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SOUTH KENT COAST HEALTH AND WELLBEING BOARD

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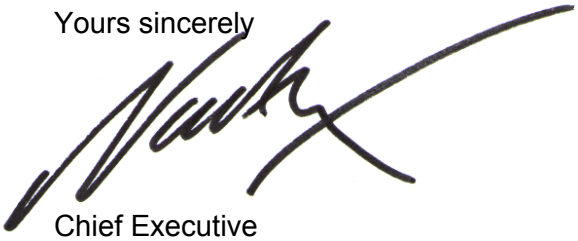
16 November 2015

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 Council Chamber at these Offices on Tuesday 24 November 2015 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:

Councillor P A Watkins (Chairman)	Dover District Council
Dr J Chaudhuri (Vice-Chairman)	South Kent Coast Clinical Commissioning Group
Vacancy	Community and Voluntary Sector Representative
Councillor P M Beresford	Dover District Council
Ms K Benbow	South Kent Coast Clinical Commissioning Group
Councillor S S Chandler	Local Children's Trust Representative
Councillor J Hollingsbee	Shepway District Council
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
Ms T Oliver	Healthwatch Kent

AGENDA

1 **APOLOGIES**

To receive any apologies for absence.

2 **APPOINTMENT OF SUBSTITUTE MEMBERS**

To note appointments of Substitute Members.

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

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

4 **MINUTES** (Pages 5 - 9)

To confirm the attached Minutes of the meeting of the Board held on 22 September 2015.

5 **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.

6 **DEVELOPMENT OF THE SOUTH KENT COAST HEALTH AND WELLBEING BOARD** (Pages 10 - 16)

To consider the report of Michelle Farrow (Dover District Council) and the Karen Benbow (South Kent Coast Clinical Commissioning Group).

7 **INTEGRATED CARE ORGANISATION WORKSTREAM UPDATE** (Pages 17 - 23)

To receive a presentation from Sue Baldwin (South Kent Coast Clinical Commissioning Group).

8 **KENT HEALTH AND WELLBEING BOARD AND LOCAL HEALTH AND WELLBEING BOARD RELATIONSHIPS AND FUTURE OPTIONS** (Pages 24 - 36)

To consider the attached report of Mark Lemon (Kent County Council).

9 **LOCAL CHILDREN'S PARTNERSHIP GROUP UPDATE** (Pages 37 - 40)

To receive a presentation from Councillor S S Chandler (Dover District Council).

10 **ESTABLISHMENT OF THE EAST KENT HEALTH AND SOCIAL CARE STRATEGY BOARD** (Pages 41 - 43)

To consider the attached report of Karen Benbow (South Kent Coast Clinical Commissioning Group) and Dr Joe Chaudhuri (South Kent Coast Clinical Commissioning Group).

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, Team Leader - Democratic Support, 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, 22 September 2015 at 3.00 pm.

Present:

Chairman:	Councillor P A Watkins
Board:	Councillor P M Beresford Ms K Benbow Councillor S S Chandler Dr J Chaudhuri Councillor J Hollingsbee Councillor G Lymer Ms J Mookherjee Ms T Oliver
Also Present:	Mr M Lemon (Kent County Council) Ms K Sharp (Kent County Council) Ms V Torey (Kent County Council)
Officers:	Head of Leadership Support Head of Communication and Engagement Leadership Support Officer Team Leader – Democratic Support

15 APOLOGIES

Apologies for absence for were received from Mr M Lobban (Kent County Council) and Councillor M Lyons (Shepway District Council).

16 APPOINTMENT OF SUBSTITUTE MEMBERS

There were no substitute members appointed.

17 DECLARATIONS OF INTEREST

There were no declarations of interest made by Members of the Board.

18 MINUTES

It was agreed that the Minutes of the Board meeting held on 23 June 2015 be approved as a correct record and signed by the Chairman.

19 MATTERS RAISED ON NOTICE BY MEMBERS OF THE BOARD

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

20 NEXT STEPS FOR THE SOUTH KENT COAST HEALTH AND WELLBEING BOARD

The Board received an update from Ms M Farrow (Head of Leadership Support, Dover District Council) and Ms K Benbow, (Chief Operating Officer, South Kent Coast Clinical Commissioning Group).

It had been agreed at the Board's Away-Day in March 2015 to investigate what would be required for it to become the first Health and Wellbeing Board in Kent to take on the role of a commissioning/decision-making body. A working group had been formed to identify the required governance arrangements to enable this and a small number of projects/themes that could be used to start jointly commissioning.

A report from the King's Fund had identified 3 broad emerging options for integrated commissioning with a single budget. These were:

- Option 1 - To build on existing organisational and policy arrangements with funding routed separately to the Clinical Commissioning Group (CCG) and local authorities.
- Option 2 - For one partner – the CCG or local government – to take lead responsibility for commissioning.
- Option 3 - To create a new vehicle – the Health and Wellbeing Board Plus – as a local executive decision-making body to support a single budget commissioning function.

The preferred option was Option 3, which would require the development of a governance model and an understanding of how the budgets could be integrated. It was intended that a report would be submitted to the meeting of the Health and Wellbeing Board in January 2016 on how Option 3 could be delivered with a shadow form in place by April 2016.

However, it was acknowledged that the realities of delivering the new model might mean that the shadow body in April 2016 could be operating in a framework of aligned budgets rather than integrated budgets. The importance of not losing sight of the objective of delivering integrated commissioning during the development of the governance arrangements was also emphasised.

The Board was advised that the preferred option did not conflict with the aspirations of the Kent Health and Wellbeing Board, although it was noted that there was no consensus in favour of moving to an integrated commissioning model amongst local Health and Wellbeing Boards at this point.

RESOLVED: That the next steps and timeline be noted.

21 PUBLIC HEALTH SERVICES TRANSFORMATION AND COMMISSIONING PLANS

Ms J Mookherjee (Public Health Consultant, Kent County Council) and Ms K Sharp (Kent County Council) gave a presentation on Public Health Transformation.

The Board was advised that there were a number of drivers for transforming public health:

- NHS Five Year Forward View (which called for a radical upgrade in prevention);
- Demographics (a growing, ageing and diversifying population);
- Financial and Contractual Drivers (£4 million reduction in grant 2015/16);
- Improving Healthy life expectancy;
- Health inequalities;
- Health and Wellbeing Board priorities (calls for radical upgrade in prevention); and

- Care Act (local authorities have responsibility to provide services that prevent the escalation of care needs).

It was intended that the transition to new service models would begin in April 2016 following a process of whole system engagement and consultation leading to the development of revised models of procurement.

The agreed key outcomes for public health services were measured against 'Starting Well', 'Living Well' and 'Ageing Well' for the following areas:

- Smoking;
- Healthy eating, physical activity and obesity;
- Alcohol and Substance Misuse;
- Wellbeing (including mental health and social isolation); and
- Sexual health and communicable disease

It was recognised that the services needed to be promoted in a manner that was more attractive to those with the greater risk to motivate them to access the services and change their behaviour. As part of this the barriers to engagement with harder to reach groups needed to be identified and understood. It was suggested that as Shepway and Dover District Councils had contact with every resident through local services, such as waste, that they would be well placed to reach local residents.

The Board was informed that the contracts would need to be more flexible to adapt to changing needs and changing budgets with more focus on co-designing services at a CCG level through integrated local commissioning rather than contracting on a countywide basis in recognition of the varying local health inequality needs of each area.

RESOLVED: That the feedback from the engagement process be reported to a future meeting of the Board.

22 INTEGRATED CARE ORGANISATION AND LOCALITY GROUP UPDATES

Ms K Benbow (Chief Operating Officer, South Kent Coast Clinical Commissioning Group) presented the report on the ICO Programme Progress.

The Board was informed that the four locality groups were now operating, each based around a hub within the area. The locality hubs were:

- Dover – New Buckland Hospital (working with East Kent Hospitals University Foundation Trust)
- Deal – Victoria Hospital
- Folkestone – Royal Victoria Hospital (working with East Kent Hospitals University Foundation Trust)
- Romney Marsh – Martello and the Romney Marsh Day Centre

The locality groups were driven from the bottom up by local General Practice and the health needs of each area. The memberships of each of the four locality areas were appointed on the same basis, although each area had its own individual projects in addition to shared CCG area wide projects such as aligning Community Nursing to General Practice to develop an integrated primary care team.

In respect of the future of the Royal Victoria Hospital, it was stated that the governing board had met with local campaigners and had invited them to join the group formed to look at the future use of the hospital. However, there were no proposals to turn the Royal Victoria Hospital into an acute hospital.

RESOLVED: That the updates be noted.

23 HEALTHIER SOUTH KENT COAST GROUP

Ms J Mookherjee (Public Health Consultant, Kent County Council) introduced the report on the Healthier South Kent Coast Group.

The Group was formed to support through multi-agency partnership working the achievement of objectives set by the South Kent Coast Health and Wellbeing Board and was made up of representatives from the South Kent Coast Clinical Commissioning Group (CCG), Kent County Council Public Health and Dover and Shepway District Councils. The key focus of the group was to imbed health prevention activity in a wide range of services.

