AGENDA

HEALTH AND WELLBEING BOARD (SHADOW)

Wednesday, 19th September, 2012, at 6.30 pm Ask for: **Peter Sass**
Pendragon Room, Invicta House, County Hall 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

Part 1 - 6.30pm - 7.00pm

3. Declaration of Interests by Members in Items on the Agenda for this meeting

4. Minutes of the Meeting held on 18 July 2012 (Pages 1 - 6)

5. Establishing Local Healthwatch in Kent (Pages 7 - 16)

6. Options for the development of the sub architecture for the Kent Health and Wellbeing Board (Pages 17 - 30)

7. Information Governance - an update (Pages 31 - 44)

8. Update on the development of the Kent Joint Health and Wellbeing Strategy (Pages 45 - 46)

Part 2 - 7.00pm - 8.30pm

9. Health Engagement: Developing engagement for Health in Kent (Pages 47 - 70)

10. Mental Health Reconfiguration: Achieving Excellence in Mental Health Crisis Care

11. Date of Next Meeting - 21 November 2012

Peter Sass
Head of Democratic Services
Tuesday, 11 September 2012

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.

Dr John Allingham	Clinical Lead, Shepway Locality, South Kent CCG
Dr Fiona Armstrong	Joint Clinical Lead, Swale CCG
Dr Bob Bowes	Chair West Kent & Weald CCG
Cllr Andrew Bowles	represented by
Cllr Lesley Ingham	Member, Housing, Health and Wellbeing, Swale BC
Cllr Paul Carter	Leader of Kent County Council
Dr Sourja Chaudhuri	Clinical Lead, Dover Locality, South Kent CCG
Cllr John Cunningham	Tunbridge Wells Borough Council
Caroline Davis	Strategic Policy Advisor (Health & Wellbeing), KCC
Michelle Farrow	Leadership Support Manager, Dover DC
Cllr Graham Gibbens	Cabinet Member for Adult Social Care and Public Health, KCC
Cllr Roger Gough	Cabinet Member for Business Strategy, Performance & Health Reform, KCC
Andrew Ireland	Corporate Director Families and Social Care
Dr Mark Jones	Chair & Clinical Lead C4 Canterbury CCG
Roger Kendall	Kent LINk
Cllr Michael Lyons	Shepway District Council
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
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 Paul Watkins	Leader, Dover DC
Cllr Jenny Whittle	Cabinet Member for Specialist Children's services, KCC
David Woodhead	Clinical Lead, Gravesham & Swanley CCG

Invited Observer

Colin Tomson	Chair, Kent & Medway Cluster

KENT COUNTY COUNCIL

HEALTH AND WELLBEING BOARD (SHADOW)

MINUTES of a meeting of the Health and Wellbeing Board (Shadow) held in the Pendragon, Invicta House, County Hall, Maidstone on Wednesday, 18 July 2012.

PRESENT: Dr B Bowes, Ms H Buckingham, Ms H Carpenter, Dr S Chaudhuri, Mr G K Gibbens, Mr R W Gough, Dr M Jones, Mr R Kendall, Kumta (Substitute for Dr R Pinnock), Dr C Mah, Mr C Tomson and Mrs J Whittle

ALSO PRESENT:

IN ATTENDANCE: Ms C Davis (Strategic Business Advisor), Mr A Ireland (Corporate Director, Families and Social Care), Mr M Lobban (Director of Strategic Commissioning), Ms M Peachey (Kent Director Of Public Health), Mr A Scott-Clark (Deputy Director of Public Health, NHS Eastern & Coastal Kent) and Mr P D Wickenden (Democratic Services Transition Manager)

UNRESTRICTED ITEMS

50. Welcome
(Item 1)

The Chairman, Roger Gough, Cabinet Member for Business Strategy, Performance and Health Reform (KCC) welcomed everyone to the meeting of the Shadow Health and Wellbeing Board.

51. Substitutes
(Item 2)

The following apologies were received and noted:

Dr Roger Pinnock
Ann Sutton
Dr Mick Cantor
Cllr Paul Watkins
Michelle Farrow
Dr John Ribchester
Cllr Michael Lyons
Paul Carter

52. Declaration of Interests by Members in Items on the Agenda for this meeting
(Item 3)

There were none.

53. Previous minutes/action points of the meeting held on 30 May 2012
(Item 4)

(1) The Board agreed that the Minutes of the meeting held on 30 May 2012 were a correct record and that they be signed by the Chairman.

Matters Arising

Dementia Friendly Communities

(2) Graham Gibbens, Cabinet Member for Adult Social Care and Public Health, informed the meeting that Anne Tidmarsh had been in touch with the Clinical Commissioning Groups (CCGs) regarding submitting an expression of interest for the Dementia Challenge Bid which was required by the end of July.

54. Engagement with Providers: current and future arrangements
(Item 5)

(1) The Shadow Health and Wellbeing Board noted the ongoing work to secure a robust methodology for community engagement and how it informs the development of the Health and Wellbeing Strategy.

(2) The Kent Health and Wellbeing Board is inheriting a scenario of diverse governance structures and relationships across health, social care and District Authority arrangements.

(3) As the Shadow Health and Wellbeing Board evolves into a statutory body it needs to consider the way forward on how it will provide system leadership in fostering relationships, and to bring together strategic leaders in commissioning and provider organisations to develop integrated working. The purpose of engaging with providers is to help the Board shape our strategy and for the Board to help the providers shape theirs.

(4) Currently there are two main strategic groups operating across the NHS and social care system in Kent and Medway which have representation from the main service provider organisations i.e. the Clinical Leadership Group and the Integrated Planning Board.

(5) Within the three local health economies, the Whole Systems Boards were being established led by the Clinical Commissioning Groups (CCGs).

(6) Kent is working on developing a District level sub structure with relevant CCGs and this will need to be synergised with the model for provider engagement.

(7) To develop a definitive model for Kent the Shadow Health and Wellbeing Board were invited to consider the following issues:-

(a) Is there a need for a mechanism at Kent level for engaging with all providers;

(b) How do we ensure that there is appropriate representation from all sectors including the Voluntary and Community Sector; and

(c) Should the Health and Wellbeing Board consider building relationships through the Local Whole Systems Boards?

(8) Following discussion it was agreed that the Health and Wellbeing Board agreed that a sub-group of the Board should be established to look at engagement with providers in more detail. The Chairman asked for volunteers. Colin Tomson stated that he was happy to input into a small sub group, but could not commit the time to attend meetings.

(9) It was agreed that Meradin Peachey would lead on taking this forward.

(10) RESOLVED that a sub-group of the Shadow Health and Wellbeing Board be established to consider what a Kent model for engagement with stakeholders should look like and report back to the next meeting of the Shadow Health and Wellbeing Board.

55. Kent Joint Health and Wellbeing Strategy: Key Milestones and process for the Strategy
(Item 6)

(1) The Shadow Health and Wellbeing Board noted the process for developing and undertaking stakeholder engagement on the Draft Joint Health and Wellbeing Strategy.

(2) The following timeline outlines the suggested engagement programme:

- End of July to end of August – more detailed stakeholder engagement (Clinical Commissioning Groups, Kent County Council, providers etc) on draft strategy
- September to November – wider public engagement on draft strategy
- Mid November – Joint Health and Wellbeing Strategy approved
- End of 2012 – Publication of first Kent Joint Health and Wellbeing Strategy

(3) The four overarching outcomes identified as strategically the most important for the population of Kent were:

(a) Every child has the best start in life;

(b) People are taking greater responsibility for their health and wellbeing;

(c) The quality of life for people with long term conditions is enhanced and they have access to good quality care and support; and

(d) People with mental health and dementia are supported to live well.

(4) The Shadow Health and Wellbeing Board divided into workshop table discussions. A summary of the points raised is as follows:

(a) Under priority 1, prioritisation does not accurately describe what we are trying to achieve. Transformation would be a better term. The focus should

be on best value, it isn't about cutting services. This priority should be the last one

(b) Under outcome 1 Health Visitors available to all and in children's centres. This should be a universal service

(c) CAMHS needs to feature under outcome 1

(d) Mental health and dementia should be separate outcomes

(e) Obesity and weight management should be a focus for the general adult population

(f) Emphasise the importance of education and the benefit of work

(g) Include the health needs of children with disabilities in special schools

(h) In 5 years, the ambition is to add 'x' number of quality years to life and how this will be achieved

(i) Could we have vignettes describing good practice

(j) Need to read across from the health inequalities plan

(k) Is the plan bold enough or do we risk raising expectations if it is too bold?

