AGENDA

HEALTH AND WELLBEING BOARD (SHADOW)

Wednesday, 28th September, 2011, at 6.30 pm
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Peter Sass**

Telephone: **(01622) 694002**

Tea/Coffee will be available 15 minutes before the meeting.

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

1. Welcome
2. Substitutes
3. Declaration of Interests by Members in Items on the Agenda for this meeting
4. Election of Chairman
5. Terms of Reference and Standing Orders (Pages 1 - 8)
6. Code of Conduct (Pages 9 - 22)
7. Needs of the Population driving change in Commissioning - Presentation of Case Studies (Pages 23 - 26)

   Summary of item
   - Care of people with Dementia;
   - Dental Services – Adult & Children
   - Health Improvements

8. Our Vision for the Role of Kent Health and Wellbeing Board (Pages 27 - 56)

   Summary of item
   - What can the H&WBB do?
   - How do we lead on population health and health economy?
   - What decision do we need to make on ensuring Health Improvement?
   - How do we assist the joining up Health, Social Care and Public Health?
   - How do we do things differently and enable others to do the same?
   - How do we ensure we address the health and wellbeing of children?
   - Developing the work programme
   - What strategic direction do we want to give?

9. Clinical Commissioning Group Authorisation Process - Presentation (Pages 57 - 62)

Dr James Thallon – Medical Director K&M Cluster
Summary of item

- Authorisation process
- Role of H&WBB
- View of the implications from CCG Lead?

10. Dover District Council (DDC) early implementer Health and Wellbeing Board (Pages 63 - 66)

Summary of item
Paper to discuss how the Dover H&WBB might best be established

11. Developing a Communication Strategy for the Health and Wellbeing Board (Pages 67 - 76)

Summary of item
Recommendations for the development of a communication strategy and plan

12. Future dates to April 2013 (Oral report)

Regularity of meetings and suitable times

Peter Sass
Head of Democratic Services
Tuesday, 20 September 2011

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

Delegates:

Dr John Allingham	-	Clinical Lead, Shepway Locality, South Kent CCG
Dr Bob Bowes	-	Chair West Kent & Weald CCG Group
Cllr Andrew Bowles Represented by		
Cllr Lesley Ingham	-	Member, Housing, Health and Wellbeing, Swale BCl
Cllr Paul Carter	-	Leader of Kent County Council
Dr Fiona Armstrong	-	Joint Clinical Lead, Swale CCG
Dr Sourja Chaudhuri	-	Clinical Lead, Dover Locality, South Kent CCG
Cllr John Cunningham	-	Tunbridge Wells Borough Council
John Fletcher Represented by		
Roger Kendall	-	Kent LINk
Cllr Graham Gibbens	-	Cabinet Member for Older People's Services including Public Health – KCC
Cllr Roger Gough	-	Cabinet Member for Business Strategy & Support & Lead on Health Reform, KCC
Dr Mark Jones	-	Chair & Clinical Lead C4 Canterbury CCG
Dr Roger Pinnock	-	Chair, Ashford CCG
Dr Chee Mah	-	Clinical Lead, Deal Locality, South Kent CCG
Dr Tony Martin	-	Chair & Clinical Lead, Thanet CCG
Dr John Neden	-	Chair & Clinical Lead, East Cliff Commissioning Practice
Malcolm Newsam	-	Interim Corporate Director for Families and Social Care
Meradin Peachey	-	Director of Public Health
Dr Roger Pinnock	-	Chair, Ashford CCG
Dr John Ribchester	-	Chair & Clinical Lead, Whitstable CCG
Dr Garry Singh	-	Clinical Lead, Maidstone & Malling CCG
Ann Sutton	-	Chief Executive, Kent & Medway Cluster
Cllr Jenny Whittle	-	Cabinet Member for Safeguarding Children, KCC
Cllr Mark Worrall	-	Leader, Tonbridge & Malling Borough Council

Invited Observer

Katherine Kerswell	-	Managing Director, KCC
Colin Tomson	-	Chair, Kent & Medway Cluster

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By: Roger Gough, Cabinet Member for Business Strategy, Performance & Health Reform

Meradin Peachy, Director of Public Health

To: Shadow Health and Wellbeing Board – 28th September 2011

Subject: Terms of Reference and Standing Orders

Classification: Unrestricted

Summary: Asks the Board to note the Terms of Reference and Standing Orders for the shadow Health and Wellbeing Board, as agreed by County Council.

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1. Under the Health and Social Care Bill before Parliament, Health and Wellbeing Boards are to be established as formal committees of upper tier local authorities, and as a HWB early implementer, KCC has now constituted this shadow Health and Wellbeing Boards as a full committee.

2. The draft terms of reference and standing orders for the shadow Health and Wellbeing Board are attached. They closely follow the roles and responsibilities for Health and Wellbeing Boards set out in the Bill, and were approved by County Council at its meeting on the 21st July.

3. Terms of Reference and Standing Orders will be reconsidered ahead of the Board taking on full statutory responsibilities in April 2013.

Recommendation:

The Board is asked to note the Terms of Reference and Standing Orders

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Appendix A

Kent Shadow Health and Wellbeing Board

Draft Terms of Reference

Role

The shadow Health and Wellbeing Board (HWB) will lead and advise 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 and 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.

The Shadow HWB also aims to increase the local democratic legitimacy in health and provide a key forum for public accountability for NHS, public health, social care and other commissioned services that relate to people's health and wellbeing.

Terms of Reference:

The HWB will:

1. Commission and endorse the Kent Joint Strategic Needs Assessment (JSNA), subject to final approval by relevant partners, if required.

2. Commission and endorse the Kent Joint Health and Wellbeing Strategy (JHWS) to meet the needs identified in the JSNA, subject to final approval by relevant partners, if required.

3. Commission and endorse the Kent Pharmaceutical Needs Assessment, subject to final approval by relevant partners, if required.

4. Review the commissioning plans for healthcare, social care (adults and children's services) and public health to ensure that they have due regard to the JSNA and JHWS, and to take appropriate action if they consider that they do not (for instance, by writing formally to the local authority leadership, GP consortium or the NHS Commissioning Board as appropriate, drawing attention to their reservations).

5. Consider the totality of the resources in Kent for health and wellbeing and consider how and where investment in health improvement and prevention services could (overall) improve the health and wellbeing of Kent's residents.

6. 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.

7. Facilitate pathway redesign to improve the patient journey and healthcare outcomes.

8. Consider and advise CQC, NHS Commissioning Board, Monitor and Providers in health and social care with regards to service reconfiguration and make recommendations to those providers to enable improved and integrated service delivery.

9. Provide advice (as and when requested) to the County Council on service reconfigurations that may be subject to referral to the Secretary of State on resolution by the full County Council.

10. Be the focal point for joint working in Kent on the wider determinants of health and wellbeing, such as housing, leisure facilities and accessibility, in order to enhance service integration.

11. Discharge its duty to encourage integrated working with relevant partners within Kent (e.g. at locality level).

12. Develop and implement a Key Deliverables Plan, which will support the HWB early implementer status evaluation report, to be submitted to the Department of Health in May 2012.

13. Will report to the full County Council on an annual basis on its activity and progress against the milestones set out in the Key Deliverables Plan.

14. Develop and implement a Communication and Engagement strategy for the work of the HWB; outlining how the work of the HWB will reflect stakeholders views and how the HWB will discharge its specific consultation and engagement duties. Work closely with LINks/Local HealthWatch.

15. Represent Kent in relation to health and wellbeing issues across localities, nationally and internationally.

16. Subject to prior agreement and meeting the HWB's agreed criteria, the HWB may delegate those of its functions it considers appropriate to another committee established by one or more of the principle councils in Kent to carry out specified functions on its behalf for a specified period of time.

Membership

The Chairman will be elected by the HWB.

1. Kent County Council:

- The Leader of Kent County Council and/or their nominee*
- Cabinet Member for Adult Social Care & Public Health
- Cabinet Member for Business Strategy, Performance and Health Reform
- Cabinet Member for Specialist Children's Services
- Corporate Director for Families and Social Services*
- Director of Public Health*

2. Clinical Commissioning Group: up to a maximum of one representative from each consortium or to be determined by the CCG leads*

3. HealthWatch/Link*

4. Three elected Members representing the Kent District/Borough/City councils (nominated through the Kent Forum)

5. PCT Cluster Chief Executive (until 2013)

6. NHS Commissioning Board*

*denotes statutory member.

Kent Health and Wellbeing Board – Terms of Reference

Standing Orders

1. **Conduct.** Members of the HWB are expected to subscribe to and comply with any code of conduct that applies to them. No code of conduct will have precedence over another.

2. **Frequency of Meetings**. The HWB shall meet at least quarterly. The date, time and venue of meetings shall be fixed in advance by the HWB in order to coincide with the key decision-points and Forward Plan.

3. **Meeting Administration.** HWB meetings shall be advertised and held in public and be administered by the County Council. The HWB will consider matters submitted to it by local partners. The County Council shall give at least five clear working days' notice in writing to each member for every ordinary meeting of the HWB, to include any agenda of the business to be transacted at the meeting. Papers for each HWB meeting will be sent out five clear working days in advance. Late papers will be sent out or tabled only in exceptional circumstances. The HWB shall hold meetings in private session when deemed appropriate in view of the nature of business to be discussed. The Chair's decision on this matter shall be final.

4. **Special Meetings.** The Chair 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.

   The Chair will be required to convene a special meeting of the HWB if s/he is in receipt of a written requisition to do so signed by no less than [three] of the [Constituent Members/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 seven days of the Chair's receipt of the requisition.

5. **Minutes.** The HWB shall cause minutes of all of its meetings to be prepared recording:

   a) the names of all members present at a meeting and of those in attendance
   b) apologies
   c) details of all proceedings, decisions and resolutions of the meeting.

   These minutes shall be printed and circulated to each member before the next meeting of the HWB when they shall be submitted for the approval of the HWB. When the minutes of the previous meeting have been approved they shall be signed by the Chair.

6. **Agenda.** The agenda for each meeting will normally include:

   a. Minutes of the previous meeting for approval and signing
   b. Reports seeking a decision from the committee

c. Any item which a Member of the Committee wishes included on the agenda, provided it is relevant to the terms of reference of the Committee 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.

7. **Chair and Vice Chair's Term of Office.** The Chair and Vice Chair's term of office shall terminate on 1 April in each year and they shall each be reappointed or replaced by another member, according to the decision of the HWB, at the first meeting of the HWB succeeding that date.

8. **Absence of Members and of the Chair.** If a member is unable to attend a meeting, then the relevant Constituent Member shall, where possible, provide an appropriate alternate member to attend in his/her place. Where possible, the Clerk of the meeting will be notified of any absence and/or substitution within 5 working days of the meeting. The Chair shall preside at HWB meetings if s/he is present. In her/his absence the Vice-Chair shall preside. If both are absent the HWB shall appoint, from amongst its members Acting Chair for the meeting in question.

9. **Voting.** The HWB will operate on a consensus basis. Where consensus cannot be achieved the subject (or meeting) will be adjourned. The matter will then be reconsidered; if at that point a consensus can still not be reached the matter will be put to a vote. All matters to be decided by the HWB shall be decided by a simple majority of the members present, but in the case of an equality of votes, the person presiding at the meeting shall have a second or casting vote. All votes shall be taken by a show of hands unless decided otherwise by the Chair.

10. **Quorum.** A third of [Constituent Members/members] shall form a quorum for meetings of the HWB. 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 Chair shall either suspend business until a quorum is re-established or declare the meeting at an end.

11. **Adjournments.** By the decision of the Chair of the HWB, or by the decision of a majority of those present at a meeting of the HWB, meetings of the HWB may be adjourned at any time to be reconvened at any other day, hour and place, as the HWB shall decide.

12. **Order at Meetings.** At all meetings of the HWB it shall be the duty of the Chair to preserve order and to ensure that all members are treated fairly. S/he shall decide all questions of order that may arise.

13. **Suspension/disqualification of Members.** At the discretion of the Chair, 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 with the prior consent of the Chair or they breach the appropriate code of conduct.

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By:	Roger Gough, Cabinet Member for Business Strategy, Performance & Health Reform Meradin Peachy, Director of Public Health
To:	Shadow Health and Wellbeing Board – 28th September 2011
Subject:	Code of Conduct
Classification:	Unrestricted

Summary: Asks the shadow Health and Wellbeing Board to note the Cabinet Office '*Code of Conduct for Board Members of Public Bodies*', and agree the code should be applicable to all Members of the shadow Health and Wellbeing Board.