The current activities of the Group were:

- CVS and health inequalities (working alongside the CCG's Cardiovascular Disease sub-group); and
- Improving physical activity and wellbeing in priority wards in Dover and Shepway by working with leisure providers and others.

The Group had made some progress in respect of the current activities and a developmental meeting would be held on 20 October 2015 to consider how the Group could further support the objectives of the South Kent Coast Health and Wellbeing Board in an environment of greater integration in respect of:

- Smoking
- Healthy eating, physical activity and obesity
- Alcohol and substance abuse
- Wellbeing (including mental health and social isolation)
- Sexual health and communicable disease
- Wider determinants of health (such as teenage pregnancy)

In respect of health inequalities it was suggested that it would be helpful for the Board to receive a presentation of health profiles for the CCG area.

RESOLVED: (a) That the progress of the Healthier South Kent Coast Group be noted.

(b) That the health profiles for the South Kent Coast Clinical Commissioning Group be presented to the next meeting of the Board.

24 CHILDREN'S OPERATIONAL GROUP

Councillor S S Chandler (Dover District Council) presented an update on the Children's Operational Group.

The Board was advised that although the Children's Operational Groups (COG) had been intended to be based on district council boundaries it had been agreed with Kent County Council that for Dover and Shepway it would be based on the South Kent Coast Clinical Commissioning Group (CCG) area. It was recognised that this would mean parts of both districts that were outside the CCG area would not be covered by the COG and the importance of ensuring that these areas was not forgotten was emphasised.

The Children and Young Peoples Plan would set the priorities for the COGs although it was accepted that local priorities may be different from countywide ones and the membership of the COGs would include representatives from education, the police and a safeguarding lead.

The COGs would report to the Kent Health and Wellbeing Board and the local Health and Wellbeing Boards, although there was uncertainty as to the arrangements for the administration of the COG.

RESOLVED: (a) That the update be noted.

(b) That the work programme of the Children's Operational Group be submitted to a future meeting of the South Kent Coast Health and Wellbeing Board.

(c) That the structure of the Children's Operational Group be circulated to the members of the Board.

25 URGENT BUSINESS ITEMS

There were no urgent items of business.

The meeting ended at 4.31 pm.

Report to: SKC HWBB 24.11.2015

Title: Recommendations for development of the South Kent Coast Health and Wellbeing Board

Authors: SKC HWBB Development Working Group

Recommendations:

1. Develop the SKC HWBB into a commissioning board, with a flexible approach, enabling the Board to adapt to changing circumstances.
2. Establish the 'revised' Board model in shadow form for a year from April 2016, with the Board commissioning, the Integrated Care Organisation (ICO) /Integrated Executive Partnership Board (IEPB) model delivering and trialling new contracting models, and the research and evaluation stream linked closely to the shadow year arrangements.
3. The Shared Intelligence development days with the ICO are used in conjunction with the HWBB development.
4. The LGA potential support for local and national developments is explored further.
5. Establish a provider engagement sub-group/link to ICO, retain the SKC Local Children's Partnership Group and the Executive Group (for agenda planning and workflow – this Group may also be tasked with monitoring progress against outcomes and reporting to the Board), and receive reports/updates on the ICO workstreams as they develop and progress.

The Board would:

- ✓ Aim to be an equal partnership of local commissioners, with a single commissioning structure and oversight of the entire health and wellbeing system, recognising the best place for decisions to be taken and working at a pace and scale that makes sense locally, as per option 3 'Health and Wellbeing Board Plus', in this report.
- ✓ However, in the first instance, the Board would operate on an open book budgeting system, i.e., each partner retains their own budget, however for the chosen outcome the budgets are considered as a whole to be redirected or utilised in a different way to achieve the outcome.
- ✓ Take a flexible approach to commissioning, e.g., with large scale providers and specialist services, across CCG boundaries and also on a much more local level working with the Locality Delivery Groups.
- ✓ Oversee strategic commissioning as and when required, for example, the local Public Health commissioning workstream due to be re – tendered early 2016.
- ✓ Unblock any potential challenges to achieving local integrated health and wellbeing, influencing regional and national decision-making and oversee and local health and wellbeing projects/programmes.
- ✓ Direct the work of the sub-groups and set outcomes to be met in South Kent Coast.
- ✓ Develop a strategic commissioning/work programme based on:
  - A small set of agreed outcomes that will have the most impact. Recommend 2 pathways for the Board to consider first (full pathway, priorities and outcomes to be identified):
    - Frail elderly (including housing)
    - Obesity (children/whole family approach)

Background:

The South Kent Coast Health and Wellbeing Board (SKC HWBB) covers the majority of Shepway District Council and Dover District Council, with the exception of 3 GP Practices in Dover District that fall within the Canterbury and Coastal Clinical Commissioning Group and 1 GP Practice in Shepway that falls within the Ashford Clinical Commissioning Group .

The board was established in 2011 as an early implementer and as a sub-committee of the County HWBB. It has its own agreed Terms of Reference and has been very much a board of commissioners, taking forward local projects, such as Healthy Living Pharmacy, Teenage Pregnancy Awareness projects, and has held workshops to take forward issues such as Cardio Vascular Disease and a local Alcohol Strategy. The Board has a localised Joint Strategic Needs Assessment, an Integrated Commissioning Strategy and a developing Local Health and Wellbeing Strategy.

The board has historically had 3 sub-groups, however, as indicated below these groups have since been streamlined to ensure there is no duplication and to embrace the workstreams of the Integrated Care Organisation:

- Integrated Commissioning Advisory and Support Group – led by SKC CCG, to enable joint working between the CCG, KCC, DDC and SDC, focusing on adults and the development of the Integrated Care Organisation, the Better Care Fund – the group has now merged with an ICO workstream focusing on Housing, Health and Social Care
- Healthier South Kent Coast Working Group – led by Public Health, to enable joint working to identify health inequalities and preventative work programmes – this group has now merged with an ICO workstream, Self Care and Prevention.
- SKC Local Children's Partnership Group – led jointly by SDC, DDC and SKC CCG, to establish existing service provision, identify gaps and needs and projects to address these.

Alongside the SKC HWBB has been the development of an Integrated Care Organisation working towards 'one budget, one service, one team'. This approach is looking at multi-speciality community provider model (MCP) based around natural communities-with 4 local delivery groups (Dover, Deal, Folkestone and Romney Marsh) and overseen by the South Kent Coast CCG Integrated Executive Programme Board (IEPB). A draft Compact Agreement has been developed with a number of workstreams, one of which is the development of the SKC HWBB, to ensure the Boards develop in parallel.

Moving forward – aiming for a shared system leadership role

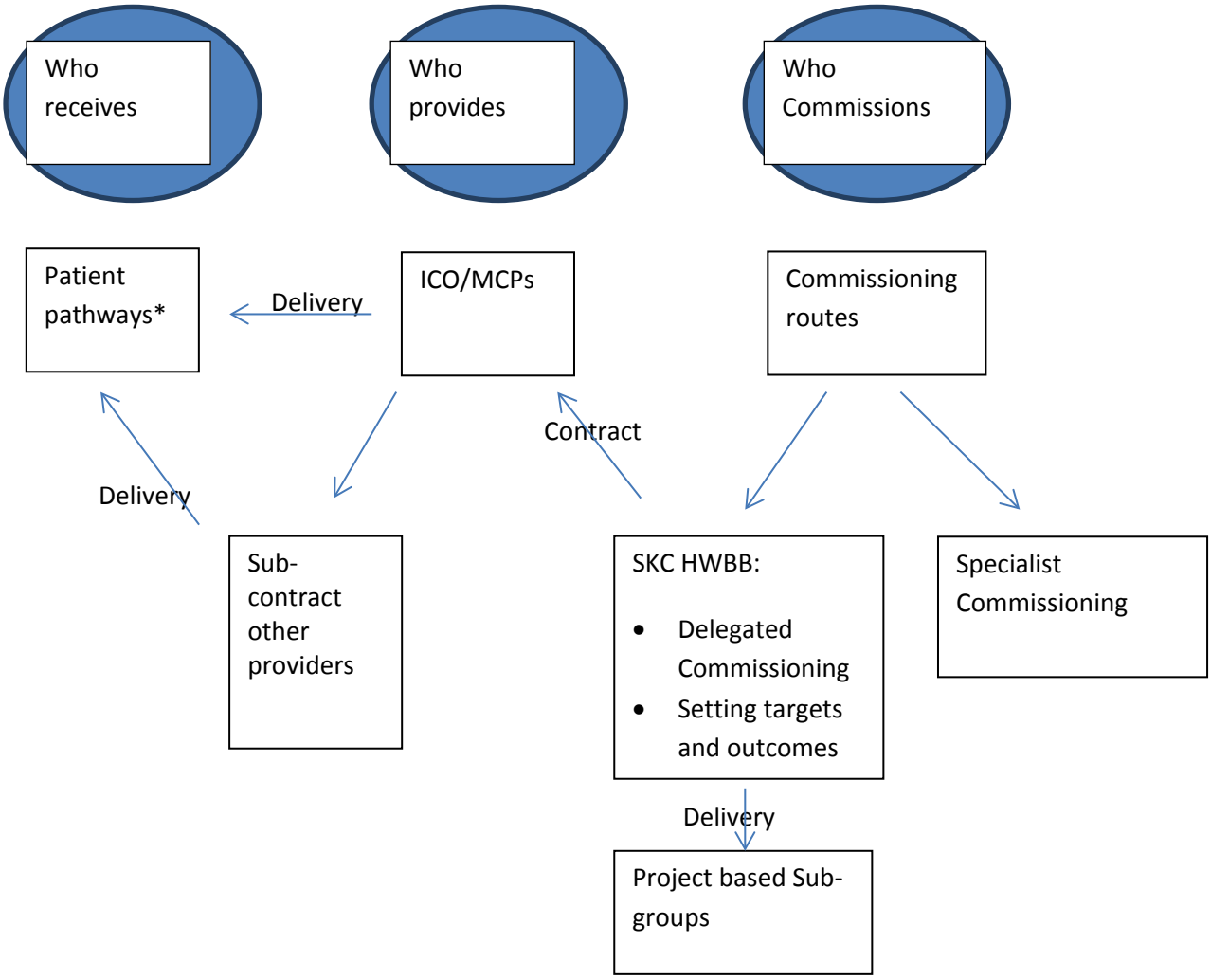
Long-term vision – ***the South Kent Coast Health and Wellbeing Board as the local executive decision-making body for the integrated budget – with a rebalanced membership drawn from CCGs and local authorities, fresh powers and duties, and supported by a single commissioning function that draws on the capacity and expertise from both the CCG and local authority*.**