(5) RESOLVED that the key milestones and process for the Strategy be noted and the items discussed in the workshop sessions be taken into account in taking the Joint Health and Wellbeing Strategy forward.

56. Workshop on Integrated Commissioning Plan
(Item 7)

(1) Mark Lobban, Director of Strategic Commissioning, Kent County Council, and Helen Buckingham, Director of Whole System Commissioning/Deputy Chief Executive, NHS Kent and Medway made a presentation on Integrated Commissioning.

(2) Following the presentation in workshop table discussion the Shadow Board addressed the following questions:

(a) what are your views on the possible integration of commissioning teams?

(b) considering the typology for degrees of health and social care integration where does the Shadow Health and Wellbeing Board want to be on this spectrum and is it the same for all the core groups? What might that mean for integrating commissioning teams?; and

(c) how do Clinical Commissioning Groups want to take this forward?

(3) A summary of the table discussions is as follows:

- The importance of the wider engagement fitting with the Local Authority Commissioning timescales and the budget consultation process was stressed;

- There was a clear need to re-align plans, to understand for example what is influencing Clinical Commissioning Group Plans and ensuring there is consistency across all the Plans.

- Mental health – specialist inpatients can be dealt with through the Commissioning Service Office (CSO).

- Community services mean more control locally

- Enhanced partnership model feels right

- Enhanced partnership working for Long Term Conditions

- Vertical integration with providers of social care

- Need a primary care community based mental health model

- At the moment there is a 9 month waiting list for CAMHS in Thanet.

- Intelligent Customer – CCGs are very new and do not understand all that is going on, where they should engage – huge amount of current development for CCGs – they do not know if bringing things together is the right thing to do? Would like to develop CCG understanding and look into integrated commissioning teams which will help them to bring expertise into commissioning plans and develop beyond health commissioning.

- A shared vision and strategy needs to be developed between commissioners and providers.

- At the moment we have 3 separate outcomes framework. We should insist on a single framework – this is what the Health and Wellbeing Board Strategy is for Kent.

- Integration needs to be right at the local level. Need to work out at the CCG level what is needed. This needs to be done at a CCG level and Kent wide.

- We need to be clear about how the CCG teams and cluster teams are working and what is needed from the CSO.

- Welcome the development of integrated commissioning teams coming into CCGs. It's not important to the customer where they sit.

- Accountable officers to be appointed for all CCGs. There needs to be a concrete proposal based on local thinking and priorities we want to achieve.

(4) The Shadow Board concluded that:

(a) There should be a single outcomes framework which should be “Kent joint Health and Wellbeing Strategy”,

(b) The preferred typology for the degree of health and social care integration was ‘enhanced partnership’; and

(c) Further work be undertaken with Clinical Commissioning Groups (CCGs) on the range of models for commissioning teams which maybe very different between the different CCGs

(5) RESOLVED that a report on how a model of Integrated Commissioning could work be brought back to a future meeting of the Board.

57. Date of next meeting: 19 September 2012

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

To: Health and Wellbeing Board (Shadow) – 19 September 2012

Subject: Establishing Local Healthwatch in Kent

Classification: Unrestricted

Summary

This paper outlines the progress on the programme of work being undertaken to ensure the successful establishment of Local Healthwatch (LHW) in Kent by April 2013. It sets out the strategic approach to developing the model and outlines the key stages in ensuring successful delivery of the new requirements.

The proposed approach has been submitted to, and further developed from the feedback from the Corporate Board Meeting (16 April 2012), the Cabinet Members Meeting (14 May 2012), the Policy and Resources Committee (11 July 2012) and the Corporate Board Meeting (3 September 2012). The final report will go to the Policy and Resources Cabinet Committee in September.

The Health and Wellbeing Board is asked to note the work currently underway.

---

1. Introduction

(1) The future vision for health and social care, outlined in the Health and Social Care Act 2012, is to modernise the NHS so that it is clinically led and built around and focused on users of services. One of the main ways of strengthening the user's voice is the creation of a new consumer champion – Healthwatch.

(2) Local Involvement Networks (LINks) will be formally replaced by Local Healthwatch (LHW) Organisations in 2013. LHW will also take on additional responsibilities including signposting to services, possibly providing advocacy support and participating in decision-making via membership on the Health and Wellbeing Board.

(3) Localism is critical and each local authority is responsible for commissioning a LHW Organisation that most successfully meets local requirements. They have flexibility and choice over the organisational form for local Healthwatch, to determine the most appropriate way to meet the needs of their communities.

(4) The key requirements are that LHW organisations must be:

- corporate bodies carrying out statutory functions
- not-for-profit organisations

- able to employ staff and (if they choose) be able to sub-contract statutory functions.

(5) LHW will be able to raise concerns about the quality of services with local CQC staff and will be able to request special reviews via Healthwatch England (HWE), which will be a statutory committee of the Care Quality Commission (CQC). HWE will be able to escalate concerns about health and social care services raised by local HealthWatch to CQC.

(6) Kent LHW will be commissioned by and accountable to but operate independently to Kent County Council. The role of KCC is therefore complex as it will:

- fund and hold Kent LHW to account for its efficiency and effectiveness, in conjunction with Healthwatch England, where necessary

- have increasingly important influence on the health and wellbeing of its population

- continue to commission and provide services about which Kent LHW may wish to comment/challenge

2. Financial Implications

(1) Costs to set up Kent LHW have been provided through two Department of Health grants - £78k designated as start-up costs and a pathfinder grant of £5k. £90k was also taken back into KCC from the LINk under-spend of 2011-12

(2) The Department of Health has issued indicative budgets to fund LHW functions from 2013. Further clarification will be provided in November/December 2012 with final allocations to be made known in January/February 2013.

(3) The current figures given for Kent County Council are:

- Funding for the citizen engagement/consumer champion role (currently provided to fund the Kent LINk) will remain the same at £490k

- Funding for the Information and Signposting function - £288k
  (This figure has recently reduced from £540k)

- Funding for the NHS Complaints Advocacy function - £357k
  (NHS Complaints advocacy is a new statutory responsibility for the Council although it does not have to be provided through Local Healthwatch.)

- Total figure including NHS Complaints Advocacy - £1.135m

- Total figure excluding NHS Complaints Advocacy - £778k

(4) KCC, as they do now, can retain part of this grant to fund contract and performance management functions within the Council.

(5) LHW funding, as with current LINk funding, will not be ring fenced.

3. Developing Kent Local Healthwatch

3.1. Developing supplier side and potential delivery models of future LHW services

3.1.1. Building on previous work

(1) Kent County Council has demonstrated its commitment to developing a LHW model that reflects the needs of its local communities through the ongoing development work with Kent citizens and stakeholders.

(2) This started in 2011 when detailed engagement was conducted by KCC and the Centre for Public Scrutiny which began to draw out the characteristics and operating model for the future Kent LHW. The full report is published on KCC website.

3.1.2. Ongoing dialogue and co-design

(1) This work was built on in 2012 with a programme of work conducted with local third sector organisations, to ensure continued engagement in the discussion and development of the model.

(2) Mutual Ventures - a social enterprise founded specifically to support the delivery of public services by independent socially focused organisations – were commissioned in February 2012 to work with KCC and voluntary organisations in progressing the previous development work, as outlined below.

(3) An initial event was held on 30 March, attended by 35 people from a range of third sector organisations, LINk members and the LINk host organisation, to explore the role and functions of a LHW and discuss possible delivery models.

(4) All participants were invited to complete an online questionnaire exploring individual organisations' interest in contributing to/delivering the services – ten organisations completed the survey.

(5) In-depth interviews were then conducted with a smaller number of potential key providers/leads based on the event and survey feedback. Meetings were also held with Kent County Council key leads to discuss the emerging themes from the above and consider potential options.

(6) Survey respondents and interviewed groups were invited to a second event on 11 May, to share the feedback from the survey and interviews, discuss the emerging delivery model and agree next steps in developing the model.

(7) As a result of this work four voluntary organisations with a wealth of insight and experience of working with people and organisations across the county - Voluntary Action Within Kent, Kent and Medway Networks Ltd (Kent LINk host organisation), Kent And Medway Citizens Advice and Activmob - expressed their particular commitment to forming a group to take forward the next stage of development. At this stage KCC withdrew from the development work to focus on the procurement process.