1. The Health and Social Care Bill will create Health and Wellbeing Boards as formal committees of all upper tier local authorities with a core statutory membership, both elected and non-elected, drawn from a range of public bodies and groups across the health and local government spectrum. Health and Wellbeing Boards are therefore a relatively unique form of joint governance arrangement.

2. The Department of Health has suggested that Health and Wellbeing Boards should operate *as if* they are statutory joint advisory committee under the 1972 Local Government Act, but will take their legal mandate from the Health and Social Care Act once enacted, whilst not taking full statutory responsibilities until April 2013. Until the Bill is enacted and further statutory guidance regarding the technical operation of Health and Wellbeing Boards is provided, early implementers must come to local arrangements for shadow Boards.

3. Even in shadow form, it is probable that the HWB will be in receipt off or consider sensitive matters, and our advice is that some form of code of conduct should apply to all Members of the Board.

4. Ordinarily, all elected Members of a committee of the County Council are covered by the Member code of conduct, which sets out the standards of behavior of an elected Member of the County Council. However with the core membership of the HWB being drawn from a wide range of bodies, the Member code of conduct cannot and does not apply to all Members of the shadow Health and Wellbeing Board.

5. In anticipating this issue, the Standing Orders developed for the shadow Board note that "*Members of the HWB are expected to subscribe to and comply with any code of conduct that applies to them. No code of conduct will have precedence over another".* However this still leaves the possibility that Members of the shadow Board are not covered by any code of conduct. `

6. To resolve this gap, it is suggested that the Board as a whole considers adopting the 'Code of Conduct for Board Members of Public Bodies' prepared by the Cabinet Office in June 2011 (attached as Appendix A) as a code of conduct that will apply to all members of the shadow Board. This generic code of conduct is light touch, does not contradict or supersede any other code of conducts that might still apply to individual members of the shadow HWB.

Recommendation:

The shadow Health and Wellbeing Board adopt the Cabinet Office '*Code of Conduct for Board Members of Public Bodies*' as being applicable to all Members of the shadow Health and Wellbeing Board.

Appendices:

Appendix A:

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CABINET OFFICE

CODE OF CONDUCT FOR BOARD MEMBERS OF PUBLIC BODIES

JUNE 2011

FOREWORD

The Government expects all holders of public office to work to the highest personal and professional standards. In support of this, all non-executive board members of UK public bodies[1] must abide by the principles set out in this Code of Conduct. The Code sets out, clearly and openly, the standards expected from those who serve on the boards of UK public bodies and should form part of individual members' terms and conditions of appointment. Any breach of the Code should be viewed as a breach of those terms and conditions of appointment.

This *Code* replaces *Guidance on Codes of Practice for Board Members of Public Bodies* issued by the Cabinet Office in 2004.

Any questions on the *Code* should be directed to:

Propriety and Ethics Team
Cabinet Office
70 Whitehall
LONDON
SW1A 2AS

Tel: 020 7276 0269/0387

Copies of the *Code* can be downloaded from:

www.cabinetoffice.gov.uk/content/public-bodies-and-appointments

[1] The principles set out in this Code should apply to all non-executive members on the boards of Government Departments, non-Ministerial Departments, Executive Agencies, Executive and Advisory non-department public bodies (NDPBs) and national public corporations.

CODE OF CONDUCT FOR BOARD MEMBERS OF PUBLIC BODIES

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CODE OF CONDUCT FOR BOARD MEMBERS OF PUBLIC BODIES

1. INTRODUCTION

1.1 As a public office-holder, your behaviour and actions must be governed by the principles set out in this Code of Conduct. It is your responsibility to ensure that you are familiar with, and comply with, all the relevant provisions of the Code.

2. KEY PRINCIPLES OF PUBLIC LIFE

2.1 The key principles upon which this Code of Conduct is based are the Seven Principle of Public Life[2]. These are:

Selflessness

You should take decisions solely in terms of the public interest. You should not do so in order to gain financial or other material benefits for yourself, your family or your friends.

Integrity

You should not place yourself under any financial or other obligation to outside individuals or organisations that might, or might be perceived to, influence you in the performance of your official duties.

Objectivity

In carrying out public business, including awarding contracts and recommending individuals for rewards and benefits, you should make choices on merit.

Accountability

You are accountable for your decisions and actions to the public and must submit yourself to whatever scrutiny is appropriate for your office.

[2] *Standards in Public Life: First Report of the Committee on Standards in Public Life*. Volume 1: Report. CM 2850-I.

Openness

You should be as open as possible about the decisions and actions that you take. You should give reasons for your decisions and restrict information only when the wider public interest clearly demands.

Honesty

You have a duty to declare any private interests relating to your public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership

You should promote and support these principles by leadership and example.

2.2 These principles should inform your actions and decisions as a board member.

3. GENERAL CONDUCT

Use of Public Funds

3.1 You have a duty to ensure the safeguarding of public funds[3] and the proper custody of assets which have been publicly funded.

3.2 You must carry out your fiduciary obligations responsibly – that is, take appropriate measures to ensure that the body uses resources efficiently, economically and effectively, avoiding waste and extravagance. It will always be an improper use of public funds for public bodies to employ consultants or other companies to lobby Parliament, Government or political parties.

Allowances

3.3 You must comply with the rules set by the board and the public body regarding remuneration, allowances and expenses. It is your responsibility to ensure compliance with all relevant HM Revenue and Customs' requirements concerning payments, including expenses.

[3] This should be taken to include all forms of receipts from fees, charges and other sources.

Gifts and Hospitality

3.4 You must not accept any gifts or hospitality which might, or might reasonably appear to, compromise your personal judgement or integrity or place you under an improper obligation.

3.5 You must never canvass or seek gifts or hospitality.

3.6 You must comply with the rules set by the body on the acceptance of gifts and hospitality. You should inform the Chief Executive (or equivalent) of any offer of gifts or hospitality and ensure that, where a gift or hospitality is accepted, this is recorded in a public register in line with the rules set by the body.

3.7 You are responsible for your decisions on the acceptance of gifts or hospitality and for ensuring that any gifts or hospitality accepted can stand up to public scrutiny and do not bring the public body into disrepute.

Use of Official Resources

3.8 You must not misuse official resources[4] for personal gain or for political purposes. Use of such resources must be in line with the body's rules on their usage.

Use of Official Information

3.9 You must not misuse information gained in the course of your public service for personal gain or for political purpose.[5]

3.10 You must not disclose any information which is confidential in nature or which is provided in confidence without authority. This duty continues to apply after you have left the board.

Political Activity[6]

3.11 In your public role, you should be, and be seen to be, politically impartial. You should not occupy a paid party political post or hold a particularly sensitive or high-profile role in a political party. You should

[4] This includes facilities, equipment, stationery, telephony and other services.

[5] Board members who misuse information gained by virtue of their position may be liable for breach of confidence under common law or may commit a criminal offence under insider dealing legislation

[6] If you are an MP, Member of the House of Lords, Member of a Devolved Administration or Local Councillor, you are exempt from these requirements - although you should still exercise proper discretion on matters directly related to the work of the body and recognise that certain political activities may be incompatible with your role as a board member.

abstain from all controversial political activity and comply with Cabinet Office rules on attendance at Party Conferences[7].

3.12 On matters directly related to the work of the body, you should not make political statements or engage in any other political activity.

3.13 In your official capacity, you should be even-handed in all dealings with political parties.

3.14 Subject to the above, you may engage in political activity but should, at all times, remain conscious of your responsibilities as a board member and exercise proper discretion. You should inform the Chair and/or the parent Department before undertaking any significant political activity.

Employment and Appointments

3.15 If you wish to take up new employment or appointments during your term of office, you must inform the Chair and/or the relevant parent Department.

3.16 On leaving office, you must comply with the rules of the body on the acceptance of future employment or appointments.

4. MEMBERS' INTERESTS

4.1 You must ensure that no conflict arises, or could reasonably be perceived to arise, between your public duties and your private interests – financial or otherwise.

4.2 You must comply with the rules of the body on handling conflicts of interests. As a minimum, these will require you to declare publicly any private interests which may, or may be perceived to, conflict with your public duties[8]. The rules will also require you to remove yourself from the discussion or determination of matters in which you have a financial interest. In matters in which you have a non-financial interest, you should not participate in the discussion or determination of a matter where the interest might suggest a danger of bias.[9]

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[7] www.cabinetoffice.gov.uk/content/public-bodies-and-appointments

[8] In general, all financial interests should be declared. When considering what non-financial interests should be declared, you should ask yourself whether a member of the public, acting reasonably, would consider that the interest in question might influence your words, actions or decisions.

[9] These are common law provisions.

4.3 It is your responsibility to ensure that you are familiar with the body's rules on handling conflicts of interests, that you comply with these rules and that your entry in the body's register of members' interests is accurate and up-to-date.

5 RESPONSIBILTIES AS A BOARD MEMBER

5.1 You should play a full and active role in the work of the body. You should fulfil your duties and responsibilities responsibly and, at all times, act in good faith and in the best interests of the body.

5.2 You should deal with the public and their affairs fairly, efficiently, promptly, effectively and sensitively, to the best of your ability. You must not act in a way that unjustifiably favours or discriminates against particular individuals or interests.

5.3 You must comply with any statutory or administrative requirements relating to your post[10].

5.4 You should respect the principle of collective decision-making and corporate responsibility. This means that, once the board has made a decision, you should support that decision.

5.5 You must not use, or attempt to use, the opportunity of public service to promote your personal interests or those of any connected person, firm, business or other organisation.

6. RESPONSIBILITIES TOWARDS EMPLOYEES

6.1 You will treat any staff employed by the body with courtesy and respect. It is expected that employees will show you the same consideration in return.

6.2 You will not ask or encourage employees to act in any way which would conflict with their own Code of Conduct.

[10] In the case of a body incorporated under the Companies Act or the Companies (Northern Ireland) Order, you will also be subject to the duties of directors under company law. In the case of a body that has charitable status, you will also be subject to the duties of trustees under charities law.

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By: Meradin Peachy, Director of Public Health

To: Health and Wellbeing Board – 28th September 2011

Subject: Needs of the population driving change in commissioning

Classification: Unrestricted

Summary: Following on from the Health & Wellbeing Board workshop that was held on the 20th July 2011, it was felt that it would be helpful to share some case studies from the Joint Strategic Needs Assessment (JSNA).
This paper is a brief summary of the presentation that will be given at the meeting.

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1. Key Facts:

1.1 The duty to undertake JSNA is set out in Section 116 of the Local Government and Public Involvement in Health Act 2007.

1.2 Healthy Lives, Health People: Our Strategy for Public Health England States:

GP consortia and local authorities, including Directors of Public Health, will each have an equal and explicit obligation to prepare the Joint Strategic Needs Assessment (JSNA), and to do so through the arrangements made by the Health and Wellbeing Board.

1.3 The JSNA can be described as an umbrella under which there are a number of supporting needs assessments which help to shape the key priorities and recommendations.

1.4 The approach taken in Kent is to provide a summary of all recommendations and priorities identified within existing and emerging needs assessments in Kent.