Following a SKC HWBB workshop in March 2015, it was agreed to look at how the Board could develop into a decision-making body, the membership and governance required to enable this, and identifying a small number of projects to look at joint commissioning.

It is widely accepted that health and wellbeing should be at the heart of all decision-making, it is also a widely held view that the current fragmentation of the organisational landscape is not sustainable (King's Fund Options for Integrated Commissioning).

Whilst pooled budgets may be a future possibility, it is not a starting point, and there is a general consensus that the starting point for developing a SKC HWBB that is a commissioning body should be open and transparent booking keeping, devolved commissioning decisions, with a commitment to subsidiarity (a principle that decisions should be taken at the most local appropriate level) and identifying a small number of priorities taking in all the wider determinants of health.

The proposed model for the evolved arrangements in South Kent Coast is as follows:



With the proposed model above, the developed SKC HWBB will be responsible for more and more of the commissioning arrangements and the ICO model responsible for the provider development and delivery through integrated contracting models.

The success of the developments will be based on having mutual trust and an agreed shared vision and purpose between all partners.

True commissioning will need to be identified and individual commissioning streams broken down around the chosen outcome(s) the Board will start with, including the development of specific and measurable objectives.

Joint Commissioning: broadly understood as the coming together of organisations in the form of a 'partnership, alliance or other collaboration' to take joint responsibility for commissioning a set of services (Glasby 2012). This can involve organisations working in partnership at all stages of the commissioning process, from the assessment of needs, to the planning and procuring of services, and the monitoring of outcomes.

Links to the Integrated Care Organisation and Integrated Executive Programme Board:

The ICO/IEPB is currently working with Shared Intelligence on a number of development days exploring culture and system leadership approaches going forward. It is proposed this is extended to the HWBB development to aim for a culture change across the whole shadow year arrangements.

Shared Intelligence has the potential to be able to facilitate a development session for the new HWBB arrangements in January 2016. The organisation is also developing a child obesity prioritisation tool for Public Health England that may be of interest to the shadow year arrangements.

Each partner to the IEPB has recently agreed to extend funding for research and evaluation for the ICO with the University of Kent, for an additional three years, and it is proposed this research and evaluation arm is steered toward the shadow year arrangements; of the HWBB becoming a commissioning board and delivered through an ICO integrated contract model.

Proposed Membership of a newly established HWBB:

- SKC Clinical Commissioning Group representative and lay member
- Dover District Council
- Shepway District Council
- Kent County Council
- Public Health
- Healthwatch
- Kent Fire and Rescue

Governance arrangements:

- A small group has been established to develop a Terms of Reference and suitable governance arrangements that enable the model to operate with all partners fully engaged
- Outcomes will need to be jointly agreed and a monitoring tool established

Capacity to deliver the programme:

As with any developing project capacity is key to meeting partner's requirements and timelines for successful delivery.

Currently a Working group has been meeting to develop the proposals outlined in this paper. The Group consists of:

Karen Benbow	SKC CCG
Michelle Farrow	DDC
Jyotsna Leney	SDC

Jess Mookherjee	Public Health (KCC)
Mark Lemon	KCC

In addition Peter Hodgson (SKC CCG) has been working with identified Finance officers within DDC, SDC and KCC to explore financial modelling. Peter Wignall and Tim Madden (both SDC) are being involved in considering governance arrangements.

Alison Davis (KCC & SKC CCG) has recently joined the group to ensure alignment to the ICO development and has the potential for some project manager capacity.

Phil Swann (Shared Intelligence) has 2 development days to offer.

The LGA South East Health and Wellbeing Co-ordinator is also willing to explore support for fast streaming the SKC HWBB into a commissioning board.

Next steps:

- A Statement of Intent is drawn up for all partners to sign up to the developments and commit the capacity of the Working group to progress the proposals
- A detailed project plan is developed and agreed.
- A development session is held on 26th January 2016 (in place of the next scheduled HWBB meeting).

Options considered:

The following options have been identified in 'Options for Integrated Commissioning', The Kings Fund report. From their assessment of existing arrangements and emerging developments in different parts of the United Kingdom, three broad options emerge for how a single commissioning function, with a single integrated budget, could be developed:

Option 1 – build on existing organisational and policy arrangements:

- This option would involve no significant nationally imposed changes to current structures, working instead with the grain of existing organisations and policy processes. Health and social care funding would continue to be routed separately to CCGs and local authorities with an expectation that they reach local agreement on how their separate funding streams should be aligned around agreed local priorities and needs, and how services should be commissioned, and by whom.
- This approach would build on local relationships that are already being developed through the Better Care Fund planning process. It would be for CCGs and the local authority to agree whether their health and wellbeing board is ready and able to take on a formal decision-making role in respect of commissioning decisions.
- This option would be the least disruptive in terms of organisational change, allowing organisations to continue using existing mechanisms such as pooled budgets and lead commissioning arrangements to promote better integration of care. This approach would build on local relationships that are already being developed through the Better Care Fund planning process. It would be for CCGs and the local authority to agree whether their health and wellbeing board is ready and able to take on a formal decision-making role in respect of commissioning decisions. This option would be consistent with other policy initiatives such as the Integrated Care and Support Pioneers Programme and the emerging Forward View vanguard programme. National accountabilities would remain unchanged although local bodies would need to agree joint accountability arrangements for pooled budgets.

Option 2 – CCG or local government to take responsibility

- Another option is to assign lead responsibility for commissioning either to local government – so that local authorities would become responsible for all health and social care commissioning – or to CCGs.
- A different way of implementing this option would be to emulate the Scottish approach and require local authorities and CCGs to agree between themselves which organisation should be the single commissioner. This avoids a prescriptive one-size fits- all approach but demands a high level of maturity from local organisations in order to reach agreement. It would almost certainly involve major organisational change at the local level and result in a mixture of arrangements across the country with either the NHS or local government being the accountable organisation.
- This would raise further issues of public and political accountability given the fundamentally different governance arrangements for CCGs and local authorities.

Option 3 – a new vehicle: 'health and wellbeing boards plus'?

- A third option is to establish a completely new local vehicle to be the single commissioner. This could appear to involve the most extensive organisational change of all as it would leave no role for either local authorities or CCGs. However, there is an evolutionary option that would not involve a complete upheaval of existing organisations but which would build on them – this is to revamp the role of health and wellbeing boards.
- Kings Fund has concluded that in their current guise, health and wellbeing boards are not fit for purpose to become the single commissioner. But there is no reason why, over time, they could not be re-cast as the local executive decision-making body for the integrated budget – with a rebalanced membership drawn from CCGs and local authorities, fresh powers and duties, and supported by a single commissioning function that draws on the capacity and expertise from both the CCG and local authority.
- This would minimise organisational change but is likely to require primary legislation to ensure that the board has adequate legal powers. This would take time but would allow existing boards to accelerate the pace of their development and capacity in the meantime. It would also require the development of a governance model that ensures the engagement of providers without compromising the essentially commissioning role of the new board, as Greater Manchester is proposing.