(8) Voluntary organisations involved in the process were asked to share the information with other groups so that they could also be involved if they wished and information was put on KCC website inviting others to take part.

(9) The group further considered and developed the three areas and how these could operate at a practical level in Kent and submitted its report to KCC at the beginning of July. It should be noted, however, that whilst there was much agreement in the ideas outlined within the paper there was also some divergence of views – the full Report is on KCC website.

(10) Conclusions from the group:

Operating model

The development work to date suggests that a new independent co-ordinating organisation is the current preferred delivery model option by many. This may be most likely to ensure an inclusive approach, bringing together a wide diversity of delivery partners who will be well placed to deliver the full range of Healthwatch services, capitalising on the goodwill and significant expertise and experience in the market, particularly in terms of providing information and advice. However one group's view remains that the best option would be for KCC to contract with an umbrella organisation that would either deliver some of the functions itself or commission other providers to do this.

Governance structure

The group supported the consultation feedback to date which suggested that a one-tier governance structure with the organisation "owned" and controlled by an independently appointed Board of Directors would be the preferred model for the LHW, with a number of advisory or stakeholder groups (perhaps enshrined in the Company's Articles of Association) to ensure the views of the broader community could adequately influence the running of the new organisation.

The Board would be held accountable through its contract with the local authority (but independent to it); by the advisory stakeholder groups; to the public through its work; and to any other regulatory body.

Legal form

The group endorsed the consultation feedback so far - and experience from elsewhere - that a Community Interest Company may be the most most straightforward and appropriate form for the LHW to take with regard to the preferred governance structure. This is compared to an Industrial and Provident Society, for example, which could pose more significant challenges in terms of identifying a clear target membership group and the practical challenges of maintaining the active involvement of members. However one organisation's view is that, whilst this organisation would need to be a social enterprise, it would not need to be a new Community Interest Company and there may be benefits to an existing organization holding the contract.

(11) Three workshops were held in July to test the recommended strategic direction with other voluntary organisations across Kent and capture any further insights and

experience in order to shape the potential model. A wide range of diverse organisations attended the event and, throughout the process, voluntary organisations – large and small – have expressed their wish to be involved and be part of the 'network of networks'.

(12) All development work is available on the KCC website, so that Kent citizens and partners who might be interested in contributing to or tendering for the service(s) can understand how the work has been developed and co-designed.

3.1.3. Supplier side development

(1) Local authorities can decide how to use the start-up costs received this year and one option is to undertake supply side activity encouraging organisations to prepare to bid.

(2) KCC is keen to support this and has made available up to £1000 per organisation requesting support to prepare their bid for the contract. A request from more than one organisation wishing to work together is reflected in the amount allocated. Three requests for this support have been successful.

4. Establishing an interim Shadow Local Healthwatch

(1) KCC is setting up an interim Shadow LHW Board from September 2012 to run for 6-8 months - until the formal LHW organisation establishes its own governance structure - to test and begin to embed the emerging model, for effective handover to the formal LHW, as it becomes established in April 2013.

(2) The interim Shadow LHW Board will work closely with LINk during the transition period to build on the LINk legacy and begin to create the developing model in practice, to ensure that the new requirements of a Local Healthwatch can be successfully met in Kent. It will also work with LINk to ensure that the commitment of existing LINk volunteers is sustained and that their contribution is shown to be highly valued.

(3) Its key functions therefore will be to:

- manage in and develop both the future organisation and the relationship with KCC
- prepare for and manage the transition from Kent LINk
- start to develop the operating procedures and practices that will be used by the formal LHW from April 2013
- start to model the desired approach to LHW that will best meet the interests of the Kent population, to have a positive impact on local health and social care services

(4) The recruitment pack and application forms to be considered for membership to the Shadow Board – which will be a member-led organisation - were made available at the end of June 2012 and shortlisting took place in August. The Chairman of Kent LINk Governors Group is ex officio a member of the Shadow Board, as transition

from LINk is a key function. 14 further applicants have been invited to become a member, subject to references and CRB checks. The inaugural meeting, being held on the 26 September, will be an induction/task-focused meeting, facilitated by the national Healthwatch Implementation Lead, to agree the Board's key deliverables, its way of working and structure.

(5) Unsuccessful applicants have been invited to become associate members.

5. Building and maintaining key supporting relationships

(1) Voluntary organisations who have attended LHW meetings have expressed their wish to be actively involved and some have asked whether there will be more local events. It is proposed therefore that further events be offered in the next 6 months so that the 'network of networks' becomes increasingly robust, in readiness for LHW in April 2013.

(2) Volunteers play a critical and valuable role, underpinning the work conducted by LINk, and KCC is keen to ensure that they are supported and encouraged to continue their commitment by becoming a part of LHW. An event is taking place on 11th September, independently facilitated, in order to create a space for LINk volunteers to share their experience and expertise of being involved in Kent LINk, to celebrate their contributions and discuss how they would like to work with LHW in the future.

(3) It is also proposed that events are organised over the next six months for potential volunteers to hear about the proposals for LHW and sign up to be a part of the new organisation, so building up the pool of available volunteers.

6. Accountability

(1) The set up of LHW is part of the NHS Reforms and so is currently part of Roger Gough's portfolio with senior officer management through Meradin Peachey.

(2) As with the current Kent LINk, LHW will have a strong citizen engagement function. A fundamental difference in arrangements is that KCC will contract and performance manage Kent LHW. Through these new arrangements (and through careful evaluation of organisations that bid to deliver Local Healthwatch functions) there is an expectation that LHW citizen engagement functions will complement those of KCC and the Local NHS.

(3) A decision has now been reached with Mike Hill and Amanda Honey that once LHW has been set up and operating effectively, accountability will be passed to Customer and Communities.

7. Procurement

(1) Plans for the commissioning of LHW are being developed with the Procurement Team to ensure a LHW Organisation is appointed by 1st April 2013.

(2) Timescales for this process are:

23 August	1st draft presented to the Cabinet Member Roger Gough

29 August	2nd Draft agreed by Cabinet Member Roger Gough
6 September	Quality Assurance of Draft Specification by the LGA Healthwatch Implementation team
13 September	Health and Social Care Partnership Specification Masterclass, to share best practice
27 September	Policy and Resources Committee
15 October	Commissioning and Procurement Board
16 October	Invitation to Tender issued
Nov/Dec	Evaluation and award
Jan – March	Induction of successful organisation

(3) As outlined above, the Invitation to Tender Specification is currently being written and tested, ready for going out to tender after 15th October.

(4) On 6 September the Local Government Association Healthwatch Implementation Team, consisting of the Programme Director and a number of Local Authority specialists working on LHW carried out a Quality Assurance exercise on the draft specification. The team were very positive about the specification and considered it a good model that other Local Authorities could follow. A few amendments were agreed as a result of the exercise.

(5) The final stage of quality assurance is on 15 September at a "mini masterclass" for the South East region run by the Health and Social Care Partnership group. The Invitation to Tender is expected to be issued on 16th October

(6) National guidance for all aspects of LHW, including specification and evaluation, continues to be issued and these could still alter Kent's specification.

Key milestones

The following table shows the key milestones to be met to ensure the successful establishment of the formal LHW in March 2013.

July	Aug	Sep	Oct	Dec	Jan	Mar	Apr 13
P&RCC for agreement re strategic direction		Corporate Board for update & agreement SOB for information P&RCC prior to final decision	Commissioning & Procurement Board				
Appoint to interim shadow LHW		Inaugural meeting of interim Shadow LHW					
Procurement specification developed	Procurement process begins				Award	LINk ends	Kent LHW established
Summary report on issues re. draft regulations		Secondary legislation	HW England Regulations to be published	Actual budget known			

8. Recommendation

The Health and Wellbeing Board (Shadow) is asked to note the work currently underway in developing the Local Healthwatch for Kent.

Contact details
Julie Van Ruyckevelt
Interim Head of Citizen Engagement for Health
KCC
Email: julie.vanruyckevelt@wkpct.nhs.uk
Tel: 07799472930;

This page is intentionally left blank

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

To: Kent Shadow Health and Wellbeing Board

Subject: Options for the development of the sub architecture for the Kent Health and Wellbeing Board

Classification: Unrestricted

Summary: The following paper outlines the options for developing a sub architecture to support the work of the Kent Health and Wellbeing Board.