1.5 Further detail can be found on the Kent and Medway Public Health Observatory website: www.kmpho.nhs.uk/jsna

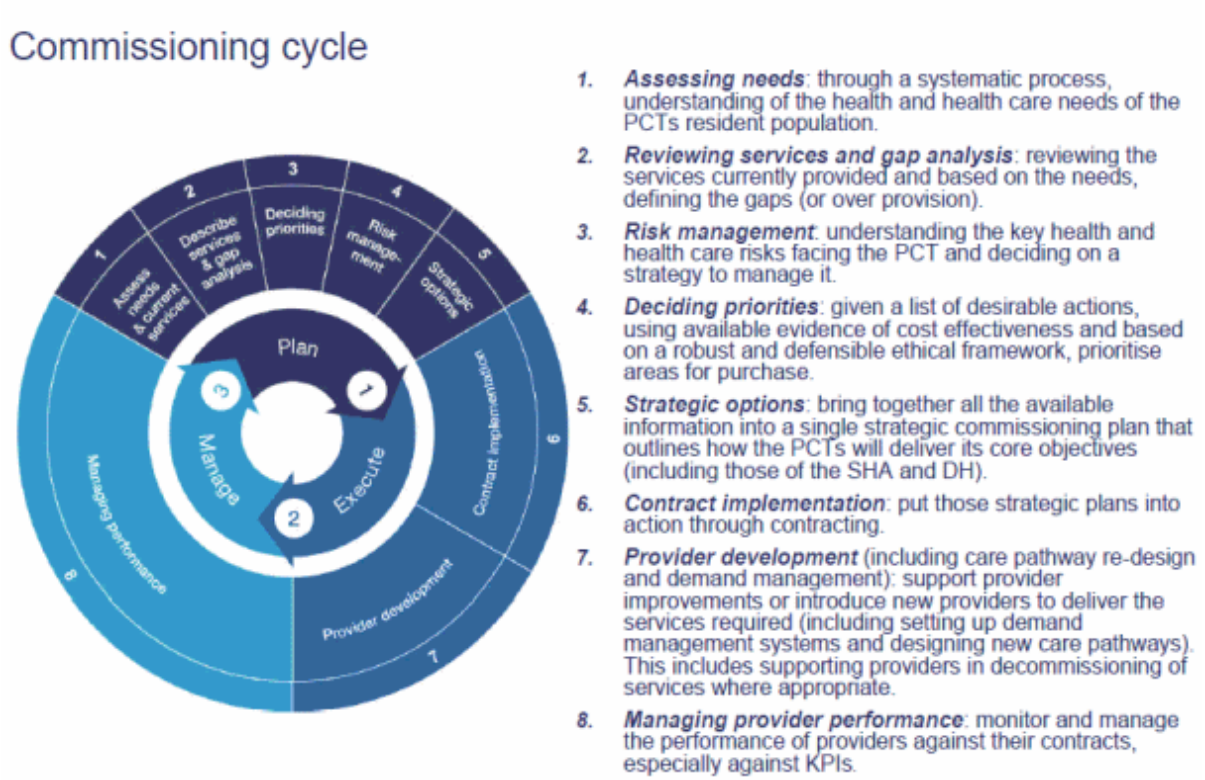
1.6 *"Responsibility needs to be shared across society – between individuals, families, communities, local government, business, the NHS, voluntary and community organisations, the wider public sector and central government."* ***Health lives, health people – our strategy for Public Health in England, Section 2.5 page 25. Crown copyright 2010***

2. Developing Clinical Commissioning Groups

2.1 Towards authorisation a draft document from Sir David Nicholson identifying 6 domains for success for a CCG. Sections relate to population needs based commissioning in health and social care.

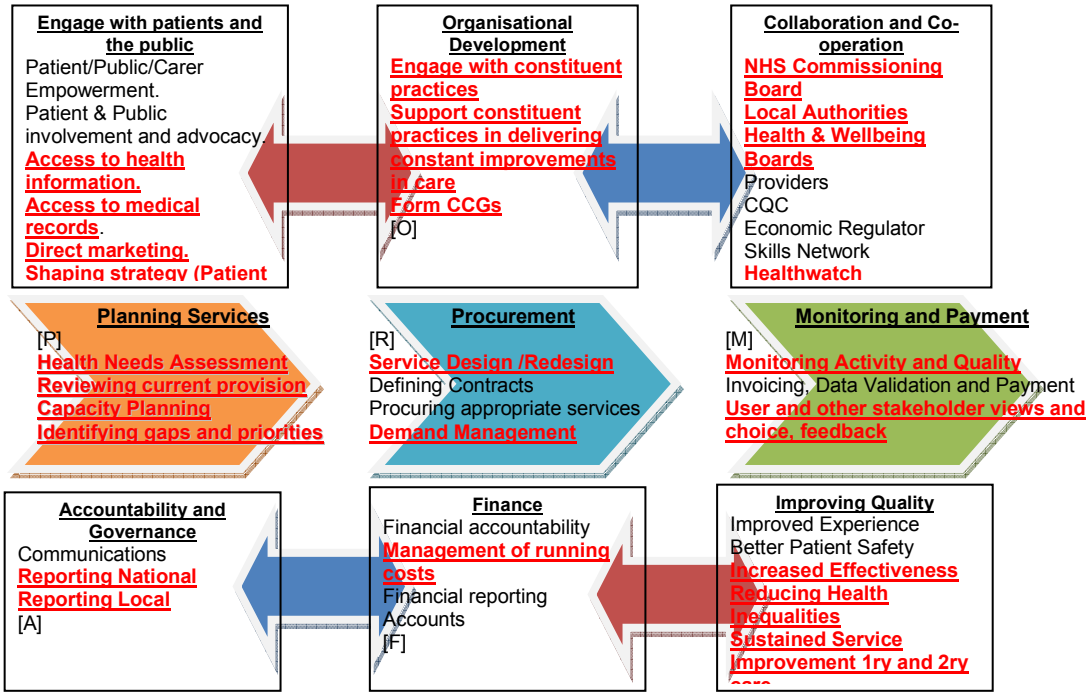
3. Needs to starting point in the Commissioning Cycle

JSNA process starts at assessing need and stretches at least to 5 and some will be to 8 (this is the classic model)



4. Future Scope of Clinical Commissioning Group responsibilities

From - Commissioning Intelligence: Better Information, Better Choices and Better Outcomes, July 2011



5. Examples from Case Studies

From – Joint Strategic Needs Assessment in South East – Review of Practice, January 2011

"**Case study – JSNA Themes in Kent**

Kent undertook two separate JSNAs, one for Adults and another for Children, as well as contributing to a JSNA for Mental Health undertaken across both Kent and Medway. The Adults JSNA was conducted in three separate phases. Year one concentrated on outlining the key demographic shift and helped concentrate the commissioners on the ageing population and long term conditions. In year two the Adults JSNA drilled down into a further three in-depth needs assessments: mental health, alcohol and dementia. Although the separation of the JSNA into themes was a product of organisational dynamics, it did allow them to focus the JSNA work and gain an in-depth view of key issues which enabled the JSNA to influence specific commissioning decisions, shape the agenda for the Kent Children's Trust and fundamentally drive the priorities of the Children and Young Person's Plan."

"Case Study – Identifying Deprivation in Kent

The JSNA work for Adults in Kent decided to include social marketing segmentation tools to identify the population profiles of people with long term conditions and people known to social services in Kent to better help commissioners understand the best ways to reach out to these groups. This approach challenged assumptions and found pockets of people living in deprivation in otherwise affluent areas and helped lead to changes in the approach to initiatives."

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By: Roger Gough, Cabinet Member for Business Strategy, Performance & Health Reform

Meradin Peachy, Director of Public Health

To: Health and Wellbeing Board – 28th September 2011

Subject: Our vision for the role of the Kent Health & Wellbeing Board

Classification: Unrestricted

Summary: Following on from the Health & Wellbeing Board workshop that was held on the 20th July 2011, feedback received expressed clarity on the role, responsibilities and expectations of the Board. This paper supplies some useful supporting documentation to assist with the discussion on the direction of travel for this Board.

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1. Background

1.1 There have been two very useful H&WBB workshops, one held in March and one in July 2011. At each session notes were taken on each table and these are attached for reference as well as the evaluation from our last workshop.

1.2 In order to understand what is happening nationally, a presentation has been attached for information from John Wilderspin, National Director Health and Wellbeing Board Implementation.

1.3 A model indicating a possible work programme leading on from discussions in the H&WBB workshops.

2. Clarifying roles

2.1 The Health and Social Care Bill outlines a new role for local authorities for the co-ordination, commissioning and oversight (including scrutiny) of health, social care (both adults and children's), public health and health improvements. Following the enactment of the Bill, Kent County Council (KCC), as the upper tier authority, will have the following key duties:

- Creation of a Health and Wellbeing Board
- Transfer of Public Health and health improvement functions from the PCT, including a ring fenced budget
- Expansion of the health and social care scrutiny functions
- Establishment of the local HealthWatch

2.2 The Health & Wellbeing Board (H&WBB) will become a formal sub-committee of KCC. Statutory Members will be drawn from KCC, Clinical Commissioning Groups (CCG) and Healthwatch. The Health and Social Care Bill identifies statutory members of the H&WBB as:

- At least one councillor of the local authority – Leader of the Council and/or their nominee
- Representative of each relevant CCG (one person may represent more than one CCG with the agreement of the H&WBB)
- Director or Adult Social Services
- Director of Children's Services
- Director of Public Health
- Representative of the local HealthWatch/LINk organisation
- Such other persons or representatives as the local authority thinks appropriate (this was specifically added to the Bill in recognition of the role and contribution of district councils and other partners to the health and wellbeing agenda)
- NHS Commissioning Board (for JSNA, H&WB Strategy and matters relating to the commissioning functions of the NHS Commissioning Board)

2.3 Before the listening exercise the role of the H&WBB was to:

- Develop a Joint Strategic Needs Assessment (JSNA) for the locality
- Drawing on the JSNA, agree a Joint Health and Wellbeing Strategy
- Ensure individual commissioning plans (health, public health and social care) align with the Joint Health and Wellbeing Strategy

The Future Forum's view of Health and Wellbeing Boards felt

"There was a degree of uncertainty as to what role the health and wellbeing boards would have in the new system.

They must be tasked with agreeing the priorities for health and care for that community and each party must account to the Board for their obligations to deliver those priorities
We have concluded that the local health and wellbeing boards are a vital part of the system that needs to be put in place".

2.4 The Government response to the Future Forum is below:

- A new duty to involve users and the public
- A stronger role in promoting joint commissioning and integrated provision between health, public health and social care
- A requirement for CCG's to involve H&WBB's as they develop their commissioning plans
- CCG commissioning plans (and other commissioning plans) need to be in line with the Joint Health and Wellbeing Strategy

- A right to refer CCG plans back, or to the NHS Commissioning Board, if they are not in line with the Joint Health and Wellbeing Strategy
- Local authorities can determine how many elected members will be on the Board

Kent County Council was awarded Early Implementer status in March 2011. There is a task group to support this and initial workshops have taken place with interested parties (including GP's)

2.5 Clinical Commissioning Groups

The draft Health and Social Care Bill proposes that groups of clinicians take on the responsibility for commissioning. Working alongside local authorities, particularly the Health and Wellbeing Boards, commissioners will need to deliver a sustainable, patient-focused system.

The Governments response to the Future Forum shows there is a universal agreement that patient care is better if it is based on input from those closest to patients – doctors, nurses and other health and social care professionals – in discussion with patients and carers, the voluntary sector and other healthcare partners.

Clinical Commissioning Groups (called "commissioning consortia" in the Bill as it stands) to organise services for their local populations, supported by a national NHS Commissioning Board. CCG's, as groups of practices, will have responsibility for bringing together a range of health and care professionals, together with patients and the public. The requirement to have a nurse, a hospital doctor and lay people on the CCG governing body will ensure that there is a broader perspective on health and care issues to underpin the work of the CCGs.

GPs and other frontline professionals already make the clinical decisions that determine how most NHS resources are used. Putting them in charge of shaping services will enable NHS funding to be spent more effectively to provide high quality care. Better commissioning can improve quality and save money at the same time, for example by helping people to manage their condition at home and reducing the need to go to hospital.

2.6 National Commissioning Board

The Government proposes establishing an NHS commissioning Board whose role will include supporting, developing and holding to account an effective and comprehensive system of CCGs. The Board will be part of a comprehensive commissioning system for healthcare services. The Board will have a dual role in that it will both deliver its own commissioning functions and ensure that the whole of the architecture is cohesive, co-ordinated and efficient.

The Board's overarching role is to ensure that the NHS delivers better outcomes for patients within its available resources. The Board can fulfil this role through its leadership on delivering the NHS Outcomes Framework, supported by its accountability framework for CCGs, its framework for choice and competition, and its framework for emergency planning and resilience.

"The purpose of the Board will be to use the £80bn commissioning budget to secure the best possible outcomes for patients."