Wider agendas:

The bigger picture of the agendas we are working towards cannot be lost and must be identified and detailed around the chosen priorities/pathways and any new model flexible enough to adapt to change around us:

<table>
<tr><th colspan="3">Local Picture</th><th>Kent wide Picture</th><th>National Picture</th></tr>
<tr><td>CCG</td><td>SDC</td><td>DDC</td><td rowspan="2">• Emotional Health and Wellbeing Strategy
• 6 ways to Wellbeing
• Joint Strategic Needs Assessment
• Health and Wellbeing Strategy
• EKHUFT Clinical Strategy
• Kent Accommodation Strategy</td><td rowspan="2">• Care Act
• Devolution Bill/Act
• Better Care Fund
• Housing Regulations
• Planning Regulations
• NHS England and CCG Co-Commissioning
• Comprehensive Spending Review
• Five Year Forward View
• NHS and Public Health Outcomes Framework</td></tr>
<tr><td colspan="3">• Corporate Plans
• Housing strategies and plans
• Regeneration/Economic Development Strategies
• Local Plans and Supplementary Planning Guidance
• State of the District report and Ward Profiles
• Leisure/Sports strategy / play provision & strategy
• CCG Operational Delivery Plan
• Environmental improvements (waste, litter, street scene)</td></tr>
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• Community Safety/Crime Reduction Plans • Troubled Family programmes • NHS South Kent Coast Annual report and accounts • Medium Term Financial Plans • NHS South Kent Coast CCG Prospectus and Constitution		

Potential Work streams and Timeline: (dates to be added)

	Sep	Oct	Nov	Dec	Jan 16	Feb	Mar	Apr
Work Stream:								
1. Define role of the newly developed SKC HWBB, through an 'Intention document'								
2. Identify commissioning streams relevant to chosen topics/pathways								
3. Identify and implement necessary governance arrangements (this may need to include strategic meetings of each sovereign body for sign off)								
4. Develop the financial framework								
5. Membership agreed and established								
6. Any identified training and/or development for Board members								
7. Membership and governance in place to 'go live' with redeveloped SKC HWBB								
8. Local Integration programme developed for further commissioning arrangements for the Board.								
9. Public Engagement programme identified and resourced								

NHS
South Kent Coast
Clinical Commissioning Group

Integrated Care Organisation (ICO) Operational Model

(Community Hubs / Primary Care)

NHS South Kent Coast Clinical Commissioning Group

NHS 111 / Care Navigation / Out of Hours Medical Services / KCC Out of Hours

Central Hub

URGENT RESPONSE SUPPORT

(KCC Short Term Pathway)

- GP Service with Physician Associates (branch to local surgeries) - Urgent Appointments
- Minor Injuries with
  - Nurse Practitioners (Minor illness overflow from GP service)
  - Paramedic Practitioners (GP home visits, rapid response, cover in MIU)
  - Rapid Response Nursing (Support to PPs, cover in MIU)
- Integrated Intermediate Care (includes KEAH) (Social care/KEAH Supervisors, Therapeutics, other HCPs, MDT support to ICT beds)
- Ambulatory Care (initial Treatment)

- Voluntary Organisations
- Housing/Benefits Advice/advocacy
- KCC Assessments Clinics

Medical Specialists (as part of MCP)

Mental Health Services/IAPT (Urgent & Planned)

Diagnostics 8am-8pm 7/7

PLANNED CARE

- Out patients – One stop "initial consultations, follow-up face-to-face or virtual via telemedicine/telephone with consultants, nurses or therapists/Frailty Clinics
- Ambulatory Care (follow up)
- MSK Physiotherapy
- Occupational Therapy
- Special & Language Therapy
- Clinical Nutrition & Dietetic Service
- Sexual health services
- Community Orthopaedic Services
- Chronic Pain Services
- Podiatry Services
- Diabetes, Lymphodema , Cardiac, Epilepsy, Respiratory, Nurse Led Clinics

- Linked IT / Shared Records / Care Plans - **'Tell us once'**

- Community Support via i.e. Voluntary Orgs, Community Wardens
- Domiciliary Care Services – Early Identification of deterioration
- Access to Step-up / Step-down Beds
- Children's Centres
- Learning & Physical Disability

General Practice

(6.30pm – 8.00pm Mon-Fri/Sat,Sun & BH's 8am-8pm covered via the 'Hub')

LONGER TERM MANAGEMENT

(KCC Adult Community Teams)

- GP's
- Nursing Team (Practice nurse, Nurse Practitioner, Community Nurses, Specialist Nurse, Hospice CNS)
- Mental Health Workers / Mental Health Specialists
- Medicines Management Support / Pharmacy
- Health Trainers (Health Checks/Prevention/Self Care/Empowerment/Carers Health)
- Case Managers (Adult Social Care)
- Health Visitors
- Midwifes
- Children's Community Nursing
- Care Navigators (General & Mental Health)
- Cardio / Pulmonary Rehabilitation
- Continence Services

Accessible Care / Co-ordinated Care / Proactive Care/Personalisation
' No wrong door ' 'Every contact counts'

Clinical Leadership / Workforce Development

Mobilise Community Assets to Build Resilience

East Kent Wide Community Services

Acute Services (General & Mental Health) Integrated Discharge Team

SECAmb 999

Equipment Services / KCC Fast Track Equipment Provision

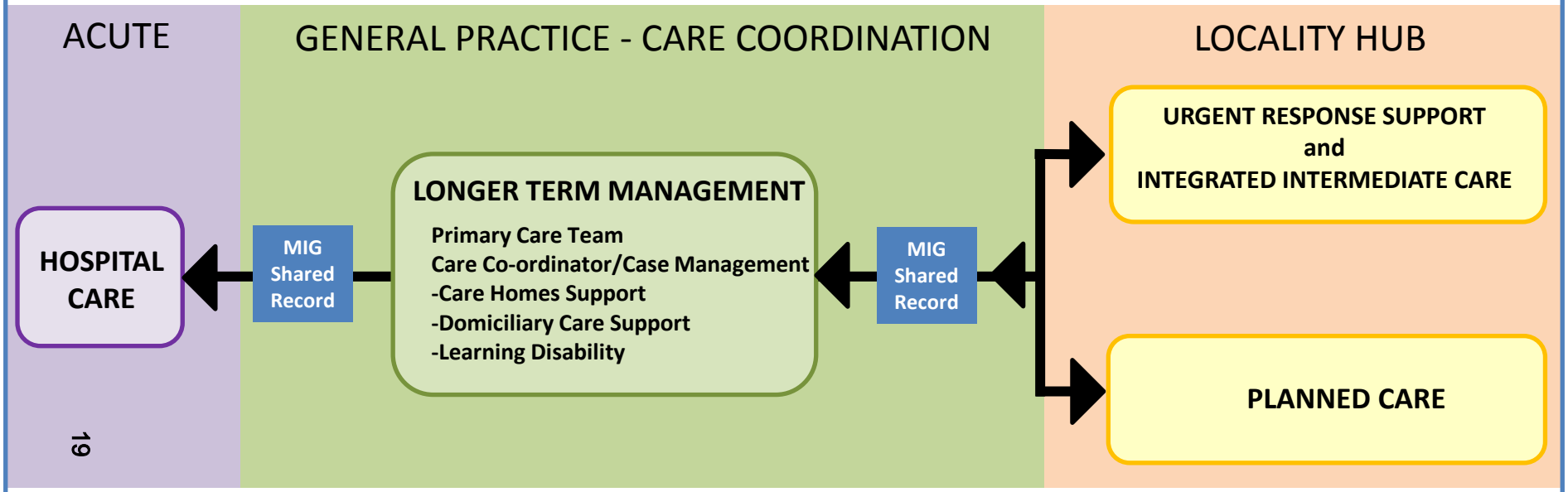
Patient Transport

Minor Surgery / Community

Dental Services

INTEGRATED CARE ORGANISATION
LOCALITY MODEL

NHS
South Kent Coast
Clinical Commissioning Group



- East Kent wide Community Services
- Acute Services (General & Mental Health) Integrated Discharge Team
- SECAmb 999

- NHS 111
- Care Navigation
- Out of Hours Medical Services
- KCC Out of Hours

- Equipment Services / KCC Fast Track Equipment Provision
- Minor Surgery
- Community
- Dental Services

Dated: 05.08.2015

ICO Development Work Streams

- **Integrated Primary Care**: bringing together a multi-agency, multidisciplinary team around GP's and their practices in order that care is coordinated and includes care hones support and education of domiciliary carers

- **Pathway Redesign**: Mental Health, Rheumatology, Cardiovascular Disease, Respiratory Disease, Dermatology, Diabetes,

- **Integrated Intermediate & Urgent Care:** bringing together, health, social care and voluntary sector intermediate care services into one response through an agreed pathway

ICO Development Work Streams Cont'd

- **Information Management & Technology:** ensure full interoperability across provider systems is in place. Promoting appropriate new technologies across the CCGs to ensure quality and accessibility of patient services

- **East Kent End of Life Strategy refreshed & Improvement plan agreed with 3 task and finish groups:** Pathway Redesign, Education & Workforce, Information Management & Technology