---

1. Background and legislation.

1.1. The Health and Social Care Act 2012 outlined a new role for local authorities for the co-ordination, commissioning and oversight of health, social care (adults and children's), public health and health improvement.

1.2. Kent is the largest two tier area to have to implement the Health and Social Care Act 2012; some of the provisions within the Act are not designed for this scale and Kent faces unique challenges in implementing a successful Health and Wellbeing Board (HWB).

1.3. This paper focuses on the development of the sub architecture for HWB functions, based on the initial year of operation in Shadow form, and the development of the Dover and Shepway Shadow Health and Wellbeing Board. The provisions for Health and Wellbeing Boards in the Health and Social Care Act do not give any formal role or responsibilities to District Councils. However, Kent County Council recognises the role of District Councils in the agenda and wants to engage proactively with them in developing the Health and Wellbeing Board and its sub architecture.

1.4. The Kent Shadow HWB was established in July 2011, meeting for the first time in September 2011. The Dover (now Dover and Shepway) Shadow HWB was established in January 2012 as a formal sub committee of the Kent HWB.

1.5. The Health and Social Care Act 2012 received Royal Ascent in March 2012. Sections 194 – 199 focus on the establishment, membership, functions and duties of the HWB.

1.6. S194 (11) states that "A Health and Wellbeing Board is a committee of the local authority which established it and, for the purposes of any enactment, is to be treated as if it were a committee appointed by that authority under section 102 of the Local Government Act 1972." Amongst other things, this also means it can establish sub-committees. In addition, s194 (12) states:

But regulations may provide that any enactment relating to a committee appointed under section 102 of the LG Act 1972 –

(a) Does not apply in relation to a Health and Wellbeing Board

(b) Applies in relation to it with such modifications as may be prescribed in the regulations.

1.7. Secondary regulations are not due to be published until the end of 2012. This may impact on the timetable through which the Kent Health and Wellbeing Board is established as a full committee, this has to be completed by the end of March 2013.

2. Rationale for the development of a sub architecture

2.1. The role of the HWB has always been envisaged as being a strategic one (moving towards system leadership) although it is not directly accountable for service delivery. This strategic focus will need to be balanced with the locality focus of GPs, the ongoing dialogue between CCG commissioning plans and the HWB and the different needs of local Kent communities. In order to manage these competing approaches, the development of a sub structure would be the most pragmatic approach.

2.2. There are a number of options that can be developed into a sub architecture for the Kent HWB. In considering the various options, we will need to take into consideration the following issues:

- The view of the Kent Shadow Health and Wellbeing Board
- The views of the CCGs
- The views of District Councils
- Additional resource pressures
- The role of HealthWatch

2.3. The development of the Dover and Shepway Health and Wellbeing Board has created an effective working model for a sub architecture; its development has seen it already agree to cover the CCG area rather than just a local authority boundary. It has also been influenced by the Kent Health Commission (whilst running in parallel, has nonetheless established outcomes that are being mainstreamed as part of the Dover Shepway HWB agenda). KCC has engaged proactively with Dover District Council and partners during the development of the Dover and Shepway HWB.

2.4. A key focus for the Dover and Shepway HWB is the development of an Integrated Commissioning Strategy and integrated commissioning plan for the Dover and Shepway area. It will focus initially on Long Term Conditions. Whilst joint commissioning has taken place before, this is the first time a fully integrated commissioning strategy and plan has been developed between health, social care and the District Councils.

2.5. HealthWatch – the commissioning of a new Local HealthWatch service is currently underway but builds on a long history of public and patient engagement in holding health services to account. HealthWatch will have a unique role on the HWB,

as it will also have a role in Health Overview and Scrutiny as well. Once the local service is established at a county level, a representative will be one of the core members of the HWB and it is envisaged that any sub architecture would also engage with local HealthWatch at a CCG level, alongside existing public and patient engagement mechanisms.

2.6. Key Roles of the Sub Committees. Whilst the upper tier authority will retain the legal duty to establish a Health and Wellbeing Board; it has become clear, both through the establishment of the Dover and Shepway HWB and the development of the Kent HWB, that any sub committee will need to focus on a number of key areas to add value. These areas are:

- CCG level Integrated Commissioning Strategy and Plan
- Ensure effective Local Engagement
- Local monitoring of outcomes

2.7. Membership. The H&SC Act 2012, sets a minimum membership (a mix of elected Members, KCC Officers, GPs and HealthWatch), with local flexibility to appoint more members to the HWB as is required locally. It is envisaged that HWBs will reflect this at local level – i.e. operate as joint officer/Member committees, with local flexibility to appoint additional members to those that are identified as the core members to be on a local level HWB.

3. Options Appraisal:

As set out in paragraph 1.6 above, we are able to develop a formal architecture of sub-committees to support the strategic work and focus of the Kent HWB. The focus of any sub-architecture will need to be in integration of commissioning at a local level for both adults and children, feeding into the county-level Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessment and other operational commissioning arrangements. In Kent, there are three options to consider:

- Option 1: Sub committees based on CCG boundaries
- Option 2: Sub committees based on District Council boundaries
- Option 3: Locality Boards

3.1. **Option 1:** Formal Sub Committees based on CCG Boundaries. If the focus of a sub committee of the HWB is to be the development and oversight of integrated commissioning at a CCG level; it is logical that this should be overseen by a CCG level sub committee as this will be the level at which integrated commissioning plans will be developed. Dover, Shepway, KCC and the CCG are developing the first CCG locality based Integrated Commissioning Plan in Kent. This model also presents an opportunity for CCGs to have a “once and done” route to access both tiers of local government. The Dover Shadow HWB has already widened its remit to take in Shepway to make the HWB coterminous with the CCG.

3.2. **Option 2:** Formal Sub Committees based on District Council boundaries. Kent is the largest two tier authority area having to develop HWB arrangements. Whilst

District-level Sub-Committees may seem an obvious starting point, there are currently 7 CCGs in Kent, with only 1 coterminous with a District Council boundary – others cover at least 2 Districts if not more. It will become increasingly complicated for CCGs to engage with a number of different HWBs. CCGs are continuing to develop their relationships with District Councils and local partners. The Dover and Shepway HWB, having started with a District boundary has ended up taking a pragmatic approach to its development, focussing on CCG boundaries rather than on local government administrative boundaries. It will also be more cost effective for all partners to focus on 7 CCGs rather than on 12 District Council level Boards.

3.3. **Option 3:** District level Locality Boards. The development of these is discretionary whereas the HWB will be a statutory function of the upper tier authority (and will provide a consistent basis for relationships with the key players). Locality Boards are developing at varying speeds across the county, reflecting local engagement; it is unclear whether all areas will establish a locality board and if CCGs would be engaged in them. They do not have responsibility for commissioning nor have officers as members (they do not sit alongside the new model of Health and Wellbeing Boards with Members, Officers and GPs working together).

4. Administrative and Policy Support (see diagram below)

4.1. An increase in the number of committees/sub committees established by KCC carries with it a cost pressure in terms of committee administration, overheads to support the board directly (the production of papers, briefings and monitoring of activity) and any additional policy support that is deemed necessary. A more detailed breakdown of potential cost pressures is set out in the Risks section.