The most important functions of the NHS Commissioning Board are:

- To agree and deliver improved outcomes and account to Ministers and Parliament for progress. There will be a clear mandate, setting out expectations for the Board and the broader commissioning system;
- To oversee the commissioning budget, ensuring financial control and value for money;
- To develop and oversee a comprehensive system of CCGs with responsibility for commissioning the majority of healthcare services;
- To commission directly around £30bn of services including specialised services and primary care services (including holding around 35,000 contracts for primary care services);
- To support quality improvement by promoting consistent national Quality Standards, a culture which promotes research and innovation and providing world class support for clinically led service improvement and leadership;
- To promote innovative ways of demonstrating how care can be made more integrated for patients;
- To promote equality and diversity and the reduction of inequalities in all its activities;
- To develop commissioning guidance, standard contract, pricing mechanisms and information standards;
- To engage with the public, patients and carers, champion patient interests and ensure patients have access to a wider range of information and services;
- To develop a framework to make choice a reality for patients, setting out guidance in consultation with Monitor about how choice and competition should be applied to particular services;
- To oversee planning foe emergency resilience and lead the NHS operational response to significant emergencies; and
- With its partners, develop a medium term strategy for the NHS, which alongside the local priorities developed through H&WBB, helps form the basis for local commissioning plans.

This list is not a comprehensive list but sets out the most important levers.

Values and culture includes:

- A clear sense of purpose focused on improving quality and outcomes;
- A commitment to putting patients, clinicians and carers at the heart of decision-making;
- An energised and proactive organisation, offering leadership and direction;
- A focused and professional organisation, easy to do business with;
- An objective culture, using evidence to inform the full range of its activities;
- A flexible organisation, promoting integration, working across boundaries and performing tasks at the right level, whether national or local;
- An organisation committed to working in partnership to achieve its goals, in particular by developing an effective and mutually supportive relationship with CCGs;
- An open and transparent approach, sharing information freely wherever appropriate; and
- An organisation with clear accountability arrangements and a grip on those things for which it will be held to account.

3.0 Vision for the H&WBB

3.1 It is important that collectively we describe what the Kent vision is for the H&WBB. We also need to collectively agree the work programme and the regularity of meetings whilst we move through this Shadow period.

3.2 Delegates are asked to participate in this group discussion that will shape the way the Kent Health and Wellbeing Board will work during its Shadow form.

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Health and Well Being Board Workshop

16 March 2011

Health & Wellbeing Boards – Shaping for the future

Roger Gough, Cabinet Member for Business Strategy & Support

Significant issues for the Board:

- The financial challenge inc. £686m QIPP target savings
- Board membership – how can this be wide enough to be representative but small enough to be effective?
- The agenda is potentially huge – how to avoid the board sitting in "permanent session"?
- What tools and support will the H&WBB need to discharge its functions?
- How do we link the county level board to localities?

Bold Steps for Health/JSNA/QIPP

Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

KCC's view of the role of the HWBB and suggesting the potential for certain key discussion themes that in the scenario that exist now in 2011 could include:

1. Bold Steps for Health (a medium term plan for health in Kent and following on from Bold Steps for Kent – the KCC medium term plan)
2. Joint Strategic Needs Assessment (JSNA)
3. Quality Innovation Productivity and Prevention (QIPP)

Arising from the above three themes, the following emerge:

- GP commissioning plans to meet the health needs of all residents
- Work with key partners including GPs, community health and districts
- How will GP consortia encourage new providers to enter the healthcare market in Kent?
- Join up and integrate health and social care services to reduce costs and avoidable demand
- Focus on a preventative approach to public health, supporting people to improve their lifestyles
- Work with GPs to reduce health inequalities
- JSNA Priorities eg; Joint commissioning for integrated health and social care services, dementia, CAMHS, prevention services
- Addressing health inequalities and ensuring equality of health provision across Kent
- Achieving QIPP; improving quality and spending less

How might Health & Wellbeing Boards work with the GPCC?

Presentation by Dr Bob Bowes, Invicta & South West PBC Group

Presently in West Kent there is not a good working relationship with the PCT with regard to Commissioning Strategies.

There is the potential for us to work in a more imaginative and creative way to solve our problems once the Health and Well Being Board is set up.

The definition of a Consortium is a collection of effective Primary Care teams. The test will be how well the consortium relates to GP practices. GPs feel they will get a lot more out of Primary Care as there will be the chance to work better together on integrated provision.

If we can get the GPs to work in this way, then it will be fantastic. If we can't keep the GPs with us then it will be very hard work.

There is too much activity in secondary care, when more could be done in primary care. Patient pathways need redesigning to reflect this.

Already we have too much capacity, bringing people into hospitals when they don't need to be admitted. We need to work in partnership with our providers.

There will be a quality premium for those practices that are successful. At the moment GPs can put every patient they want to into hospital. In the future GPs will get charged to put patients into hospital if they don't need to go.

Question by Paul Carter:
There is currently overcapacity in Secondary Care. In Primary Care presumably you can support the concept of providing new markets?

Response by Dr Bob Bowes:
We are certainly interested in responsive providers. It will be good if their organisation is fearful of a mistake. They must be responsive and interested.

Presentation by Dr Tony Martin, Chair, Thanet Consortium

In East Kent we do have a good relationship with the PCT and we feel that sets us ahead.

Thanet have set up their own Health and Well Being Board and this gives us something of what we would like to see in the future for the Kent Health and Well Being Board.

We want joined up Community Care. We need to be agreeing at the top level as GP Commissioners what we are actually commissioning at a local level for our patients. We need to look at the local issues and address them through cross working.

We need to look at what this Board will do for us. We can use it to address specific issues such as Dementia and Carers. We are looking for change locally. We need to change, broaden and integrate PCTs and GPs etc.
At each level we have members of staff that have to change what they do and how they are doing it.

We have the opportunity and need to drive members of staff. This is a real opportunity to work more closely with KCC. To us it is a very welcome move.

How is it working in Dover

Presentation by Councillor Sue Chandler, Dover District Council

It appears that there has been a lack of drive between local authorities to the centre. Dover has more of a relationship with our Health providers.

We have already been undertaking work on a Health and Well Being Project in Dover, working with Housing, Scrutiny and Neighbourhood Forums.

We spoke to PCTs in the autumn and we already had good working relationships with them. We set up an integrated Health Pilot around using our relative expertise around emerging consortium. There was a very clear agenda and joining things up, avoiding duplication and working in a more joined up way. The Health and Well Being Board and good communication will enable this. We have also set up two specific projects around Dementia and Elderly Care.

We then applied for Early Implementer and got confirmation yesterday.

Workshop Discussion

Table 1

- Katherine Kerswell – Group Managing Director, KCC
- Cllr Pam Carr – Shepway BC
- Cllr Ken Pugh – Deputy Cabinet Member for Business Strategy & Support
- Dr Sarah Montgomery – GP & Clinical Executive E&CK PCT
- Cllr David Turner – Gravesham BC
- Malcolm Newsom – Interim Managing Director, Children's, Families and Education
- Meradin Peachey – Director of Public Health & Facilitator

Table 1 Round Up

- Challenging debates between partners will be essential
- Trying to be modest about what can be achieved in a year
- We should write the ToR now and share amongst partners
- What works locally – it cannot just be another meeting
- Dementia as part of the JSNA priority
- Strategies making sense locally

Table 2

- Chris Mackenny – Deputy Leader for Dover & Aylesham GP Consortia
- Ann Sutton – Chief Executive Kent & Medway Cluster
- Cllr Peter Lake – Deputy Cabinet Member Specialist Children's Services
- Cllr John Cunningham – Tunbridge Wells DC
- Cllr Graham Gibbens – Cabinet Member for Older People's Services including Public Health
- Cllr Fleming – Sevenoaks DC Leader
- Dr Abraham George-Public Health consultant & Facilitator

Table 2 Round Up

- Successful coterminous working with PCTs, GPs and Councils
- Tackling not all of the issues at once, but a few of the big issues at a time
- Situation is evolving. It is down to everyone to all have the arrangements in place by April 2012.
- We need to manage public expectation

Table 3

- Dr Simon Lundy – representing Canterbury & Coastal Commissioning Consortium
- Colin Tomson – Chair, Kent & Medway Cluster
- Cllr Jenny Whittle – Cabinet Member for Specialist Children's Service
- Cllr Gordon Court – T&M BC
- Cllr Chandler – Dover DC
- David Barr – LMC
- Angela Slaven – Director Youth & Community Support Services & Facilitator
- Dr Bob Bowes – Invicta & South West PBC Grp

Table 3 Round Up

- The Board needs to set the right tone and address the fears that are out there in the communities
- We should define the added value of the Kent H&WBB agenda
- Set out several priorities of what should be concentrated on first and can be translated to the local level
- The Board has an enabling function

Table 4

- Dr Tony Martin – Chair, Thanet Consortium
- Dr Darren Cocker – Clinical Executive E&CK PCT
- Dr John Allingham – LMC
- Cllr Paul Carter – Leader of Kent County Council
- Cllr Roger Gough – Cabinet Member for Business Strategy & Support
- Cllr Lesley Ingham – Swale BC
- Roger Kendall – Kent Links
- Anne Tidmarsh – Director or Commissioning & Provision East Kent & Facilitator

Table 4 Round Up

- Identify the gaps in service. How will the services need to be funded
- Citizen engagement (local)
- Lack of engagement of clinicians. Need to ensure they are on board
- Quick wins linking services better
- Deciding "do-able" priorities
- Improving quality by holding providers to account
- Co-terminus HWB with GPCC
- Different models needed within Kent
- Inequity of service in different areas
- Duplication of bureaucracy
- Creation of monopoly providers and continuity of inadequate services

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Round up and Conclusions by Roger Gough

- There needs to be a sensible and manageable level of ambition (not too many priorities)
- Importance of communication and engagement with GPs and the wider population in terms of what we are trying to do at each level
- Need to ensure effective relationships between what happens at the Board and local level and the real challenges around that. Building on what we have and the need to ensure that we build effectively
- Relationship with the providers needs to happen. Diversity of provision and managing stability of provision

How to take these ideas forward

KCC will bring something to their July Cabinet meeting
Kent Forum – this will be an item for discussion
Strategic Oversight Board with GPs – this can be discussed
GP Consortia events – KCC will come out and visit GPs

Paul Carter

There is a risk regarding capacity to deliver this change. Who will support the Board and drive it forward? There is money in the Big Society Fund that we could use to do that.

There have been some good conversations this evening and I have been inspired by the two presentations given by the GPs. We all need to reflect on how we can become well established with a Shadow HWBB in 12 months time, trying not to do too much and ensuring that what we choose to do, we can deliver.

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Notes from the Kent Health & Wellbeing Board Workshop
7.00 – 8.30 pm on 20 July 2011
County Hall, Maidstone

The summary below is based on the discussions which took place after the JSNA and dementia presentations and also captures what the HWB should do to address dementia in Kent.

JSNA

- Will the Kent wide JSNA be relevant at the CCG level? What will the local arrangements be?
- There needs to be a strong locality element and it should be more bottom up than top down
- The JSNA website needs to be user friendly. A good example is the Nottingham website
- How will the JSNA add value to community strategies and how wide does JSNA influence go?
- Can JSNA information be made available to GPs on a population basis rather than a geographical basis?
- Can email alerts be provided to GPs so that they know when new information has been uploaded onto the JSNA website.
- GPs need to be better linked in to Public Health professionals

Dementia

What needs to happen within acute and community care to improve dementia services in Kent?

Early diagnosis

- Greater emphasis on the need for early diagnosis of dementia and for an analysis of what and where the need is and what is the gap in service
- One of the problems in the Dover area is that GPs are unsure of the pathway to access dementia services
- It was important that where there was good practice in relation to dementia services this is shared
- One of the GPs expressed the view that where the service was "rubbish" for dementia patients why diagnose it?
- In the Maidstone area Admiral Nurses played a significant role in supporting dementia patients. However, it was evident from the table discussion that not everyone was aware of the Admiral Nurse Service.
- Health checks in GP surgeries would help with early diagnosis

Integrated model

- 2 pronged approach is needed – single referral process (one-stop shop) *and* Integrated Team (multi-disciplinary)
- This should be via 1 dementia provider to deliver the entire service. Each GP Clinical Commissioning Team would tender providers separately.
- KCC and its partners would need to unpick the contracts it currently has in place for the provision of dementia services. Decommission services in preparation for the 'new' commissioning of services via Clinical Commissioning Groups.
- It was commented that we need a mechanism to force the dementia services to work together cooperatively. Specialist Teams working in silos don't work. We need to bring together a multi-disciplinary team combined of specialist workers. This would be part of the tendering specification. Specific KPIs in place to measure performance.
- There was a discussion around Community nursing which was considered good in the Maidstone area. It was felt that the model which needed to be developed was an Integrated Model broader than Health and Social Care but needed to include Housing, Admiral Nurse and all other agencies involved in the provision of services for dementia patients and carers
- Health and Social care co-ordinators should be employed in primary care settings. Torbay has an integrated service. These teams can work with those who receive an early diagnosis
- Need a crisis/rapid response team integrated with Social Care and Health in the community that has varied skills. Care could then be provided at home.