- **Pharmacy & Medicines Management**: Identify Medicines Management processes, across providers in SKC CCG, that require improvement, to ensure the safe and cost effective use of medicines

Prevention & Self Care

To ensure that there is proactive targeted work to ensure that ill health is prevented where possible and inequalities reduced:

- Through information and structured education and the use of technology support people to self care and improve their own outcomes
- District Councils, KCC, Public Health, CCG and patients representatives working collaboratively to combine resources and knowledge to improve health and wellbeing ie: maximising the use of the community workforce developing cross organisational ‘community agents’
- Joint approach to health messaging to the wider public
- Collaborating on work with troubled families, community wellbeing
- Reviewing the ward profiles and developing joint initiatives for improvement
- Collaborating on the Healthy & Active Strategy linking to the prevention pathway
- Joining District Council Initiatives with existing commissioned services to maximise outcomes

Health, Housing & Social Care

Health, social care, district councils, public health and voluntary sector will work together to address poor housing that leads to poor health to improve outcomes. Two task & finish groups being planned:

Healthy Housing:

- Health proofing homes form excess cold, damp & mould
- Home safety – slips, trips & falls
- Access to support services ie: Age UK, Citizens Advice
- Healthy eating
- Fuel Poverty – keeping warm, keeping well

Accommodation Strategy:

- Review of sheltered provision; potential remodelling?
- New extra care housing
- Develop intermediate care in housing settings
- Independent living including use of telecare
- Care home bed modelling
- Discharge to assess
- Other specialist accommodation LD, MH, PD

From: Roger Gough – Cabinet Member for Education and Health Reform

To: **Kent Health and Wellbeing Board**

Subject: **Kent Health and Wellbeing Board and Local Health and Wellbeing Board Relationships and Future Options**

Summary:

This report provides a brief overview of the piece of work being undertaken to review the relationship between the Kent Health and Wellbeing Board (KHWB) and Local Health and Wellbeing Boards (LHWBs). This report outlines the current relationships between the boards and provides details gleaned from an audit carried out to determine how the KHWB and the LHWBs are functioning and working locally and together.

In addition, this report describes the insight gathering, which has been undertaken with key stakeholders, and the key themes, issues and ideas which have emerged from this process. This insight gathering and audit material has helped to provide some context which has shaped the future options and recommendations for the Kent Health and Wellbeing Board and the Local Health and Wellbeing Boards.

Recommendation – for the Kent Health and Wellbeing Board to discuss the recommendations outlined in section 7 of this report.

1. Background

1.1 The Kent Health and Wellbeing Board was established following the enactment of the Health and Social Care Act 2012. From 1 April 2013 it became a committee of Kent County Council, prior to April 2013 the Health and Wellbeing Board operated in shadow form.

1.2 Bringing together County and District Councillors, senior officers from KCC, the NHS Area Team, Clinical Commissioning Groups, Social Care and Public Health, as well as representation from Kent Healthwatch, the intention was to provide an effective body where commissioners, patient representatives and elected officials could have a collective overview of the health system in Kent, align areas of work, and share commissioning plans and good practice.

2. Local Context

2.1 Given the scale and geography of Kent, it was agreed that a series of sub-committees known as Local Health and Wellbeing Boards should be created. It was intended that the local Boards would lead and advise on the development of integrated commissioning strategies and plans at the local CCG level. This would ensure that there was a local focus on health and wellbeing, including a clear interest and emphasis on prevention, and enabling effective local engagement and monitoring of local outcomes.

2.2 It is recognised that the LHWBs have delivered good work at a local level. However, it has been identified that since their introduction, they have struggled to achieve clarity on the scope, purpose and direction of the local boards. In addition there is a lack of a clear mechanism for communication between the local boards and the Kent Board. LHWB priorities may differ in line with local needs and demands, but the membership, size of the Board, and level of engagement with member organisations can also differ. This has consequently led to a variety of ways of operating at the local level. Whilst this is inevitable, and to a certain extent desirable, it can create difficulties in terms of monitoring progress and empowering the Local Boards to deliver key outcomes.

3. Scope of the work

3.1 In response to the issues highlighted above, and the LHWBs' request for a stronger sense of purpose, it was decided that work was required to look in detail at how the KHWB and the LHWBs are currently operating, and how an audit and insight gathering process can be used to support and develop future recommendations for the boards. The Audit captures the current priorities and actions of both the Kent board and the LHWBs, and the mechanisms for sharing information between the boards. The audit has helped define current roles and responsibilities, aiming to provide clarity and consistency in the future. This process has identified gaps within the relationships between the boards. The Audit provides some key context for current issues and therefore provides a basis for future options and possible changes to ways of working and relationships, described within the future options section of this report.

3.2 The second phase of the project concerned engagement with key partners and stakeholders. It was important to identify these key stakeholders and partners and arrange individual and group meetings with a wide variety of people to obtain a clear understanding of where the current issues lie, as well as identify how we can ensure that the LHWBs feel empowered to deliver their responsibilities with greater clarity and purpose, whilst the Kent Board focusses on strategic issues.

3.3 The conversations with stakeholders and partners have provided key themes and information which has helped to identify gaps in the ways that the LHWB and the Kent Board are working, and identify possible options for future relationships. This has informed proposals as to how the boards should operate in the future to ensure stronger and more sustainable relationships.

4. Audit

4.1 Audit Process

4.1.1 The audit process was designed to establish the current relationships and ways of working of both the LHWBS and the Kent HWB. This process has also helped to identify how these two tiers of boards are working together, and how effective this relationship is.

4.1.2 The audit process has mostly been carried out through desk top research which has involved looking at the LHWB and the Kent HWB published data and information online. Assessing the content of the minutes has also helped to identify a lot of key information concerning the quality of the discussion and actions taken forward from each meeting.

4.1.3 The attendance and the membership of the boards has also provided some key context around the roles and responsibilities of those on the board, and helped to shape some ideas around the capabilities and willingness of these members. Whilst looking at this in detail it was also important to assess the frequency of the meetings, and whether there is a consistent and regular approach for the boards across Kent.

4.1.4 A key part of the process of understanding the current ways of working and relationships between the Kent HWB and the LHWBs is by looking into the Boards' Terms of Reference and Work Plans, if they should have them. Again, this has aided in determining any variation between the boards, as well as between what the Terms of Reference and Work Plans suggest should be done, and what is actually achieved.

4.1.5 A further piece of work has been undertaken to add to the audit which highlights the LHWB priorities (as reflected in the CCG and others' plans), the specific agenda items discussed at the LHWB meetings, and the health priorities in each local area. This information helps to map the boards' position in relation to the issues that have been identified locally.

4.2 Audit Outcomes and Emerging Themes

4.2.1 The Kent HWB is a statutory body; therefore the minutes and agendas are published online. The LHWBs publish information, minutes, agendas and attendance details on their local authority websites. From studying this information, however, there seem to be discrepancies concerning the quality and quantity of the information provided. In some cases, information was not provided at all and the frequency in which boards meet is also unclear.