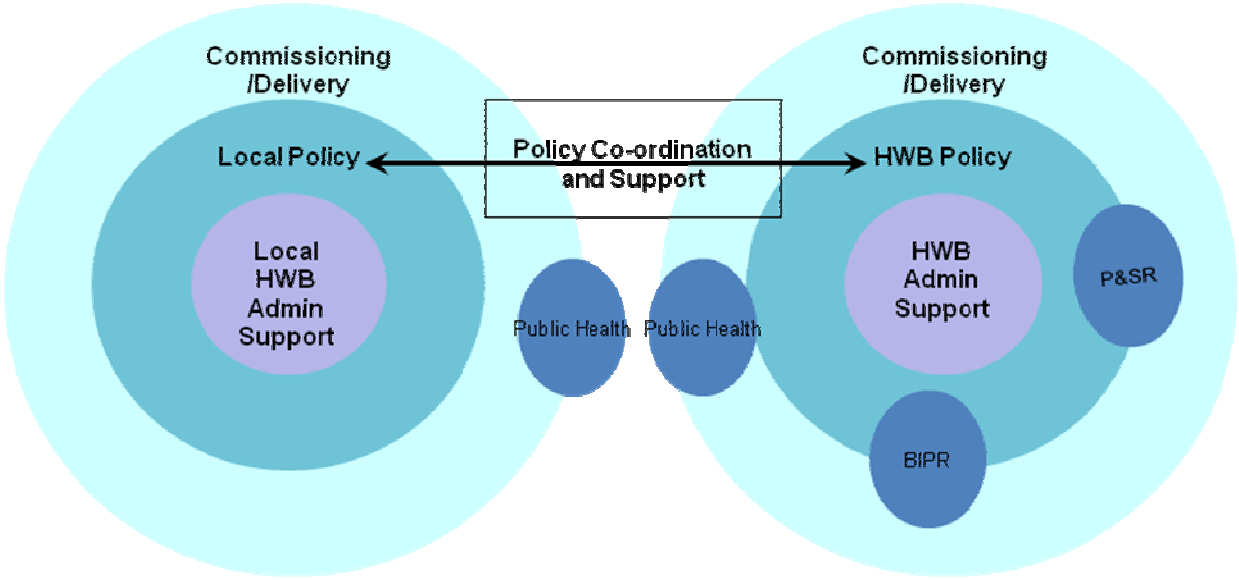
4.2. Irrespective of the type of sub architecture established for the Health and Wellbeing Board, KCC will need to ensure that it is confident that it has the knowledge and capacity to support the policy requirements of the Health and Wellbeing Board and the wider health and social care policy agenda. Whilst we cannot guarantee it, nor are we responsible for it (unless we choose to be), there would also be a need to ensure that there is robust local policy support for health/health and wellbeing board(s) at a local level.

4.3. There remains a danger that, unless the development and delivery of the work programme for the HWB is effectively managed; the HWB may become irrelevant and sidelined (passive engagement) with limited impact on major decisions/problems. Early identification and engagement will be key; it may not be the role of the HWB to solve identified problems, but it does have a clear role as system leader in identifying priorities for action and facilitating solutions e.g. integration of services. Consistent and timely policy support, alongside the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy will be important in enabling the HWB to move towards being a system leader. The appropriate use of sub committees and the wider partnership architecture that is already in existence will be critical to this, as will a consistent approach to policy support.

4.4. Any policy support will need to encompass both the wider health policy context as well as the local health policy context. It has already become clear from requests

from the Kent Policy Officer Group that at a district level there is a lack of strength and depth in health policy knowledge, but a desire to develop one.

4.5. Consistent policy support and advice will also prove crucial in strengthening relationships with CCGs who will cover multiple local authority boundaries and may struggle with different organisational approaches. In addition, if the focus of the sub committees will be the development of integrated commissioning, this will need to be supported in order that it is a true integrated approach, rather then being led by one partner. A single, consistent and dedicated approach to policy will support this. Any single policy approach will need to develop a level of independence so that all partners (KCC, DC's and CCGs) will be able to develop a strong level of trust in the advice and support given to them and the Health and Wellbeing Boards.



4.6. The HWB has a clear and strategic role working across the health system in Kent as described above. It will need to establish a distinct role that does not duplicate other arrangements while at the same time developing effective working relationships with existing or proposed partnerships. There remain a wide number of partnerships and groups (both statutory and non statutory) that continue to deliver various strategies and commissioning responsibilities for health and social care across Kent. They are currently managed by a variety of organisations including the NHS; reporting links and governance arrangements are mixed and will need to be mapped at a high level to ensure that we are not left open to challenge.

4.7. **Public Health.** A distinction needs to be drawn between the district level Health and Wellbeing Partnerships/Groups, which were established across Kent a number of years ago to tackle health inequalities. These have built up effective local relationships to tackle health inequalities and should remain focussed at District level but with a link across to the CCG level HWB via the Public Health Consultant for that area. Health and Wellbeing Partnerships have strong links to District Councils and Locality Boards because of their geographic focus (and the delivery of the Health Inequality Action Plans is at this level). However, if we are to continue with these Partnerships, they will need to be renamed in order to avoid confusion with the CCG

and County level Health and Wellbeing Boards. We would be grateful if they could be renamed Public Health Groups or Health Inequality Partnerships. In addition, Public Health money from KCC (if made available) would go to these groups. The role of Public Health is crucial to both the local and CCG HWB agenda.

5. Risks

5.1. **Financial Implications**. There will be a financial pressure associated with establishing the sub architecture for Health and Wellbeing in Kent, both in terms of admin of the committee and sub committees and policy support. Based on a sub committee meeting quarterly, and being at CCG level, there will be an additional 28 meetings to support (or 42 meetings a year if it meets bi monthly) (if KCC provides admin and policy support in all CCG areas).

5.2. However, it is felt that additional costs can be successfully mitigated if existing resources are utilised across KCC, wider local government and health. For example, Dover DC has taken on the support and administration of the Dover & Shepway HWB, as part of the arrangements in which it acts as a sub-committee of the Kent shadow HWB. This arrangement has worked well, and as there is a strong appetite for CCG level HWB, KCC will explore opportunities to share similar support arrangements with both CCGs and District Councils

5.3. **Relevance of the Health and Wellbeing Board**. If the HWB wants to develop to its full potential of being a system leader and avoid becoming sidelined and irrelevant, it will need to develop a strong and consistent position supported by an empowered leadership with consistent advice and policy support.

6. Consultation and Communication

6.1. A version of this paper was presented to a sub group of the Kent Forum, the Leaders group on the 20th July. There was wide spread support of the pragmatic approach of developing the sub architecture around CCG boundaries, although there remains some key challenges at local level i.e. where Districts are split between CCG's (Sevenoaks and Swale). The resource implications were seen to be secondary to the roll out of the sub architecture (the Leaders expressed support in providing committee services resources to run the groups as sub committees). Phasing of the rollout of any sub architecture was also discussed, but no clear conclusions were drawn.

6.2. Roger Gough has written to all the Leaders and Chief Executives of the District Councils seeking their wider views on the options for developing the sub architecture.

6.3. The Kent Health and Wellbeing Board as well as the lead GPs have also expressed strong support for the development of a sub architecture based on CCG boundaries, and would like one in place as soon as is practicable.

7. Conclusion

7.1. The Kent HWB have recently supported the development of both CCG level Integrated Commissioning Plans and CCG level HWBs. If the main focus of a local

level HWB is to oversee the development and delivery of integrated commissioning plans (between health, social care and District Councils) it will need an appropriate governance arrangement, at an appropriate geographic level to oversee this. Coterminosity will always present a challenge in an area as large as Kent, and any sub committee boundary will inevitably lack coterminosity with all partners' boundaries. We believe that CCG level HWB are the best fit possible and the most pragmatic approach to take.

7.2. There is also wide spread support for the development of CCG level Health and Wellbeing Boards to support the work of the Kent HWB, from both District Council Leaders and CCG lead GPs.

8. Recommendation

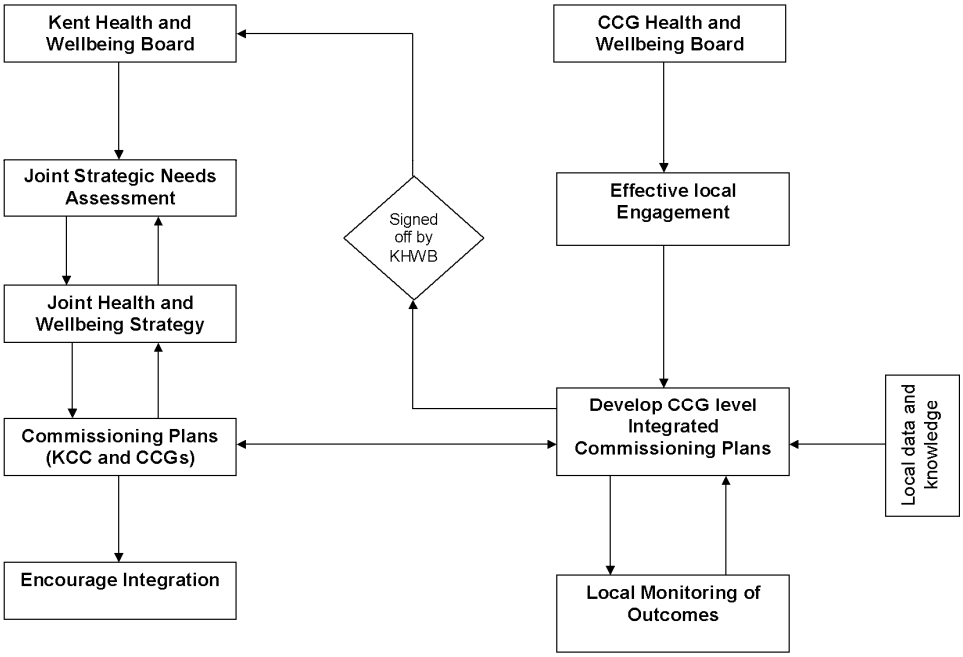
8.1. This paper recommends that a Health and Wellbeing Board sub architecture is developed based on CCG boundaries; and that the appropriate steps are taken to ensure the Kent Health and Wellbeing Board and Kent County Council, (working in partnership with District Councils and Clinical Commissioning Groups) undertake this.