Accessible care pathways

- It was important to develop a care pathway which could be accessed, One GP spoke of an excellent model he had experienced in Bedfordshire which had worked well. Here there was an aligned Social Worker to each GP practice one day a week.
- Need to have a Quality Strategy for Dementia and a clear pathway for dementia sufferers and their carers.
- Need a Communication Strategy.
- Treatment and assessments tend to happen in secondary care and out of hours care is also focused on acute care. This needs to be shifted to community care
- Memory Clinics work well and there is a good example in Croydon
- Concentrate on getting this to work right in one area first
- Up skill GPs and build relationship with social and intermediate teams
- Has anyone else in the country got this right? Look for examples in the UK and internationally
- The current care pathway recommends that patients call their GP. GPs are not aware of all of the services available. GPs need to be made aware of all of the options available.

- Another suggestion was to have practitioners who have skills in both dementia and Health. More care homes are moving towards EMI.
- If more patients are diagnosed with dementia earlier, the support networks must be there and in place for them.
- People don't like to talk about them having dementia but we need to ensure that they plan their future and discuss it.

What can the big society/community prevention do to assist in the shift from acute to community care?

- Education, Education, Education!
- Communication, Communication, Communication!
- Where is the Carers Pathway?
- Integrate the voluntary sector into an integrated model.
- Explore the possibility of an Independent agency/charity taking the lead for example Help the Aged
- Whilst the achievements in improving the service for dementia patients was acknowledged i.e. 24 hour helpline – was there a way of improving the awareness of these services are available to the general public and those who commission the service.
- Through the Local Delivery Frameworks and Section 106 agreements ensure that Community Services are provided.
- Early access to services without having to have a diagnosis and easy access.
- The classic model of diagnosis and treatment is not always helpful for dementia patients. You might want to give someone support but they are in denial of having dementia.
- Life Planning is essential. Perhaps to make the change of moving to a bungalow. Drugs treatment is not recommended as can make things worse.
- A huge number of people have no access to treatment at all and so they don't get diagnosed. Access through the carer support function is therefore sometimes better to enable a proper diagnosis.
- In the delivery of an integrated model it was suggested that community organisations could assist KCC and its partners to break down what services are already in place i.e. unpick dementia delivery across Kent. Identify what the key performance deliverables should be.

As a Shadow Health and Wellbeing Board what are we now going to do with this? What outcomes do we want to achieve?

- Ensuring that information on Dementia Services and support for Carers is available to **ALL.**
- All stakeholders/agencies taking a responsibility for the delivery of high quality dementia services.
- The Health and Wellbeing Board should:-
  (a) Agree the Strategy;
  (b) Set out the standards and a quality framework;

(c) Drive the strategy and standards through the Clinical Commissioning Groups and the established infrastructure for Health and Wellbeing; and
(d) Be the vehicle for braking log jams and overcoming barriers.

- Dementia should be a key priority for the Health and Wellbeing Board
- Dover is running in parallel with the local Health and Wellbeing Board. Dementia remains a key priority there too.
- The Health and Wellbeing Board can make links with District Councils looking at awareness and also to ensure that people have an awareness that more people are going to get older and potentially suffer from dementia.
- Pooling of budgets and resources. KMPT wants to come on board with us and pool budgets.
- The Torbay Model is a good way forward. It is very small but has made the life of GPs much easier. In Torbay they have a rapid response social care package to keep people at home for a few days until their package services kick in.
- The Health and Wellbeing Board should be an enabler and a promoter.
- Needs to be aware of the wider population and what they need.
- The out of hours rapid response team is more critical than in hours.
- The HWB should ask CCGs what they are already doing to address dementia for residents
- More publicity regarding the data sets available to GPs
- Promote local delivery
- Ensure equity for everybody
- HWB need to recognise that GPs are commissioners – they are not concerned with the operational side/or how a provider delivers a service unless there are performance issues and the provider is not performing against the contract specification.
- The GPs' job is to simply request tenders from providers against the relevant specification (steered by the JSNA and HWB Strategy), commission the most suitable provider and then monitor performance against KPIs. Need to move away from a historical public sector approach of getting involved at every level of service delivery.
- HWB should identify the strategy (without political interference) i.e. based on JSNA and HWB Strategy and not politicians' agendas.
- HWB need to provide information on how KCC and its partners should decommission services in preparation for the commissioning of services.
- GPs felt that there was a need to address risk aversion in primary care i.e. why do GPs always default to a secondary care referral?
- Agreed that there needed to be a link from locality Groups/Boards established around Health and Wellbeing to the Strategic Health and Wellbeing Board for Kent.

Department of Health

Health and Social Care Partnership
South East

Health and Wellbeing Leads Network
11th August 2011

John Wilderspin – National Director Health and Wellbeing Board Implementation

What am I going to cover?

- The current national picture
- The national Learning Network
- Dovetailing the national network with your network
- Addressing hopes and concerns in the South East

Health and Wellbeing Boards before the Listening Exercise

- A formal sub-committee of "upper tier" local authorities
- Membership drawn from local authorities, GP consortia and Healthwatch (*including Directors of Adults Services, Children's Services and DPH*)
- The role of the Board
  - develop a Joint Strategic Needs Assessment for the locality
  - drawing on the JSNA, agree a Joint Heath and Wellbeing Strategy
  - ensure individual commissioning plans (health, public health and social care) align with the Joint Health and Wellbeing Strategy

The Future Forum's view of Health and Wellbeing Boards

"There was a ***degree of uncertainty*** as to what role health and wellbeing boards would have in the new system.

They must be tasked with ***agreeing the priorities*** for health and care for that community and ***each party must account to the Board*** for their obligations to deliver those priorities

We have concluded that local health and wellbeing boards are a ***vital part of the system*** that needs to be put in place".

Recommendations from the Future Forum

- Through the joint health and wellbeing strategy, health and wellbeing boards should ***set and monitor outcome*** goals.

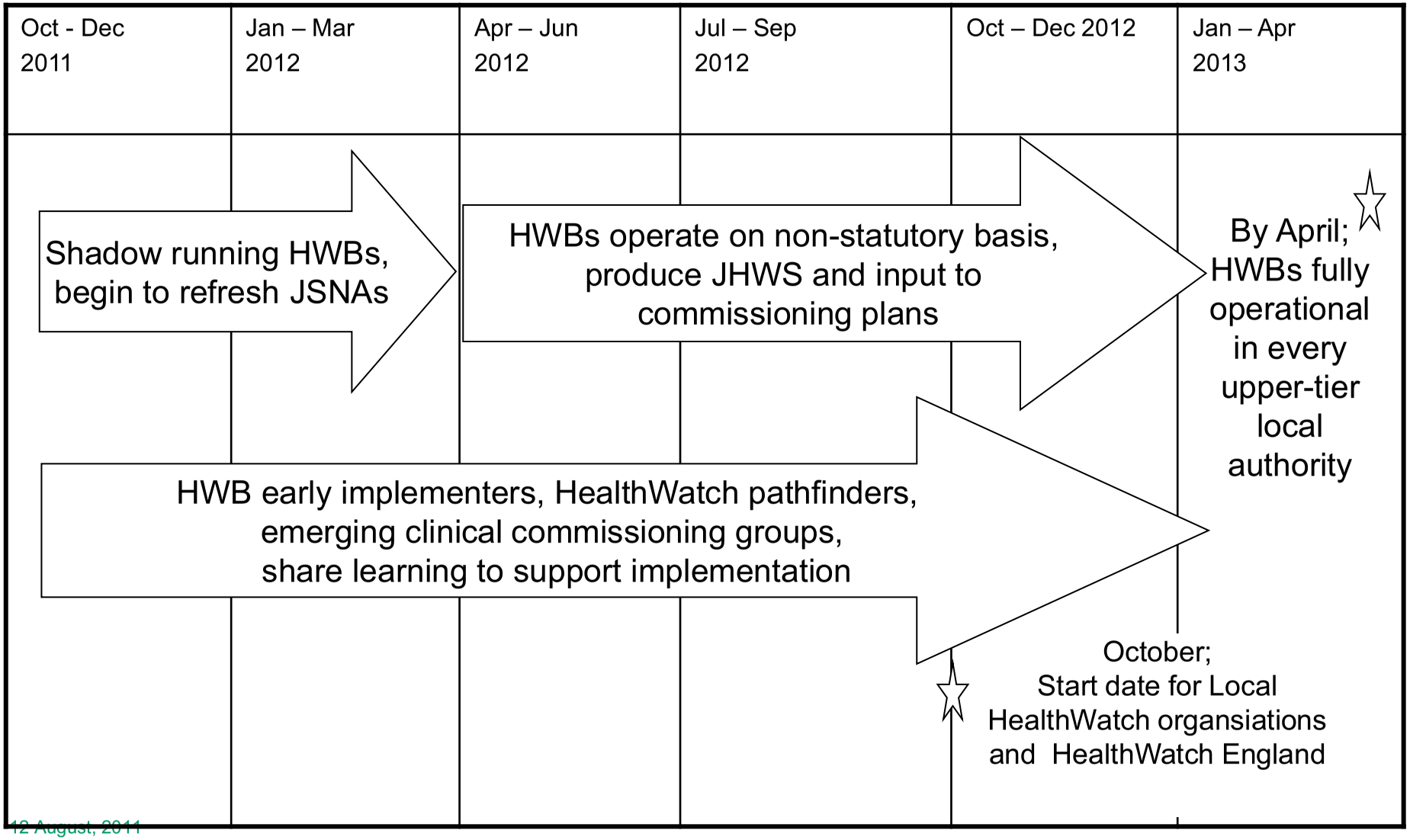
- Health and Wellbeing Boards must be the ***focal point for decision-making*** about health and wellbeing, bringing together NHS and local authority commissioners with patient representatives. ***The Bill needs to strengthen their role***

- Health and wellbeing boards should have a role in ***identifying*** any potential or actual ***conflicts of interest in respect of commissioning consortia decisions.***

The Government response to the Future Forum

- A new duty to involve users and the public
- A stronger role in promoting joint commissioning and integrated provision between health, public health and social care
- A requirement for Clinical Commissioning Groups to involve HWBs as they develop their commissioning plans,
- CCG commissioning plans (and other commissioning plans) need to be in line with the Joint Health and Wellbeing Strategy
- A right to refer CCG plans back, or to the NHS Commissioning Board, if they are not in line with the Joint Health and Wellbeing Strategy
- Local authorities can determine how many elected members will be on the Board

Programme Timescales – Health and Wellbeing Boards and HealthWatch



Health and Wellbeing Boards; The "Early Implementer" approach

- 136 formal expressions of interest in January
- But, every emerging Board wants to engage, so…
- Learning Network approach; "all share; all learn"
- Emphasis on "co-production"
- Combines existing development resources + £1million from DH Transition fund
  - DH + SHA regional development resources (**i.e.you!)**
  - Aligning NHS transition programmes (eg CCGs) with HWB development
  - New funding to support new work e.g. elected member development

What are we doing to support local development ?

- Establish a National Learning Network
  - *A virtual learning "hub" across local government and the NHS (the LGG "Community of Practice")*
  - *National learning sets around key themes of common interest*
  - *2 National Events (stimulate thinking +showcase work of learning sets)*
  - *Elected member development (incl joint work with CCGs and DPHs)*
  - *Wider stakeholder engagement (eg providers, voluntary sector)*

- Issue "guidance" - where necessary and useful
  - *Joint Strategic Needs Assessment/ Health and Wellbeing Strategies*
  - *Summary Lessons from the Learning Sets*

"Themes" for the national learning sets

- **Improving service provision**

Children and Families, Mental Health, LTCs, PLD, Dementia, Frail Elderly, Offender Health

- **Improving public health**

Prevention, protection, tackling health inequalities

- **Handling major service reconfigurations**

partnership working under the spotlight

Health and Wellbeing Strategies

- **Effective Governance**

Scrutiny, Board membership, 2 Tier authorities, Board development

- **Public engagement**

Healthwatch pathfinders programme to lead?

- **JSNA/JHWS**

Focusing and aligning the planning process

- **Making best use of combined resources**

Joint commissioning, joint provision, shared support services

NB These will be framed as questions, not as themes

What does "co-production" mean?