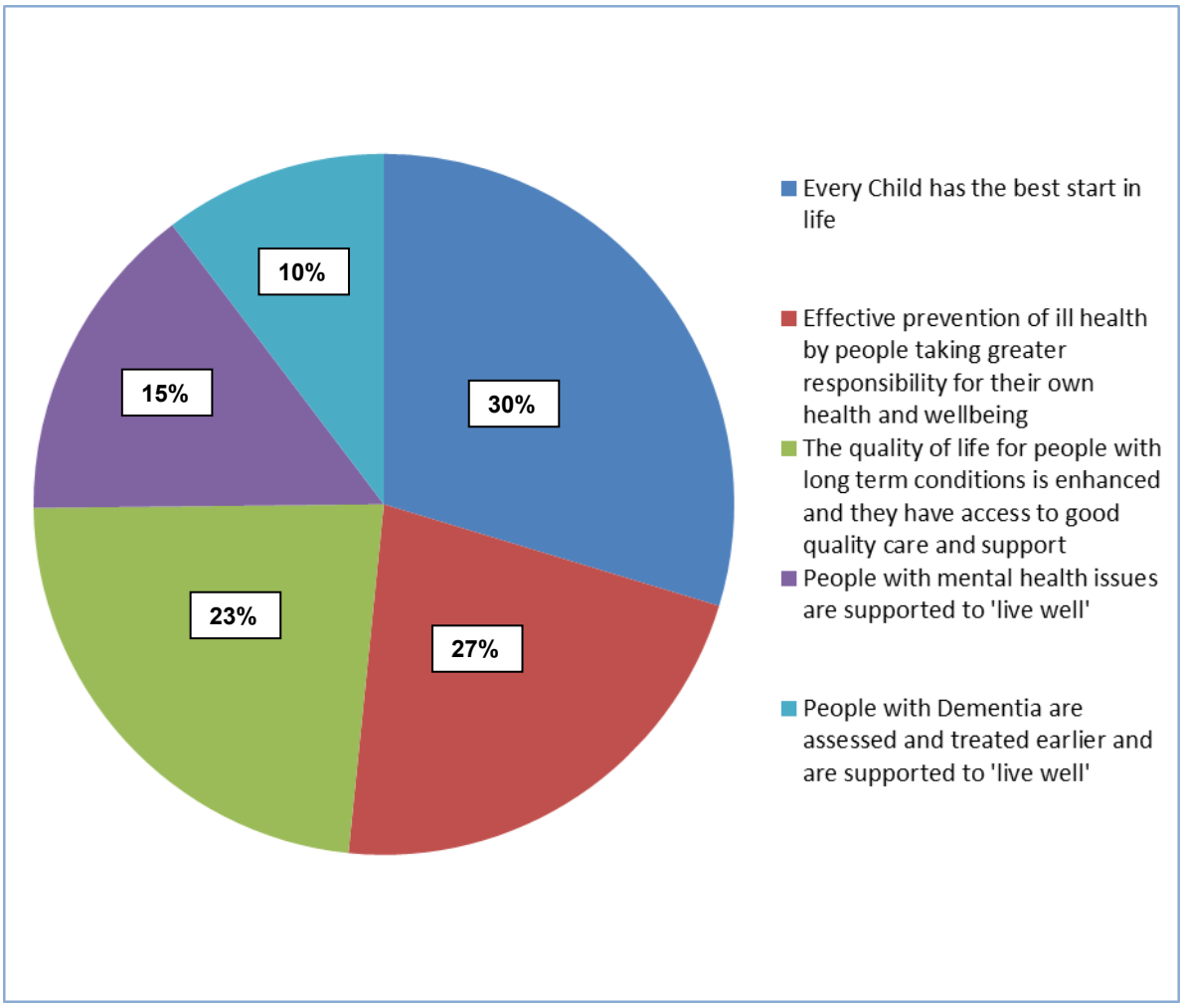
4.2.2 It has been recognised that there are several differences between the seven boards in the ways in which the meetings are scheduled and consequently run. Some of the LHWBs meet regularly and fairly frequently, every two or three months, others appear to meet less frequently with irregular timing between meetings. Similarly, the attendance differs significantly across the boards where some have frequently high levels of attendance, with many of the same members attending each time; however, some of the LHWBs have more inconsistent attendance. It is also important to note that some of

those who attend on a regular basis are official members; however, some LHWBs have frequent attendance from unofficial members, or representatives. In some cases there is reliance on a smaller 'core' group of attendees. This raises questions around membership, sustainability and succession planning.

4.2.3 A key part of the audit process was to assess the level and quality of work currently being undertaken by the LHWBs. It was recognised that within this scope, it would be important to understand not only the Local Priorities but the content of the LHWB meetings plus the quality of these conversations and the actions taken forward. As part of this process, the health and wellbeing priorities have been identified for each local area. This helps to inform the accountability and functions of each of the boards. Whilst this information usually relates specifically to public health priorities it raises wider questions about how the local boards are focusing on local priorities, how these are identified by the board and subsequently how they influence the agenda setting.

4.2.4 From this part of the audit it is clear that the specific health issues and priorities within a local area have been discussed in some detail within the LHWB meetings. In some cases there is a clear link between the priority and agenda items of the LHWBs, but in other cases there seems to be no obvious link. Due to the lack of publicly available LHWB work plans, it is difficult to identify whether the boards are addressing the priorities by design, or whether they are identified locally in a different way, such as being discussed at sub groups. It could for example be the case that other sub groups are taking forward local priorities and that the LHWB is providing a platform to discuss these issues through update reports from these group as opposed to specific agenda items.

4.2.5 The chart below represents the Kent Health and Wellbeing Strategy Outcomes, and the percentage of time the LHWBs spend on activities relating to these outcomes. Broadly speaking this shows that LHWBs are maintaining a focus on the five outcomes of the Joint Health and Wellbeing Strategy. Concerns that, for example, children's issues may not receive sufficient attention because agendas may concentrate on those regarding adults would appear to be unfounded. However, the chart does not give any indication as to whether discussion of issues on the agenda has led to concrete action or improved outcomes.



4.2.6 There is a wider issue about transparency which should be considered, given that the LHWB's are public facing and information about their work should be more readily available. However, there also needs to be a much closer connection and communication stream between the LHWB and the Kent Board and an agreement about the work plan and focus of the local boards. In this sense the issue around transparency links with the role of the Kent HWB and its role as a co-ordinating and to some degree 'tasking' group for the local boards. It has been suggested that the Kent Board needs to be operating at a higher strategic level and consequently feeding information and direction down to the Local Boards. From this, the LHWBs should have the knowledge, capacity and capability to deliver outcomes locally and consequently feed this information back up to the Kent Board. In this way the Local Boards will be more accountable and empowered to improve the health and wellbeing within their geographical areas.

5. Insight Gathering

5.1 Insight Gathering Process

5.1.1 Ensuring partner and stakeholder engagement was a vital process within this piece of work. It was identified that it would be important to have some attributable and informal conversations with relevant colleagues and partners to determine their views. It also provided the opportunity for issues to be raised.

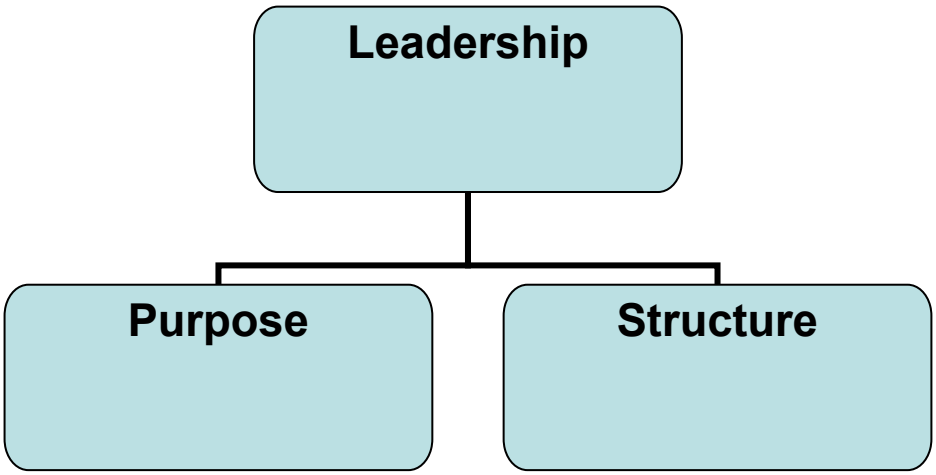
5.1.2 A number of key individual stakeholders and groups of people were identified as part of this engagement process. These included the following:

- A group meeting for the Chairs of all 7 LHWBs in July.
- Individual meetings with the Chairs of the LHWB
- Group or individual meetings with key KCC Members such as Graham Gibbens, Peter Oakford, Chris Smith, and Geoff Lymer
- Some KCC Corporate directors and Heads of Commissioning
- We also met with key external Partners such as Steve Inett (Healthwatch) and Dr Robert Stewart. (Chair of Pioneer Steering Group and Director of Clinical Design)
- The Kent Leaders (through attendance at their meeting on the 21st July).
- The Joint Kent Chiefs (through attendance at their meeting of March 12th)

6. Key Themes derived from Insight Gathering

6.1 The LHWBs have carried out good work to deliver outcomes locally but there are several issues which have been identified through conversations with partners and stakeholders, as areas for improvement.

6.2 Many of these key issues were identified in a number of different ways, and are common across different organisations represented on the boards. These common themes were raised by LHWB chairs, partners, senior officers and Members. Indeed there were common themes identified from across both the audit and the insight gathering. The key issues concern communication and relationships between the boards, accountability and purpose, engagement and representation, confidence and competence and the role of the Kent HWB. They can be grouped under three key headings; Leadership, Purpose and Structure.



Where there is a lack of leadership, the purpose and structure of the Local Boards is likely to be unclear. All three are required to ensure a fully functioning and effective working model.

6.2 Leadership

6.2.1 Feedback identified that there are issues around whether the members of the LHWBs have the perceived confidence or the skills to make a difference locally. One of the issues highlighted was that the boards are not statutory and therefore membership is voluntary and that this meant some partners were not willing to engage or share information freely. It was felt that members needed to be empowered to deliver outcomes.

6.2.2 Some stated that that there needs to be stronger communication streams coming from the Kent board to ensure that the Local Boards understand the high level priorities and strategies and feel as though they have the power to make a difference. It was felt that the Kent Health and Wellbeing Board needed to have a greater focus on the overarching strategic plan and priorities and consequently feed these messages down to the local boards. It was also felt to be important to recognise that the communication streams need to be improved from the LHWBs back to the Kent Board, and that they could provide a platform for Kent Board to understand what is being delivered locally, which would give the local boards greater confidence that the work they were undertaking was contributing to the Kent priorities and that it was having an impact.

6.2.3 Another common area of concern was that there is no agreed work plan between the Kent Health and Wellbeing Board and the LHWBs, and a lack of clarity around the ways in which the boards could be communicating to each other. It is this lack of clarity that has caused some members of the LHWBs to feel as though they are not empowered to deliver outcomes and make a difference. It is felt that the Kent Board should be working hard to be a strategic body which filters relevant information down.