9. Background Documents

- Health and Social Care Act 2012

Contact details
David Whittle, Head of Policy and Strategic Relationships
Davod.whittle@kent.gov.uk
01622 696969

Appendix 1: Potential Workflow Diagram between County HWB and CCG HWB



Appendix A

CCG Level Health and Wellbeing Boards

Draft Terms of Reference

Role

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

Terms of Reference:

The CCG level HWB will:

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

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

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

4. 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.

5. Undertake monitoring of local outcomes.

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

7. Provide advice (as and when requested) to the Kent Health and Wellbeing Board on local service reconfigurations that may be subject to referral to the Secretary of State on resolution by the full County Council.

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

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

Membership

The following is a suggested minimum membership level, additional members can be appointed at the discretion of the CCG level HWB. The Chairman will be elected by the HWB.

1. Local Government:

    - The Leader of the District Council(s) and/or their nominee(s)
    - At least one Kent County Council Member (Cabinet Member or his/her nominee)
    - District Council(s) Cabinet Member for Health
    - KCC Senior Locality Officer for Families and Social Services
    - Public Health representative

2. Clinical Commissioning Group

    - At least one GP
    - Senior CCG Officer e.g. Accountable Officer or Chief Operating Officer
    - Representative from the Commissioning Support Service

3. HealthWatch and/or other public engagement forum representative

4. Other local representatives as identified by the CCG level HWB.

CCG Health and Wellbeing Board – Terms of Reference

Standing Orders

1. **Conduct.** Members of the CCG level 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 CCG HWB shall meet at least quarterly. The date, time and venue of meetings shall be fixed in advance by the CCG HWB in order to coincide with any key decision-points and/or Council Forward Plan.

3. **Meeting Administration.** The CCG HWB meetings shall be advertised and held in public and be administered by the District Council (Administering Authority). The HWB will consider matters submitted to it by local partners. The Administering Authority shall give at least five clear working days' notice in writing to each member for every ordinary meeting of the CCG HWB, to include any agenda of the business to be transacted at the meeting. Papers for each CCG 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 CCG 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 CCG 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 CCG 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 CCG 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 CCG 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 CCG HWB when they shall be submitted for the approval of the CCG HWB. When the minutes of the previous meeting have been approved they shall be signed by the Chair. Copies of minutes will be sent to the Kent Health and Wellbeing Board.

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 CCG HWB, at the first meeting of the CCG 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 CCG HWB meetings if s/he is present. In her/his absence the Vice-Chair shall preside. If both are absent the CCG HWB shall appoint, from amongst its members Acting Chair for the meeting in question.

9. **Voting.** The CCG 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 CCG 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 CCG HWB. No business requiring a decision shall be transacted at any meeting of the CCG 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 CCG HWB, or by the decision of a majority of those present at a meeting of the CCG HWB, meetings of the CCG HWB may be adjourned at any time to be reconvened at any other day, hour and place, as the CCG HWB shall decide.

12. **Order at Meetings.** At all meetings of the CCG 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 CCG 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.

This page is intentionally left blank

By: Helen Buckingham. Director of Whole System Commissioning and Deputy Chief Executive, NHS Kent and Medway

To: Kent Shadow Health and Wellbeing Board

Subject: Information Governance – an update

Classification: Unrestricted

Summary: This report summarises the activity that is being undertaken both nationally and locally on Information Governance.

Executive Summary

The following brief has been written based on the past discussions by the Kent HWBB May and July 2012. It summarises the importance of, and the work carried out till date around the development of Information Governance arrangements for the implementation of the Kent & Medway Long Term Conditions Programme.

To date there has not been a consistent or effective framework for sharing of personal and sensitive patient data between data silos, which sit in different information systems across health and social care organisations. Patient consent for sharing of records is available but in a limited capacity. Blocks also exist around sharing of information (coded data) and the linking of information systems from multiple agencies for the collecting and collating of robust health and social intelligence.

The current LTC programme advocates a whole systems transformational change, particularly breaking down silos caused by commonly perceived barriers due to information governance in two key areas: the linking and sharing of health and social care data for robust population intelligence including risk stratification; and sharing of care of records for effective real time patient care management by the multi-disciplinary health and social care integrated teams.
Over the last few months the K & M Information Governance team has led the design of appropriate protocols to enable the sharing of data and information in these two areas under the auspices of the Kent & Medway Information Sharing Agreement. Work is currently underway to sign them off by the respective agencies and data controllers starting with primary care. Other notable developments include the proposed set up and piloting of a virtual solution for online personalised care planning service in two CCG areas, known as 'Patients Know Best'.

NB. To ensure consistency, other critical elements and interdependencies (of the LTC programme) such as technical aspects of enabling technologies (for eg. Medical Interoperability Gateway) are not described in detail here but further information can be found in the K&M LTC operational guidance *http://www.kent.gov.uk/adult_social_services/social_services_professionals/social_care_events/long_term_conditions_programme.aspx*

Background

Major changes to the culture and infrastructure of health and social care are expected over the next 3 to 5 years. Much interest has been re-energised by the input from QIPP (Quality Innovation Productivity Prevention) National team for LTCs in collaboration with consortia leaders in the South East by designing a specific programme of work in this field. The K&M Integrated Plan Board representing all providers and commissioners is committed to encouraging the systematic adoption of the three principles of the LTC model of care approach:

- Population risk stratification to identify patients with the highest risk of crises. These are usually patients with multiple long term conditions requiring a wide range of health and social care agencies for their care management.
- Creating functionally integrated generic care teams at a locality level comprising all relevant health and social agencies to provide joined up and personalised services.
- Empowering patients to maximise self-care, self-management and choice, through access to their medical records, co-production of their care plan leading to delivery of coordinated interventions and targeted care.

It is also important to acknowledge HWBB terms of reference that its mandate for integration and the work being done to develop integrated commissioning and provision which also supports the vision of the QIPP LTC programme being led by Kent & Medway PCT cluster and hopefully by the CCGs after April 2013.

Governance of the LTC Programme

A multi-agency team exists to see through the project locally, at all levels across health and social care organisations from Chair & CEO level through to practitioners delivering services within their organisations. In this time of transition, governance arrangements look to the Health & Wellbeing Board as the future vehicle for oversight and delivery of the programme, linked to the Integrated Strategic Operating Plan (ISOP) as well as the Health and Social Care Integration Programme (HASCIP). Programme support is provided on a “matrix delivery” basis, combining business intelligence, technology support. IT infrastructure support, programme management and so on, which is expected to move to the local Kent & Medway Commissioning Support service and commissioned by CCGs should they wish such support to continue in this form. Additionally, project managers have been recruited for the purpose of supporting (for each CCG) the LTC programme in various workstreams, particularly embedding risk stratification process into routine practice and support the completion of necessary information governance arrangements.

What needs to change?

While the national team have emphasised the 3 key principles for implementation (highlighted in yellow below) in Kent & Medway, at least 17 other key interdependencies and elements have also been identified as critical to the success of the programme, and explained in detail in the LTC operational guidance that was pulled together on behalf of the governance group. In it the fifth element is about developing robust information governance arrangements.

