chair - Canterbury & Coastal CCG
- Dr Bob Bowes, Chair of West Kent CCG
- Dave Holman, Head of Mental Health Commissioning for West Kent CCG
- Ian Ayres, Accountable Officer – West Kent CCG
- Dr Tony Martin, Clinical Chair, Thanet CCG
- Dr Jonathan Bryant, Clinical Chair, South Kent Coast CCG
- Dr Joe Chaudhuri, Governing Body Member, South Kent Coast CCG
- Hazel Carpenter, Accountable Officer – South Kent Coast CCG and Thanet CCG
- Steve Inett, Chief Executive – Healthwatch
- Paul Bentley, Chief Executive, Kent Community Health Foundation Trust
- Dr. Mike Parks, Kent Local Medical Committee
- Dr. Gaurav Gupta, Kent Local Medical committee
- Matthew Scott, Kent Police and Crime Commissioner
- Cllr Paul Watkins, Leader of Dover District Council
- Cllr Fay Gooch, Deputy Leader, Maidstone Borough Council
- Cllr Ken Pugh, Swale Borough Council
- William Benson, Chief Executive, Tunbridge Wells District Council
- Roger Gough, Cabinet Member for Children, Young People and Education, KCC
- Andrew Ireland, Corporate Director - Social Care, Health and Wellbeing, KCC
- Graham Gibbens, Cabinet Member for Adult Social Care and Health, KCC
- Andrew Scott-Clark, Director for Public Health, KCC