- Joint ownership by DH and Local Government Group
- Network delivered by DH, LGG, NHS Institute and others
- Alignment between HWB development and other transition workstreams (JSNA/JHWS, Healthwatch, CCGs, Public health transition)
- Joint work at a regional level (eg Health and Social care Partnership)
- Principles owned by national stakeholder organisations (publication shortly)
- Co-design of the Learning Network (60 people attended event on 27th July)
- Engage all Early Implementers in co-design through 2 Webinars in September

N.B. How do we best model the approach HWB members will want to use?

Concerns and issues for emerging Boards in the South East

- What is on the mind of your emerging Boards?
- What is on your minds as leaders and facilitators?
- How can the national learning Network help you, and your Boards to develop over the next 8 months (and beyond)?

Health & Wellbeing Board

H&WBB

Health & Social Care Model	Care Close to Home	Sustainability
Prevention Strategy for Children Healthy Schools Dementia Model Diabetes Model End of life care Teletechnology	Personalisation Strategy Self Care Strategy	Configuration Models of provision Market Voluntary Sector Compacts Finance

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Integrated Commissioning Plans

Communication/dialogue with big providers/ Acute Trusts/small providers

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Implement Change

Draft

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By: Ann Sutton, Chief Executive – Kent & Medway Cluster

To: Health and Wellbeing Board – 28th September 2011

Subject: CCG Authorisation process

Classification: Unrestricted

Summary: The consultation publication '*Developing clinical commissioning groups – Towards authorisation'* sets out the draft process for Clinical Commissioning Group (CCG) authorisation. There are three phases leading up to full authorisation which will commence from October 2012:

- Development phase
- Application
- Authorisation process

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1. Development Phase

1.1 Configuration of CCG

The initial development phase will commence in October 2011 with a risk assessment of the proposed configuration of a CCG. There are four element of the risk assessment which is designed to help CCGs understand whether their current proposed arrangements are likely to meet the criteria defined in the Health and Social Care Bill, the first three are:

- **Member Practices** – that member practices are supportive of the proposed CCG configuration especially in relation to the consideration of shape, local authority boundaries and proposals for organisational viability.
- **Geography – boundary/population** – that a CCG will have responsibility for persons who are provided with primary medical services by a CCG practice including people who are not registered with a practice.
- **Geography – relationship with local authority boundaries -** that the boundaries of local CCGs should not normally cross those of upper tier local authorities, with any departure needing to be clearly justified and in the interests of patients.

The fourth aspect is intended to help CCGs understand the likely impact of their proposed size both on their organisational viability, and the degree of sharing of roles and functions or use of commissioning support they will need to consider, and their ability to secure local practice engagement in the case of very large CCGs. A national Ready Reckoner Calculation tool is in development – it provides an opportunity for CCG to calculate running costs which gives examples of costs associated with corporate responsibilities as well as potential for bought in commissioning a back office functions.

1.2 **Self Assessment Development Diagnostic**

In addition to understanding their configuration, each CCG will be undertaking a self assessment of development needs. Strategic Health Authorities are being asked to consider and rate (red amber green') ratings, each CCG within their area by the end of October 2011 from the self assessment. This risk assessment is only looking at size and geography as a pre-requisite to achieving a track record through shadow running in 2012/13. Upper tier and Unitary authorities will be asked their views of size and geography through this process. No stakeholder, including the SHA has a veto on the ambition of a CCG to continue development to authorization.

Completion of the self assessment is fully supported by the SHA and will provide CCG with a detailed understanding of their development needs.

In addition to the risk assessment CCGs are being supported to follow through a 'pipeline' development process and identifying a development plan for the new organizations agreed with the PCT Cluster and SHA's. The PCT Cluster and SHA will work with each CCG to ensure that a tailored development plan is in place that will be worked on throughout the shadow period.

The PCT Cluster will support CCG through the development period ensuring CCG have opportunity for increasing responsibility for service redesign and delegated budgets. Further support will be available as the Cluster develops an understanding what CCG will need in terms of commissioning support.

1.3 **Commissioning Support**

Key to authorisation will be CCG plans to build, share or buy commissioning support for non clinical aspects of commissioning. Even the largest CCG's will be unable to undertake the full range of commissioning functions in isolation.

Work is ongoing to define the way commissioning support functions can develop alongside CCG's. This includes listening to the full range of current and potential providers of CS including local authorities, third sector and commercial organisations

Work includes:

- Business reviews across all PCT clusters to assess maturity of approach
- Analysis of the scale at which individual CS functions are best undertaken
- Modelling potential CCG running costs and how they could most effectively be deployed
- Supporting CCG to become intelligent purchasers of commissioning support

The DH will be publishing a range of information on the expectations for commissioning support in the autumn

2. Application

CCG's will need to apply to the NHSCB to be authorised. The process will look at six domains covered by the self assessment pipeline:

1. A strong clinical and professional focus which brings real added value
2. Meaningful engagement with patients, carers and their communities
3. Clear and credible plans which continue to deliver the QIPP (quality, innovation, productivity and prevention) challenge within financial resources in line with national outcome standards and local joint health and wellbeing strategies
4. Proper constitutional and governance arrangements with the capacity and capability to deliver all their duties and responsibilities, including financial control, as well as effectively commission all the services for which they are responsible
5. Collaborative arrangements for commissioning with other clinical commissioning groups, local authorities and the NHS Commissioning Board as well as the appropriate external commissioning support
6. Great leaders who individually and collectively can make a real difference

It will focus on confidence in a CCG potential to deliver - and the ability of the CCG to build up a track record. Understanding the configuration of each CCG by December 2011 will provide a period of stability (the shadow term) whereby CCG can gain experience. The Development Path/Plan will be used to describe the experience gained.

Earliest applications for authorisation can be received in Summer 2012. The PCT Cluster will support CCG to take on delegated responsibilities within legislative framework and the DH will be tracking the level of delegation to build a picture of the extent to which this is taking place. The development of commissioning support models is a prerequisite to the success of building a track record.

3. Authorisation

There are three aspects to grant authorisation:

- Submission of evidence - CCG's will be required to pull together a range of evidence to demonstrate capability. The evidence should include a 360° assessment of views from all partners including the public, HWB Boards and clinical networks
- NHSCB satisfaction of the validity of the evidence including the 360° review, reviewing how the CCG is working with partners, and involvement of local professionals
- NHSCB will finally draw together all its background knowledge and information for a discussion with CCG and any local stakeholders, it would include assessing the level of risk in the particular system

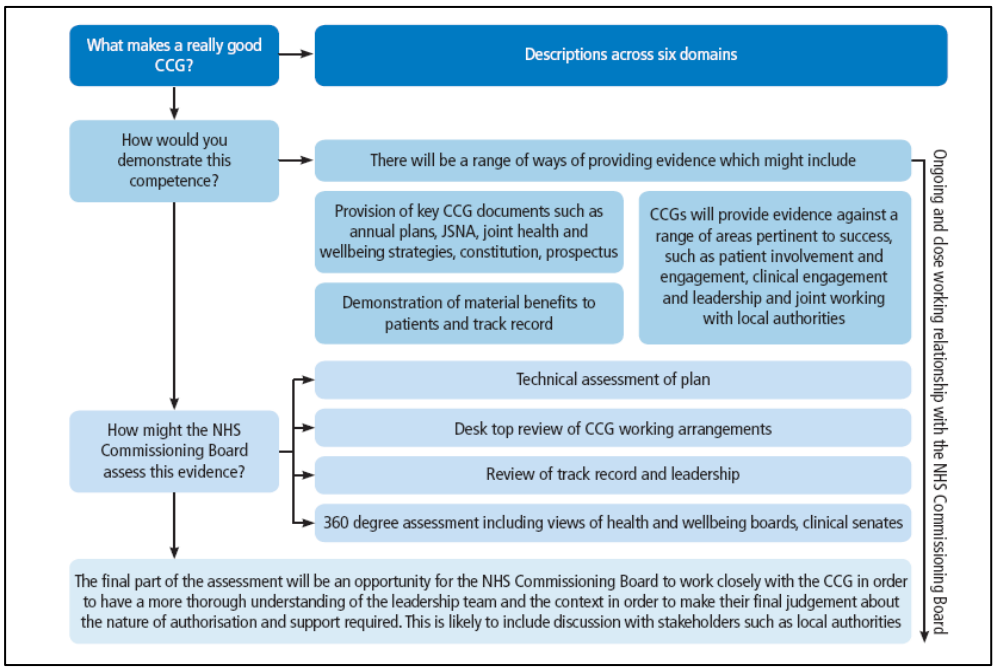
CCG's could be established from October 2012, this would allow CCG's to operate as a statutory body, sign contracts and take on formal employment of staff. However, they would not be able to take on commissioning

responsibilities of their PCT cluster until 1st April 2013. Consultation is ongoing to determine the potential outcomes for the authorisation process and how the NHSCB might wish to determine these outcomes.

There will be two levels of authorisation and an opportunity for CCG to remain in shadow form:

- Shadow CCG's: If CCG did not wish to undertake any commissioning, or the NHSCB deemed they were not yet competent – the CCG would operate as a shadow CCG with the NHSCB taking responsibility for ensuring the functions are discharged
- Authorised with conditions – CCG's who were established but not fully authorised, who did not have a comprehensive infrastructure or who were not ready, willing or able to take on the full range of commissioning responsibilities
- Full Authorisation - where the NHSCB judged the CCG to be a competent commissioner of all services without additional support

Process for authorisation



4. Roles and responsibilities

4.1 PCT Clusters - will have a role preparing and supporting CCG's. They will not be involved in the decision about authorisations of local CCG's. The final decision for authorisation will rest with the NHSCB and relevant legal powers for this will commence July – October 2012.

4.2 The SHA Cluster – will be responsible for supporting the CCG configuration exercise by providing a RAG rating in review of each CCG risk assessment. They will also have the role of overseeing and managing the flow of applications for authorisation ahead of the establishment of sectors of the NHSCB

4.3 The Health and Wellbeing Board (HWB) – The County Council Chief Executives will be invited to give a view on the efficacy of CCG configuration arrangements in their area to promote health and wellbeing and support integration through the 2011 risk assessment process.

There will be a role for shadow HWB in the full authorisation process through bringing together local leaders and patient/ public representatives to develop joint strategies. The 360 ° review will provide views on the CCG willingness and ability to be involved in partnership working.

4.4 Clinical Senates - will be involved in authorisation by providing expertise, advice and support which commissioners will draw on. They will provide the link between local clinicians and national leadership to gauge the extent to which CCG's are including the full range of professional in commissioning. This will be confirmed through the 360 ° review.

4.5 NHS Commissioning Board

Authorisation and establishment can only be undertaken by the NHS Commissioning Board itself. Working with the central team and to a single operating model with consistent standards it is anticipated this function will then be overseen by the proposed four sectors of the NHS Commissioning Board.

5. Timetable	Milestone date
PCT Cluster to support CCG to find a configuration that will meet legislative requirements (membership, geography, size and arrangements for collaboration and securing commissioning support)	OCT – DEC 2011
PCT Cluster to support CCG through the self assessment development tool	DEC 2011
CCG to undertake self assessment and draw up a Development Plan	DEC 2011
CCG to take a lead role in the planning round and QIPP delivery	DEC 2011
Facilitate discussion with Healthwatch and local authorities and engagement with HWB in shadow form during 2011/12	OCT 2012
CCG to articulate commissioning support requirements	OCT 2012
Ensure CCG have appropriate earned autonomy/delegation of budgets which can be reported and tracked through the Operating Framework Indicators	OCT 2012
Support CCG to build a track record	OCT 2012
PCT Cluster to maximise the responsibilities delegated to CCG's in 2011/12 and for 2012/13 within their delegated powers	OCT 2012
Ensure CCG have, in addition to the £2ph appropriate management support either directly assigned or working across several groups	OCT 2012
Ensure all practices are members of a CCG	APR 2012
Support CCG in engagement with critical aspects of provider development and in particular the future of NHS Trusts.	OCT 2012

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By: Roger Gough, Cabinet Member for Business Strategy, Performance & Health Reform

Meradin Peachy, Director of Public Health

To: Health and Wellbeing Board – 28th September 2011

Subject: Dover District Council (DDC) early implementer Health and Wellbeing Board (HWB)

Classification: Unrestricted

Summary: Dover District Council has been awarded early implementer status for a Health and Wellbeing Board by the Department of Health, as it seeks to identify best practice for HWB's operating in two tier local government areas. This paper discusses how the Dover HWB might best be established to compliment and support the relative roles that District and County level HWB might play whilst in shadow form.