6.2.4 In summary it was felt that the Kent Board needed to provide stronger leadership and direction based on the priorities set out through key documents such as the Joint Health and Wellbeing Strategic and JSNA and relating this to the work of the local boards more effectively. It was often

expressed that the Kent Board focused too much on the detail and rather should be setting the strategic direction whilst empowering the local boards to deliver the outcomes that are collectively agreed.

6.2.5 Whilst it is important to note that it was felt that the Kent HWB should be the leader for the Local Boards and be empowering the boards to be achieving outcomes locally, local partners must accept this role and invest responsibility and accountability in their representatives on the LHWBs. Without support from partner organisations, the LHWBs cannot function simply on the clear direction of the Kent HWB.

6.3 Purpose

6.3.1 Many stated that the Kent Board needed to start focussing more on policy as the county wide statutory board. However, there is some confusion over the role of the LHWB to support these responsibilities with the activities that they carry out locally and whether the LHWBs are acting as a statutory sub structure of the Kent Health and Wellbeing Board.

6.3.2 A key issue raised was that of accountability and whether the LHWB's were an important or indeed the right vehicle for taking forward specific areas of work. Due to the lack of clarity around the purpose of the boards, some organisations and members did not appear to be bought into the LHWB as a vehicle for tackling priorities and this was felt to be a particular issue for social care. In fact some commented that members of the LHWBs could sometimes focus too much on operational and local issues rather than considering the wider priorities.

6.3.3 This was felt to emphasise that the local boards are more of a collection of partners than an entity in their own right with partners not devolving accountability to the LHWBs as a vehicle to deliver their activities. The effectiveness of boards to make decisions and to hold their constituent members to account can therefore be compromised.

6.3.4 There is no standardised terms of reference represented across each of the LHWBs. This adds to the difficulty in understanding the representation of the members on the boards, as well as the roles and responsibility to the boards, and in sharing information with partners and to their own organisations. Some local boards have adopted terms of reference especially where there is a degree of co-terminosity between CCGs and district councils. Where boards straddle more than one district boundary issues of comparative influence in any decision making process has been difficult to resolve. The status of district authority officers has also proved problematic including whether they can be bound by the KCC code of conduct which would require them to declare any interests they may have that are relevant to the meeting.

6.3.5 Some district councils also find themselves having to attend multiple boards where their district straddles two CCG areas.

6.3.6 Whilst the good work being done locally by the boards was highlighted, the lack of clarity of purpose can mean some partners do not see the board as an effective vehicle for delivering their priorities. The purpose of the boards needs to be revisited and clarified in order to empower members. This is very much linked to the discussion around leadership and direction from the Kent Board.

6.4 Structure

6.4.1 Many respondents expressed confusion around representation on the LHWBs and the capacity in which people attended. From local government there is representation from both officers and Members. A number of members will fulfil more than one role. For example a local authority member of the local board could be chairing the board, representing their own district at a local board whilst also attending the Kent Board as a representative of their own authority, district councils more generally and their own health and wellbeing board. Who speaks for whom and when is not always clear. There is no mechanism to determine who should represent local boards at the Kent Board and vice versa.

6.4.2 There has also been a question raised around the roles of VCS on the local Boards. Some boards have VCS representatives but this is not consistent and there remains a question over the capacity in which they attend; is this as a provider or as a champion of the sector and if so what are the mechanisms for filtering information back in to the local VCS? An additional report has been provided on this issue setting out the opportunities for a future relationship between the VCS and the Kent HWB and local boards and should be read in conjunction with this report.

6.4.3 There is also an issue around how the Kent Board engages with partner organisations who are not board members. It has been established that providers should not be board members; however, an effective communication stream was felt to be vital to ensure that the provider relationship with the local board is constructive and effective. Some areas have established, or are proposing, arrangements where commissioners and providers meet collectively at a health economy level outside the local board structure. The relationships between these groups and the local boards are unclear apart from sharing membership of a number of people.

6.4.4 There are inconsistencies around how the LHWBs work with their sub committees. It has been recognised that some of the sub groups to the boards have been set up directly through the LHWB, for example the Mental Health Task Group in Canterbury. However some of these groups existed prior to the LHWBs being introduced. This has, in some cases, caused difficulty in developing a clear link between the sub groups, and a lack of a clear communication stream throughout.

6.4.5 Some LHWBs utilise their Integrated Commissioning Groups to a greater extent than others. Similarly Children's Operational Groups that exist in most areas are still exploring their relationships with local boards. (Also known as

Local Children's Partnership Groups these are intended to give consistency to partnership working to drive improvements in specific outcomes related to children and young people). It has also been recognised that some of the LHWBs may have effective relationships with some but not all of their sub groups. For example Ashford has a Lead Officer Group which acts as a steering group for officer prior to putting issues to the board, and also a Health Infrastructure Working Group. Ashford LHWB works well with these sub committees but less effectively with others, where communication streams and links are less clear.

6.4.6 Different boards are developing different substructures in order to address local priorities. Other differences exist in the existence of groups that may supplement the work of the boards such as Integrated Commissioning Groups. It is clear that there is no common work plan or strategy for the LHWBs and how they should be utilising their sub committees to improve the health and wellbeing within their geographical areas. There is a lack of clarity around the purpose of these sub committees and how the LHWBs could, or should, be relating to them.

7. Recommendations

7.1 Kent Health and Wellbeing Board

7.1.1 The Kent Health and Wellbeing Board will produce an outline work programme for the start of each year to enable local boards to plan their activity accordingly.

7.1.2 The Kent Board will clarify the means by which local issues can be escalated to the Kent Board.

7.1.3 The Kent Health and Wellbeing Board will ensure that relevant issues are referred to local boards with clear expectations regarding further action at a local level.

7.1.4 The Kent Board will provide policy support to the local boards to assist in the development of relevant substructures and work programmes.

7.1.5 Opportunities for development work for both chairs of the boards, and individual boards themselves, will be investigated and made available to local board members.

7.1.6 The Kent Board will provide data and information through its sub-group the Multi-Agency Data and Information Group.

7.2 Relationship between the Kent Board and local boards

7.2.1 The LHWB chairs will meet with the chair of the Kent Board every six months. This meeting will include consideration of the workplan of the Kent Board, and its relationship to the work plans of local Boards.

7.2.2 Each LHWB will send a representative to every Kent HWB, to update the Kent board on their activities locally, and to take any relevant information from the Kent board back. This representative will also be responsible for liaising with the Kent Board concerning issues and matters that would benefit from consideration at the Kent Board.

7.2.3 Proceedings of the Kent Board to be a standing item on all local board meeting agendas with particular reference to issues referred from the Kent Board for local consideration and action.

7.2.4 All agenda items that come to the Kent Board will be considered as to how local boards could and should be involved in their future progression.
All local boards will provide an annual report to the Kent Board regarding how they have been progressing with the five outcomes of the Kent Joint Health and Wellbeing Strategy, and their engagement with the commissioning plans of their constituent organisations. The report will also describe how issues referred from the Kent Board have been considered and how local implementation of any necessary activity has been supported.

7.3 Board business

7.3.1 All local boards will develop a work programme for the coming year. This work programme will relate to:

- the five outcomes of the Kent Joint Health and Wellbeing Strategy
- the health and wellbeing priorities of the area as identified by the Kent Public Health department
- the health inequalities within the area and between the area and others in Kent
- Engagement with the development of commissioning plans of the organisations represented on the board.

7.3.2 Engagement with the commissioning plans of partner organisations should focus on opportunities to promote integration, especially between health and social care services. Whether the plans offer the best possible approaches to local issues should also be considered.

7.4 Structure and Governance of local boards

7.4.1 All LHWBs should have an agreed Terms of Reference by March 2016. Proposals for Terms of Reference, to be drafted following discussion at meeting of Chairs of Boards, to be brought to the Kent Health and Wellbeing Board at its meeting in January 2016.

7.4.2 Local boards to review their membership, substructures and associated working groups to ensure they are fit for purpose. Substructures should provide capacity to deliver the activity required to implement the work of the

board to deliver the five outcomes of the Joint Health and Wellbeing Strategy and allow proper oversight of commissioning plans. The substructure may include the local Children's Operational Group(s) and Integrated Commissioning Groups. The responsibilities of groups in a Board's substructure for reporting to the Board on specific outcomes from the H&WB Strategy should be clearly defined.

7.4.3 Relationships between the local boards and other meetings of commissioners and providers should be clarified.

7.5 Wider relationships

7.5.1 The substructure adopted by the local boards must also ensure that the appropriate relationships with service providers within the area are properly represented.

7.5.2 Appropriate relationships with representatives of other important sectors and organisations should also be reflected in the membership of the board or within its substructures. These should include the Voluntary and Community Sector and could include other local stakeholders such as Parish Councils.