1. Ensuring robust CCG governance arrangements for successful implementation of LTC programme
2. Improved understanding of population need using risk stratification to deliver better JSNA and CCG health profiles
3. The importance of a robust minimum dataset from different provider agencies' information systems
4. Achieving financial balance and transforming payment systems by commissioning based on need / risk profiling (based on DH 'Year of Care' model)
5. Setting up robust information governance arrangements
6. A common data repository / warehouse – managed by K&M Health Informatics Service
7. Decision management system – developing a robust dashboard (eg. GPMIS in DGS CCG)
8. Making information accessible and sharing it across organisations *(Medical Interoperability Gateway)*
9. The use of telemedicine and interactive care (technology to enable multi-disciplinary tele and video conferencing)
10. The use of technology for staff to enable agility mobility connectivity (eg. use of ipads and other handheld devices)
11. The use of technology for the patient (rollout of the telehealth and telecare services)
12. Choosing the ideal risk stratification / risk profiling tool
13. Developing and operating integrated health and social care teams
14. Empowering patients to self care and self manage
15. Moving towards a common assessment framework - building on the nationally accredited Functional Assessment in Community Environments (FACE)
16. Applying the LTC model of approach towards the End of Life Care agenda
17. Preventing Long Term Conditions using Audit +
18. Transforming Social Care – developing pooled health and social care budgets to enable the LTC model of care approach
19. Robust evaluation of whole systems change with the help of local academic support
20. Communications and Engagement – to ensure efficient real time cascading and dissemination of best practice across Kent & Medway

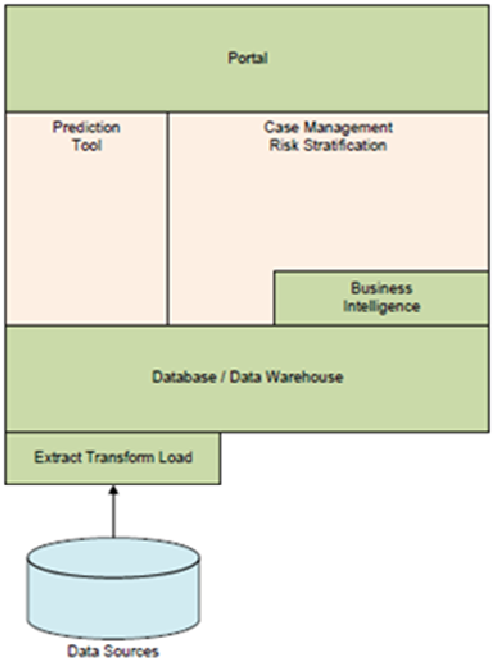
Why information governance is important?

There are two critical areas where robust information governance arrangements are urgently needed:

1. The sharing of health and social care intelligence (coded) data to enable robust population risk stratification and accurately estimate population need.
2. The sharing of care records between the various stakeholders of the individual patient's care, contributing towards a more effective, efficient, prompt and real time development of the patient's care plan.

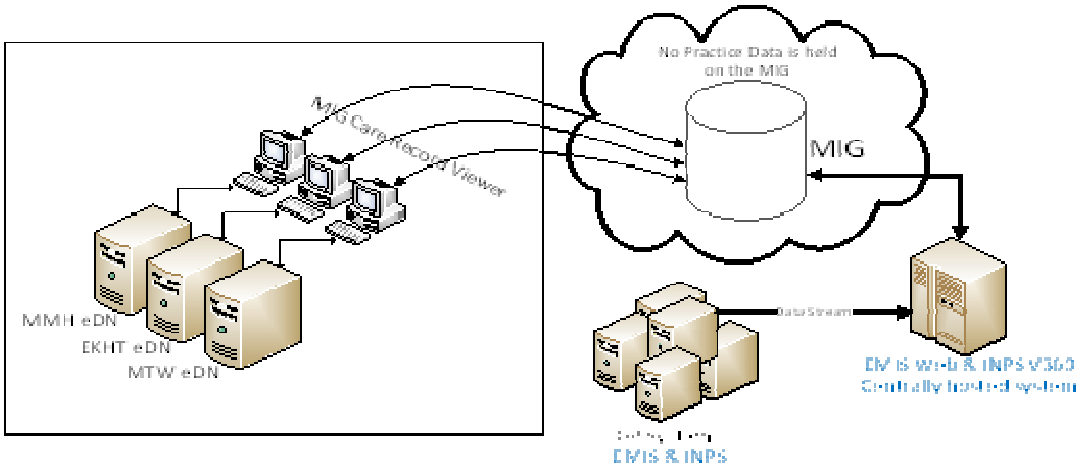
   From the list above, information governance should not be viewed in isolation but is critical and complements the successful development and delivery of almost all the 20 important elements and interdependencies, most notably:

- Development of a common data warehouse - Patient level activity real time data from our main health and social care organisations will need to be pooled and collated in one place, namely the data warehouse run by the Kent and Medway Health Informatics Service, of which the Business Intelligence wing will have operational supervision. Data that is sent to the warehouse will be clear format, undergo pseudonymisation process before undergoing risk stratification. The data will then be sent back to GP practices in a clear format for case management. Another extract of pseudonymised data can be made available to organisations such as Public Health for the purpose of population health intelligence (see diagram below).



Source: K&M LTC Operational Guidance 2012

- Development and operation of CCG Clinical Dashboards / Decision Management Systems - A single, consolidated review of organisational performance from a wide range of existing, disparate data sources, which will enable senior managers to see what is going on in parts of the system they would not normally have sight of, by enabling disparate information within existing systems to be consolidated and presented in a single, graphical, easy-to-understand dashboard view as shown in the diagram above.
- Development and operation of the Medical Interoperability Gateway – Based on the NHS Connecting for Health Interoperability Toolkit, its purpose is to share care records between multiple organisations such that it will not alter the way the care record is managed as shown in the diagram below.
- Patient care management by the integrated care teams - A locally delivered online personalised care planning service that will allow patients to be active partners in their care, working together with their care professionals (health and social care). Information will flow between the care records and the personalised care plan, which can be developed by the patient, and enables the digital delivery of targeted information and learning material based around the plan.



Source: K&M Operational Guidance 2012

What is the current situation on Information Governance?

To date there has not been a consistent or effective framework for sharing of personal and sensitive patient data between data silos. In this context data silos sit at various points within the local health economy, on GP Patient Administrative Systems, on mental health provider systems, acute systems and Social Services records etc.

Interoperability between electronic systems and inconsistency of record keeping has proved problematic to resolve. This has been further compounded by a lack of a clear and understandable patient data sharing consent model that has the capacity to establish patient trust that records will be shared appropriately and shared and stored securely.

Nationally the NHS has a poor record for data breaches and inappropriately shared or lost records form regular news stories which undermine patient trust. In addition to this, the Information Commissioner's Office (ICO) has recently begun to exercise their powers to fine organisations for data breaches and recent months have seen the first fines levied against NHS bodies.

Historically, there has been an implied consent model for the use of personal data by the NHS. This was refined by the Summary Care Record project which established informed consent but only against a basic dataset. Recent developments in clinical provision, including more proactive approaches such as LTC, envisage scenarios for cross service working to provide improved care. However, the patient consent model for sharing information in this way has not been present or at least has not been explicitly communicated to patients.

Blocks also exist around sharing of information and the linking (and compatibility) of information systems (using coded data) from multiple agencies for the collecting and collating health and social intelligence. This has become of paramount importance because of the growing cohort of people with multiple morbidities who are most commonly the frail elderly who are at the top of the population pyramid of need in terms of requiring services from a wide range of health and social care agencies as mentioned earlier. This implies an urgent shift and emphasis towards a more robust

approach to accurately quantifying and estimating population need using risk stratification.

A national review is under way to look at the Caldicott Guardian principles.

The vision for the future: What does national policy say?

The latest DH paper entitled “The power of information: Putting all of us in control of the health and care information we need”, sets out the following ambitions for information governance:

- Information used to drive integrated care across the entire health and social care sector, both within and between organisations
- Information regarded as a health and care service in its own right for us all – with appropriate support in using information available for those who need it, so that information benefits everyone and helps reduce inequalities
- A change in culture and mindset, in which our health and care professionals, organisations and systems recognise that information in our own care records is fundamentally about us – so that it becomes normal for us to access our own records easily
- Information recorded once, at our first contact with professional staff, and shared securely between those providing our care – supported by consistent use of information standards that enable data to flow (interoperability) between systems whilst keeping our confidential information safe and secure
- Our electronic care records progressively become the source for core information used to improve our care, improve services and to inform research, etc. – reducing bureaucratic data collections and enabling us to measure quality
- A culture of transparency, where access to high-quality, evidence-based information about services and the quality of care held by Government and health and care services is openly and easily available to us all
- An information-led culture where all health and care professionals – and local bodies whose policies influence our health, such as local councils – take responsibility for recording, sharing and using information to improve our care

The progress so far in Kent & Medway

Stakeholder Consultation - The first Kent & Medway workshop in May 2012 led by the cluster Information Governance team discussed in detail the set up and proposed features of how the Medical Interoperability Gateway will function and the importance of designing an explicit patient consent model to enable different stakeholders to access different care records. A follow up workshop is to be planned later this year / early next year to describe progress so far.