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1. Background:

1.1 The Department of Health has identified three county authorities to act as early implementers for Health and Wellbeing Boards (HWB) where they have also granted early implementer status to district authorities within the county area. These are:

- Hertfordshire County Council & St Albans City Council
- Suffolk County Council & Great Yarmouth District Council
- Kent County Council & Dover District Council

1.2 The decision to award early implementer status references the important role that district authorities have to play in helping to improve the health and wellbeing of local communities, especially given the clear links between the statutory services provided by district authorities and NHS and public health provision. In particular:

- Waste Collection
- Environmental health
- Housing services
- Leisure services
- Planning policy and enforcement
- Licensing policy and enforcement

1.3 The need to reflect the contribution and role of district authorities has been reflected by the appointment of three District representatives on the shadow Kent HWB. However, with diverse populations and varying health needs across localities, the ability of a single strategic HWB

operating at county level being able to focus on very local and specific needs might prove difficult. Some form of sub-county architecture for HWBs might therefore be necessary.

1.4 The principle challenge to the establishment of district-level HWB is that the Health and Social Care Bill is clear that the statutory responsibilities of Health and Wellbeing Boards lie with upper-tier authorities. There is no specific role or responsibilities set out in the current Bill (or as yet any subsequent Department of Health guidance) for lower tier authorities beyond any that may be delegated by a County HWB or delivered through any joint arrangements agreed to by both County and District authorities within the legislative framework local for local government (principally the 1972 Local Government Act).

1.5 This raises the simple, but challenging question of what specific responsibilities District HWB might be responsible for and how they might go about discharging those duties. These are the issues that need to be worked through during the shadow period of operation ahead of the Kent HWB taking on statutory responsibilities in April 2013. So whilst the establishment of a Dover HWB as an early implementer is a matter for Dover DC, the extent to which it is formally involved in the specific functions of HWB as set out in the Health and Social Care Bill (in both pre and post shadow form) is de-facto also a matter for shadow Kent HWB. Neither should a Dover HWB be seen as setting a precedent that all Districts might have a HWB. Any sub-county architecture for the HWB will depend on local appetite, identified need in the local area and that a clearly defined and appropriate role being agreed by all relevant parties.

1.6 Dover DC has not yet formally constituted a HWB in the same way as KCC (i.e. as a formal committee of the Council) and a dialogue between the two authorities and other partners has been opened through an ongoing programme of facilitated workshops supported by Health & Social Care Partnerships South East (which is charged by the Department of Health with supporting the development of HWB in the South East).

1.7 However, the need to constitute some form of Dover HWB is necessary if an adequate period of operation is to occur before evaluating and recommending an appropriate sub-county architecture for the Kent HWB ahead of April 2013 (and potentially reporting issues/lobbying DoH for changes to guidance). Moreover, whilst the County HWB and Dover HWB might operate in shadow form through to April 2013, it seems necessary to pilot a model robust enough to continue in operation (subject to evaluation) once statutory functions for HWBs are in place.

2. Criteria against which to consider options:

2.1 There are a number of options in which the Dover HWB can be established, however, in considering which model might be suitable;

there are a number of criteria that should be considered:

- **Delegation of Function:** The County HWB as an ordinary committee of the County Council has the power to delegate functions to other committees or authorities, but these must be properly constituted legal bodies – namely another committee or sub-committee of the county council or another local authority. If the County HWB wishes to consider the possibility of delegation of function, then the Dover HWB needs to be constituted in such a way to allow this.

- **Ease of Establishment:** The need for any Dover HWB to be established quickly rather than go through protracted approval process, especially whilst in HWB are running in shadow form and do not yet have statutory responsibilities.

- **Flexibility:** The running of the shadow HWBs ahead of them taking on statutory responsibilities is designed to be a learning exercise about how the HWB's can best operate at the strategic and local level. Any model for District Level HWB should be as flexible as possible, to allow room for innovation and variation in the role and need for HWB's across different localities.

- **Transferability:** As early implementers, both the KCC and DCC are seeking to identify the best possible working model for HWB at the county and district level. The aim should be for any working model at the shadow stage to potentially be transferable to other District council areas across Kent (and potentially other two tier county areas).

3. Assessment of preferred option:

3.1 Given the above criteria, in particular the issue of delegation of function, it seems clear that establishing Dover HWB on an informal or partnership basis, either through the Local Strategic Partnership or the new Locality Board should be ruled out given that neither option would allow for the potential delegation of function from the Kent HWB if it were agreed by all parties.

3.2 This leaves a number of options open:

- Joint committee under S.103 of the Local Government Act 1972
- Committee of Dover District Council
- Sub-committee of the Kent HWB

3.3 Whilst the joint committee option remains open, the practicality is that this would require a complicated approval process involving formal resolutions of full meetings of both councils. It is also likely to require separate and formal arrangements for scrutiny of the joint committee to be in place before approval can be given, which in past experience of establishing joint committees, can be long and protracted process to

gain agreement and approval. Dover DC can establish a Health and Wellbeing Board as a full committee of the council, which might be suitable whilst in shadow form, but the practical arrangement for any delegation of functions between the Kent HWB and Dover HWB would then have to be agreed by both councils on a case-by-case basis and then approved separately through both councils decision making agreements, which would clunky and inflexible when flexibility is a key criteria.

3.4 Establishing the Dover HWB as a sub-committee of the Kent HWB provides a number of advantages. Once established (and there would still be some technical details to confirm) decisions about the relationship between the Kent Board and Dover Board would be a matter for Board itself, it would also be possible to quickly rethink and redefine the role and responsibilities of the sub-committee (and perhaps even geographic area covered) as events dictate and relationships emerge as the NHS reforms develop further. It would allow for delegation of function more easily than the other formal options available, but most importantly perhaps, it would clearly link the two tiers of HWB together within a single governance structure, providing a robust relationship between the two. Informal discussions with Dover DC suggest that they would support a sub-committee model at the shadow stage.

4. Recommendations:

4.1 The HWB is asked to:

a) Invite Dover DC to agree its early implementer HWB should be a sub-committee of the countywide HWB for the duration of the period the County HWB is operating in shadow form (i.e. until April 2013).
b) Agree that the Director of Public Health (as the lead officer for health reform), in consultation with the Director of Law and Governance, liaise with Dover DC and agree terms of reference, membership and a Memorandum of Understanding (MOU) over the practical operation of the Dover HWB.

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Developing a Communications Strategy

By:	**Susan Gibbin, Project Consultant**
Sponsor:	Meradin Peachey, Director of Public Health
To:	Health and Wellbeing Board
Subject:	Developing a Communications Strategy
Classification:	Unrestricted

Recommendations

The Health and Wellbeing Board is asked to:-

(a) Note the challenges and opportunities identified by local stakeholders and national agencies identifying any significant gaps that need to be addressed

(b) Decide whether it wishes to pursue the proposed priorities for action as it develops its purpose and functions

(c) Agree the next steps in developing more detailed communications plans to support its statutory duties, goals and objectives

1. INTRODUCTION

1.1 The Health and Wellbeing Board requires a communications strategy that supports the delivery of its statutory duties, strategic goals and objectives. The active involvement of a wide range of stakeholders, both members of the public and partner organisations, will be essential in supporting changes that improve the health and wellbeing of the local population.

1.2 This paper captures the thoughts and observations of a number of stakeholders and agencies through a series of telephone discussions and web based research (full summary of the challenges and opportunities identified can be found in Annex 1). Although it not comprehensive in its coverage it provides an early snap shot of some of the priorities that the Health and Wellbeing Board might wish to address as it develops its leadership role in Kent.

2 RATIONALE

2.1 The Kent Health & Wellbeing Board (HWB) has responsibility for:

- Encouraging integrated working, including increased joint commissioning and pooled budgets (proposing to start with a focus on Dementia care)
- Conducting a Joint Strategic Needs Assessment (JSNA) to assess health and wellbeing needs of local people, and identify local priorities.
- Using the JSNA to agree a Joint Health and Wellbeing Strategy across the NHS, public health, social care and children's services
- Supporting individual organisations, including GP led Clinical Commissioning Groups (CCG), to align their commissioning strategies to the Joint Health and Wellbeing strategy for the county.

2.2 To deliver these objectives a new form of partnership working will be required, built upon positive relationships, strong leadership and a commitment from the top. It also needs to be underpinned an approach to communication which is two way, accessible, transparent, easy to understand and delivered in a cost effective way.

2.3 Given the early stage of development not only of the Health and Wellbeing Board but also of some of the key constituent organisations (Clinical Commissioning Groups) there is also a need for a communications strategy which will:

- support the Boards ongoing development, increasing a common understanding of its purpose and functions
- establish new ways of engaging with stakeholders to achieve its strategic commissioning goals and objectives
- link to a process of ongoing evaluation and review and where gaps appear, enhance and improve its approach (i.e. the early implementer evaluation process)

3 COMMUNICATION CHALLENGE

3.1 Recognising the complex environment and the changing set of relationships within which the HWB operates as well as the emerging set of local goals and objectives this paper structures the communication challenges facing the HWB into three areas:

- Statutory roles and responsibilities and associated decision making processes
- Stakeholder relationships to improve understanding, engagement, participation and ownership
- Communications capacity and infrastructure to support information flows, consultation, engagement and participation

3.2 Governance & Decision making

3.2.1 Once established, the HWB will act as a full KCC committee operating in shadow form until the final legislation detailing the statutory duties of the HWB is enacted. However embedding the business of the HWB into the governance framework for other constituent organisation will be just as important to strengthen its influence on wider policy and investment decisions.

3.2.2 Key reporting relationships will be to the:

- Kent Cabinet,
- Kent Ambition Board 2 for 'Tackling disadvantage' (see Annex 2)

- Locality Boards as they develop,
- Clinical Commissioning Group (CCG) Boards
- National Commissioning Board.

And to make these relationships work there will be a need for timely and relevant reports to and from the constituent organisations represented on the Board including links to Local Authority and NHS planning and budget cycles.

3.2.3 To make sure that functions are not duplicated and strategies are aligned the communication links between the Kent HWB and those HWBs established by Districts / Boroughs (particularly the early implementer in Dover) also need to be well articulated. This will be particularly important as new structures emerge and discussions around the delegation of budgets take place.

3.2.4 As part of the HWB duty to review local commissioning plans clear lines of communication will be needed to support a scrutiny process which does not over burden constituent parties. The first test of this will be seen in the authorisation process for CCGs.

3.3 Stakeholder Relationships

3.3.1 Communication between the HWB and all of its stakeholders is critical to providing legitimacy, intelligence and support for the difficult decisions the Board may need to face. Local stakeholders linking in with the work of the HWB will include:

- The Public, Patients and Carers
- HealthWatch (Links)*
- Voluntary sector providers and representatives (e.g. client specific groups)
- NHS Provider Organisations (Acute, Community, Mental Health)
- Criminal Justice Organizations (e.g. Probation, Prisons, Police, YOT)
- Housing Associations
- Private sector providers (e.g. Care homes, Health and Social care providers)
- Kent County Council*
- District / Borough Councils*
- Clinical Commissioning Groups in Kent*
- NHS Commissioning Board / PCT Cluster*
- Unions (e.g. LMC)
- Medway's Health & Wellbeing Board

* represented through core membership of the Health and Wellbeing Board

To support these relationships targeted communication strategies will be required to engage stakeholders' based on areas of interest and expertise.

3.3.2 Further discussions are still needed to map out the exact level of information and areas for engagement supported by a range of communication tools (e.g. briefings, formal public consultation, internet links & signposting on web sites, social marketing, focus groups, specialist advisors, membership of Pathway Advisory Groups). However use of these tools will allow the Board, in its decision making and enabling role, to:

- hear from and shape views of users and communities;
- gather information around emerging technologies, new techniques and evidence based research
- learn from and work with the changing provider landscape

3.3.3 Partnerships are ultimately based on personal relationships where individuals working together know and trust each other. Given the wide range of professional groups involved in delivering the health and wellbeing agenda there will inevitably be differences in perspectives, roles, culture, beliefs, language and experience as well as differences in organisational structures particularly between those who operate within a local democratic framework and those who don't.