8. Background Documents

Appendix 1 Kent Health and Wellbeing Board Organisational Structure

9. Contact details

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Mark.lemon@kent.gov.uk

Kent HWB

Members

Roger Gough (Chairman), Dr Fiona Armstrong, Dr Bob Bowes (Vice-Chairman), Ian Ayres, Cllr Andrew Bowles, Hazel Carpenter, Paul Carter (KCC Leader), Andrew Scott-Clark, Dr Darren Cocker, Ms Patricia Davies, Graham Gibbens, Felicity Cox, Steve Inett, Andrew Ireland, Dr Mark Jones, Dr Elizabeth Lunt, Dr Navin Kumta, Dr Tony Martin, Peter Oakford, Simon Perks, Dr Robert Stewart, Cllr Paul Watkins, Cllr Lynne Weatherly

Ashford CCG HWB	Canterbury and Coastal CCG HWB	Dartford, Gravesham and Swanley CCG HWB	South Kent Coast CCG HWB	Swale CCG HWB	Thanet CCG HWB	West Kent CCG HWB
Members	**Members**	**Members**	**Members**	**Members**	**Members**	**Members**
Cllr Michael Claughton Dr Navin Kumta Cllr Peter Oakford Simon Perks Bill Millar Neil Fisher Paula Parker Faiza Khan Mark Lemon Caroline Harris Tracy Dighton Martin Harvey Stephen Bell Philip Segurola John Bunnett Sheila Davison Christina Fuller	Eileen Shrubsole Debbie Smith Jayne Faulkner Faiza Khan Dr Mark Jones (Chairman) Sue Chandler Velia Coffey Amber Christou Michelle Farrow Neil Fisher Graham Gibbens John Gilbey Joe Howes Steve Inett Mark Lemon Paula Parker Simon Perks Cllr Ken Pugh Jonathan Sexton Sari Sirkia-Weaver Anne Tidmarsh Paul Watkins Alison Hargreaves (Secretary) Christopher Ives	Councillor Mrs Ann D Allen MBE Lesley Bowles John Britt Andrew Scott - Clark Andrew Scott- Clark Councillor Jane Cribbon Councillor Roger Gough Catherine Handley Dr Elizabeth Lunt Melanie Norris Councillor Tony Searles Debbie Stock Ann Tidmarsh	Councillor Paul Watkins (Chairman) Dr Joe Chaudhuri (Vice-Chairman) Theresa Oliver Karen Benbow Councillor Sue Chandler Councillor Patrick [Pat] Heath Jennifer Hollingsbee Mark Lobban Geoff Lymer Michael Lyons Ms Jessica Mookherjee Jan Perfect Mr Steve Inett		Colin Thompson Dr Tony Martin Councillor Mrs Iris Johnston (Vice-Chairman) Hazel Carpenter Dominic Carter Esme Chilton Councillor Graham Gibbens Councillor Elizabeth Green Madeline Homer Mark Lobban	Gail Arnold Julie Beilby William Benson Councillor Mrs Annabelle Blackmore Dr Bob Bowes (Chairman) Lesley Bowles Alison Broom Cllr Alison Cook County Councillor Roger Gough Jane Heeley Fran Holgate Dr Caroline Jessel Dr Tony Jones James Lampert Mark Lemon Jonathan MacDonald Reg Middleton Cllr Mark Rhodes Dr Sanjay Singh Penny Southern Malti Varshney Cllr Lynne Weatherly

Sub Groups

Children's Health and Wellbeing Sub Committee	Children's Operational Group	Children's Operational Group	Integrated Commissioning Group	Health improvement partnership	Children's Sub Committee	Task and finish group on long term conditions
Lead officer group	Mental Health Action Group	Health Inequality groups	Children's Strategic and Operational group	Swale/DGS Integrated Operational Commissioning Group		Childhood obesity task and finish group
Health Infrastructure Working Group	Joint Commissioning Delivery Group	Mental Health group	Healthier South Kent Coast Group	Children's Operational Group		Tobacco control and smoking cessation working group
	Alcohol strategy group and safeguarding group					Children's Operational Group
	Children's Centres District Advisory Board					
	KIASS Local Delivery Group					
	Troubled Families Local Operational Group					

South Kent Coast
Clinical Commissioning Group

Action plan priorities

- Paediatric dental health provision
- Obesity
- Breastfeeding
- Perinatal Mental Health
- Smoking at the point of delivery

How we will deliver?

- Review current contracts to identify any gaps in service provision
- Agree the outcomes
- Identify trends – where are services making a difference?
- Ensure communities are aware of the services available to them
- Continue to hold child health network meetings to focus on specific priorities
- Inform the Health & Wellbeing board of service gaps
- Improve links with GPs and the local communities, e.g. schools, health visiting.

Next steps

- Local Children's Partnership group (LCPG) will meet on 15th December to agree the action plan
- The plan will be shared with the Health & Wellbeing Board, LCPG Chair's group and the Children's Health & Wellbeing Board
- Build on and improve relationships with GPs and community services via the Integrated Primary Care workstream

Meeting:	Health Overview and Scrutiny Committee
Date of Meeting:	9 October 2015
Subject:	Briefing Paper: Establishment of the East Kent Health and Social Care Strategy Board
Action Required:	This paper is for information
Purpose:	To update the Health Overview and Scrutiny Committee on developments on the establishment of the East Kent Health and Social Care Strategy Board, its purpose, method of working and aims.

1. Introduction

The HOSC has received a number of briefings and update reports over the last two years from both East Kent Hospitals University NHS Foundation Trust (EKHUFT) and the four east Kent Clinical Commissioning Groups (CCGs) relating to clinical strategy and the development of new models of care.

With the ongoing development of the Trust's clinical strategy, the now accelerated development of new models of care in primary and community services, and the ongoing need to integrate social care with health, it has become increasingly clear that east Kent needs the means to develop a whole system strategy.

Not least, east Kent needs to ensure the full benefits of the out of hospital new models of care are realised, a sustainable future for both hospital and primary care services is developed, and integration of social care is achieved that ensures future service needs are met making the very best use of scarce resources.

To this end a Board has been established comprising the Clinical Chairs and Accountable Officers of the CCGs, the Chief Executives and Medical Directors of the health Trusts, the Corporate Director of Social Care, Health and Wellbeing for KCC, the Chair of the Whitstable and Canterbury Vanguard and NHS England. The Board had its first meeting in September and will continue to meet monthly.

There is wide recognition among Board members of the need for collaboration to oversee the development of strategic change and reconfiguration plans and the need to share resources to do so. There is also a good understanding that we need to build on work already started, not begin again. Early work of the Board will be to:

- Develop clinical criteria for change through key stakeholders.
- Determine the jointly developed and owned assumptions that underpin wider strategy.
- Bring together and develop existing work on capacity and demand modelling at an east Kent level.
- Develop communications and engagement capacity and a clear plan to support this work.

The focus of the Board will be to develop new models of care, develop new provider models and to determine the future shape of commissioning arrangements. At this stage this programme of work will be developed with the expectation of formally consulting with the public on future plans in early spring of 2016.

This paper provides a briefing to the HOSC on how the east Kent Board will operate.

2. Role of the Board

The respective individual organisations will retain decision making authority while recognising that delegated authority to develop the plans will be given to the Programme Board. The role of the East Kent Strategy Programme Board is to ensure that the Programme is delivered within the scope and to timescales agreed at the September 2015 Programme Board meeting by:

- Ensuring the delivery of a safe, quality, affordable and sustainable clinical strategy for the population of east Kent.
- Overseeing the work of and providing strategic guidance to the programme team and other associated work streams.
- Approving project plans and managing any deviations.
- Ensuring resources are managed appropriately across the Programme;
- Reporting, by exception, any risks, issues and exceptions related to the Programme.
- Brokering the competing priorities, providing advice and support on the strategic management and direction of the Programme.
- Approving, supporting and disseminating the communication and engagement programme related to this Programme.

3. Responsibilities

The East Kent Strategy Programme Board will have oversight of the Programme, ensure its delivery and make recommendations regarding future health and social care service configuration.

The Board's responsibilities are to:

- Promote and endorse the vision and objectives of the Programme.
- Oversee the work of, and provide strategic guidance to, the Programme Team and other associated work streams.
- Ensure that the Programme is delivered within scope and to timescales.
- Establish and ensure compliance with the communications strategy.
- Ensure that patient interests, rather than organisation-specific vested interests, remain at the heart of the process and to ensure they are actively engaged in discussions on service re-design.
- Broker competing implementation priorities across the Programme, ensuring adherence to agreed criteria for prioritisation.
- Ensure regular review of risks and issues that could impact on the Programme.
- Consider any external strategic impact on the delivery of the Programme.

- Manage/coordinate any change requirements necessary to maintain alignment with the Programme.
- Advise the respective organisations as necessary and appropriate.
- Ensure the Programme runs within budget.

4. Recommendation

The HOSC is asked to note the establishment of the East Kent Health and Social Care Strategy Board, its purpose, method of working and aims.

The HOSC is asked to advise how it wishes to work with this Board as it develops its work.

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