3.3.4 To minimise the hazard this may present to partnership working opportunities for shared learning and or joint training should be established (e.g. understanding commissioning) where relationships can be reinforced whilst learning the same language. This will be particularly important as the HWB looks to make significant commissioning or decommissioning decisions which require local political agreement.

3.4 Capacity and Infrastructure

3.4.1 Most stakeholders are already linked to local communication and engagement networks through their use of and or provision of services; in established planning groups or in scrutiny or monitoring roles. Partner organisations also have their own local communications infrastructure and are able to use a wide range of established tools and techniques to communicate informally or formally with individuals and with groups. The Kent HWB as a symbol of partnership and collaborative stakeholder working in Kent should harness and not discard this approach building on established relationships and optimising Kent's available resources.

3.4.2 The opportunity to launch the HWB as a brand could help reinforces this symbol of partnership and collaborative working. In doing so show how its role in 'holding the ring' between health, social care and public health is very different to the role of previous partnership groups with the same name.

3.4.3 Sitting as it does within KCC the HWB is well placed to promote its work through a link to other KCC web sites particularly the Kent Forum. Offering the Kent community a 'place' for a whole range of supportive information e.g. documents and briefings, signposts to other partnership networks, discussion forum, tools for stakeholder feedback and public surveys would be greatly advantageous in widening knowledge and engagement.

4 CONCLUSION

4.1 From the evidence collated as part of this review there appear to be a number of communication priorities that the HWB in Kent may wish to consider ranging from the need to:

- Develop effective internal relationships within the Board
- Engage the skills and experience of the local stakeholder family
- Account to the wider electorate through local and national accountability structures

4.2 The proposed areas for action arising from these priorities include:

Short term

- Map out business timetables of key partner organisations and build these into a decision making and communications plan for the Board

- Build on links within the early implementer programme as well as the development of CCGs to establish joint learning opportunities for council and NHS leaders
- Identify leadership capacity to support communication planning for each of the HWB goals and objectives (building on the capacity and infrastructure already within the Kent community)
- Test out a communications plan around a couple of strategic objectives with a clear set of milestones and measurable outcomes e.g.
    - Developing a JSNA
    - Supporting the authorisation of CCGs,
    - Improving Dementia care
- Continue to work to ensure all stakeholders understand the purpose, function and objectives of the HWB including a simple explanation around:
    - The differences between public health and health and wellbeing
    - The way commissioning will work including decision making processes
- Establish a web page linked to the Kent Forum to post briefings / documents (as a base for a range of information links and communication tools)
- Develop a directory of partner organisations which identifies
    - key communication contacts (with a clear link for feedback)
    - roles and responsibilities
    - areas to target engagement (local and central)

Longer term

- Develop new and innovative approaches with which to communicate to all stakeholders (e.g. discussion forum, blogs, interactive consultations & surveys, i-phone links) to strengthen ownership and engagement
- Establish a joint media management and PR protocol to help respond to significant commissioning and decommissioning decisions
- Review changes needed in the links between Localities and KCC as new structures emerge and proposals to delegate commissioning budgets are agreed
- Evaluate communications across and between partner agencies and its impact on delivering the HWB's strategic goals and revise its strategy and priorities for action

5 NEXT STEPS

5.1 For the HWB to review the contents of this paper, share with stakeholders and identify any significant gaps in the framework

5.2 Identify leadership within KCC to start to address the short term priorities for action and in doing so bring together the communications and engagement expertise available in other partner organisations to deliver a clear, simple and cost effective communications plan to support the work of the Kent HWB.

Author: Susan Gibbin, Project Consultant

Annex 1 Stakeholder Observations – Factors to address within a communications strategy

Challenges to address	Opportunities to grasp
Board Relationships • Securing collective ownership and commitment to the Board through limited statutory leverage and powers • Building a constructive relationship with the National commissioning board to support the delivery of local solutions (representative may not have a local focus) and the tensions there may be with CCGs • Handling cultural and terminology (language) differences between partner organisations i.e. tensions between central policy and local mandates; politics and science	**Board Relationships** • Increase contact between GPs (CCGs) and councillors – building trust and relationships for a common purpose • Facilitate a better understanding of roles and responsibilities, the boundaries and policy framework within which each agency operates and its relationship with delivery plans • Build on the learning available through the early implementer network
Stakeholder engagement • Dedicating sufficient energy and resource in direct engagement with the public (in all its forms) • Working with NHS providers who offer expertise and specialist knowledge whilst not providing individual organisations with inappropriate business advantage • Don't presume that commissioners speak for providers and sit along side these organisations as the market framework changes • Not duplicating HOSC scrutiny role – not adding layers of bureaucracy and burdensome costs on decision making process. Too many phases of scrutiny delays the benefits • Managing business continuity whilst developing new approaches • Recognising the role acute hospitals play in securing the safety of local people in times of crisis (winter) • Differing appetite in localities to engage	**Stakeholder engagement** • Take a new approach to previously intractable commissioning issues through a wider stakeholder perspective • Tighten up process and priorities – being specific to secure appropriate engagement • Build on web sites and communication networks • Establish directory of organisations and individuals to support communication and networking • Use the established networks commissioning and communication tools already in place (e.g.: District experience contacts and influence) • Use the specialist expertise that sits within NHS Trusts within targeted pathway advisory groups • Build links to Medway HWB securing joint approaches for key client groups • Ensure people not only on the core group but in the wider family have influence and strong engagement • Keep messages simple and concise
Delivery agenda • No track record and still on a development path • Understanding difference between operational and strategic commissioning (clear definitions required) • Strategic system leadership different from local government leadership – where quality, safety and sustainability are key factor in decisions. • Recognising the complexity of health commissioning (need for specialist capacity) • Managing risks and uncertainties given the changes in organisation and local leadership for commissioning • Balancing the benefits of integrating provision with commissioning for diversity and an open market • Balancing local freedoms with central intervention to maintain pace and direction • Managing change in an environment of a chronic deficit e.g. Tackling tough reconfiguration issues linked to new pathways	**Delivery agenda** • Maintain momentum on important development already in progress • Support localisation through the development of Locality Boards as part of the wider Kent forum. • Building on the capacity and skills already within organisations • Establish links between communications and engagement leads in both health and social care • Sharing good practice – sharing evidence of better outcomes – driving out inequalities of access • Test out delegation – allow locality to flourish – take risks (Swale, Dover) • Focus on a few priorities with built in evaluation process • Learn from the early implementer network • Build on experience of other local successful partnerships

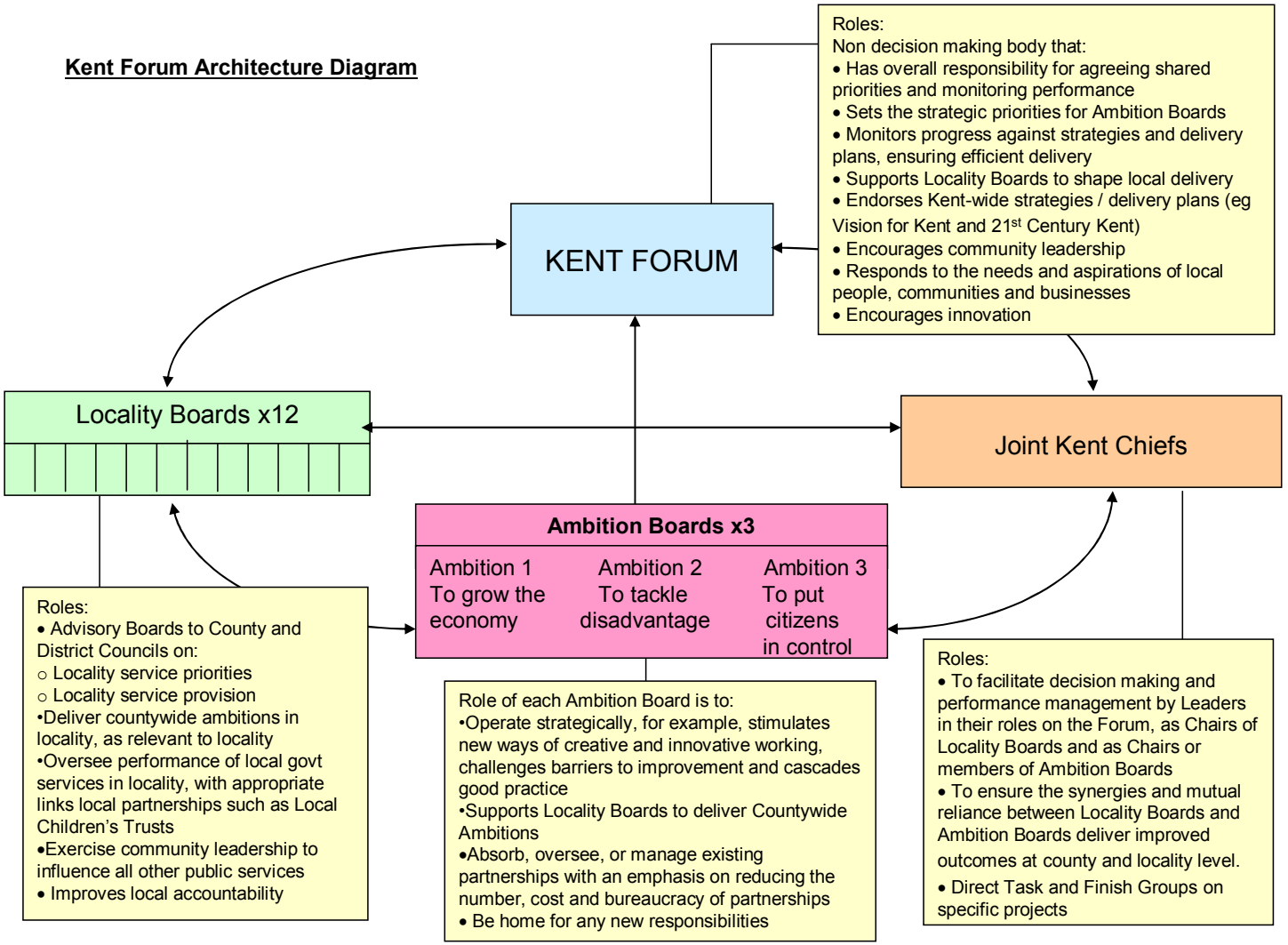
Sources of data, information:

Thanks to the following local stakeholder:	
Susan Acott	Chief Executive, Dartford & Gravesham NHS Trust
John Allingham	Local Medical Committee Representative
Bob Bowes	Chair for SWK Clinical Commissioning Group
Graeme Brown	Partnership Manager, Kent Forum Team
Jim Carmichael	Governor HMP Blantyre House & HMP/YOI East Sutton Park
Hazel Carpenter	Director of Commissioning Development and workforce K&M Cluster
Amber Christou	Head of Housing, Swale Borough Council
Paul Coles	Chief Executive, Age Concern Maidstone
Bob Deans	Chief Executive, K&M Partnership NHS Trust
Michelle Farrow	Leadership Support and Corporate Communication Manager, Dover Council
David Gardener	Senior Probation Officer, Kent Probation service
Roger Gough	Cabinet Member (KCC) Lead on Health reform and NHS /KCC transition
Roger Kendal	LINK transition lead (HealthWatch)
Katherine Kerswell	Managing Director of Kent County Council
Roger Pinnock	HWB lead for South Kent Coast Clinical Commissioning Group
Angela Slaven	Director of Service Improvement (KCC)
Peter Turner	Chief Executive, Carers First, West Kent

Written sources: Title	**Organisation**
Health and wellbeing Boards: developing a successful partnership	Health Services Management Centre, University of Birmingham http://www.birmingham.ac.uk
Healthy lives Healthy people: Our strategy for public health in England	Department of Health, HM Government http://www.dh.gov.uk/en/Home
Vision for Kent Consultation Draft June 2011	Kent County Council http://www.kentforum.org.uk
Selection Committee Paper: Establishing a Health and Wellbeing Board in Kent June 2011	Kent County Council
HealthWatch Transition Plan March 2011	Department of Health
Working in Partnership to reduce re-offending in Kent & Medway	Kent Probation http://www.kentprobation.org
Other Web sites:	
http://healthandcare.dh.gov.uk/the-health-and-wellbeing-board-national-learning-network/	
http://www.idea.gov.uk : Partnership working	
http://www.dover.gov.uk : Health and Wellbeing Board development	

Annex 2 – Kent Forum Architecture

Kent Forum Architecture Diagram



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