Kent & Medway Information Sharing Agreement (KMISA) - This agreement has been developed to provide a framework for embedding best practice with regard to the exchanging of information proactively. All key health and social care organisations across Kent & Medway have signed into this agreement. It sets out a legal gateway making reference to key legislation such as the Data Protection Act 1998. It also contains the standard operating procedures (SOP) for which the signatory partners have agreed in detail how and what information they are to share with each other, while ensuring compliance with legal and regulatory responsibilities. These SOPs are expected to be reviewed on an annual basis. A sample template is shown in Appendix 1. Details of those developed in connection with the LTC programme are outlined in the next section.

Completing Privacy Impact Assessments leading to design and development of SOPs - A Privacy Impact Assessment is usually completed when there is a need to explore in detail the privacy risks before the commencement of a new project or piece of work and to determine whether less privacy invasive options can be used. The PIA describes in detail the generation, transmission, storage and use of data in two stages: Data processing and data protection. Signing off the PIA will lead to the design and development of the SOPs to be incorporated in the KMISA.

Between July to September 2012, the K & M Information Governance team along with KCC colleagues led the completion of the necessary PIAs and SOPs (involving weekly teleconferences) in the following key areas:

- Acute trust and Community Health to view access to GP records using explicit patient consent.
- The sharing and linking (with SUS or hospital data) of pseudonymised primary care data for the purpose of risk stratification and population health intelligence with permission of data controller but explicit patient consent not required.
- The sharing of care records by the Multi-Disciplinary / Integrated Care Team. This has been drafted primarily for the use of sharing of data between KCC and KCHT. Other agencies will be incorporated once the scope of the MIG has been widened to include them.
- *The sharing and linking (with SUS or hospital data) of pseudononymised social care data for the purpose of risk is on hold whilst clarification from NIGB/ICO is being sought on merging Health and Social Care data without consent. This is further described in a later section.*

Agreement signing off by data controllers - GP practices in the East Kent Federation have been selected first to arrange necessary sign off of SOPs by their data controllers which should be completed by September / October 2012. It is expected that all 265 practices across K&M will have signed their agreements by the March 2013 along with consecutive roll out of the risk stratification tool. The LTC project managers have been specially delegated to ensure task completion. Parallel discussions are also taking place with respective Local Medical Committees to explore how they could facilitate this process.

Caldicott Information Governance Review - KCC is coordinating a response back to the national review of Caldicott requirements (mentioned earlier) in terms of an evidence gathering exercise, summarising the information sharing process across adult social care in Kent and how this will be altered as we move to closer integration with health providers. This will hopefully contribute to the review of Information Governance at a national level and bring about a change in legislation so that our vision of integration can be achieved.

Piloting of 'Patients Know Best' - Patients Know Best is an national award winning approach towards virtual online solution for sharing the patient care plan where the patient is the 'asset control manager'. It is currently the only product on the market that currently offers the following set of critical and unique functionalities:

- Enabling patients to decide and authorise access to all or parts of their records on the system (including healthcare professionals, carers and others).
- Enables patients to decide and withdraw access to all or parts of their records on the system (including healthcare professionals, carers and others).
- Should allow patients to add or annotate their records, without changing the original record on the system.
- Provide full audit trails for access to all or parts of the patients' record.
- Allow secure messaging between patients and health professionals.
- Ability to integrate and synchronise with health records held by various health providers and carers.
- Use encryption for all traffic.
- A agreement has made to pilot the use of Patients Know Best approach towards sharing of care records in the Swale and South Kent Coast CCG areas. This is expected to commence in October and will be mainly used for patients identified through risk stratification. Evaluation of patient experience will be one of the main outcome measures. If successful, the Patients Know Best will be adapted to provide an explicit patient consent model, built into the Medical Interoperability Gateway once it is up and running, to facilitate the sharing of care records between different agencies.

Key challenges

Most of the national and local debate on designing effective IG arrangements has been so far around sharing of care records by the integrated team through the MIG, but not enough around the linking and sharing of data for combined health and social care intelligence and risk stratification. Latest guidance from the National Information Governance Board on risk stratification was developed to clarify its

position and explain the necessary IG arrangements for the same. However, it suggests using the explicit patient consent approach (as in the case of sharing of care records) for the purpose of linking health and social care data which is deemed not practical to obtain for the whole K&M population of 1.7 million. A solution is currently being looked at by KCC FSC leads on this. In addition, it is hoped that this will be clarified in the national review.

As this is a Kent & Medway programme it is imperative that our partner organisations in Medway, particularly Medway Council are involved in the necessary discussions to progress the equivalent workstreams over there as well.

Conclusion

The national policy clearly states that the sharing of information is the first critical step and milestone towards system and service integration. A considerable multi agency effort has been made so far to achieve the progress till date. But further work is still required to complete any remaining SOPs for the sharing of information through all possible methods from the various agencies. The Kent HWBB can help facilitate this by raising awareness and promoting the importance of this workstream as part of the whole systems change in the context of the LTC programme, particularly to CCGs and its constituent GP practices. It can also establish appropriate links with the Medway HWBB ensure a common consistent approach towards implementation across Kent & Medway.

STANDARD OPERATING PROCEDURE TEMPLATE

This Template provides advice (in red) and the standard format and words (in black) to assist staff preparing a Standard Operating Procedure (SOP) document. (See live examples in Appendix C)

Type of Agreement

This SOP is to be read in conjunction with the Kent & Medway Information Sharing Agreement and Method XX (Description to be inserted). There is the option to include more than one Method.

Personnel involved in the information sharing process must be fully aware of the requirements of Agreement Method XX.

Parties to this Agreement and contact number to identify Primary Designated Officer (PDO)

List the parties to the specific agreement and contact numbers as indicated above. The details are to include the job roles as well of the names of the individuals currently holding those positions.

A list of regular PDO and Designated Officer (DO) contacts is to be maintained for easy reference and is to be attached to this document (electronic and paper version). If there is any doubt about the contact or the information requested check with your supervisor before disclosing information.

Purpose

List the purpose and the reason for considering the disclosure of information e.g. targeting/investigating crime and disorder incidents, notices seeking possession or eviction, child curfew notices or noise abatement investigations and notices.

Administration/Process

List specific administration/processes that are relevant to the particular SOP, such as the response times. There is always a need to specify how each partner will keep a record of decisions and the reasons, whether it is to share or not (see Golden Rules item 5, above). Apart from this requirement, there may not be a need to add more text if the standard wording provided in the Information Sharing Agreement (ISA) is sufficient. For example, the requirement for PDOs, a standard information sharing form and the need to keep records are all specified in the ISA, but if there is a need to identify other roles, vetting levels if required, or be specific about the format of a meeting/minutes additional information will need to be inserted here.

Information Disclosure Types (Examples)

Disclosure for the following relevant areas for each partner will be considered. Specific exclusions are also listed.

List information for which disclosure will be considered for each partner. Specific exclusions are also to be listed, if required (e.g. evidence in council led court cases will not be disclosed until the conclusion of the hearing).

Signatory partners recognise that any data shared must be justified on the merits of each case.

Information Governance – an update
Long Term Conditions Programme in Kent & Medway
September 2012

Appendix 1

Current Information Governance Work streams	What is already happening	Lead contact	Timescales
Stakeholder consultation	The first Kent & Medway workshop in May 2012 led by the cluster Information Governance team discussed in detail the set up and proposed features of how the Medical Interoperability Gateway will function and the importance of designing an explicit patient consent model to enable different stakeholders to access different care records. A follow up workshop is to be planned later this year / early next year to describe progress so far.	Jenny Thomas AD Long Term Conditions Tony Obayori Programme Manager IM&T Jamie Sheldrake Information Governance Lead Kent & Medway PCT Cluster	First workshop completed in May 2012
Kent & Medway Information Sharing Agreement	This agreement has been developed to provide a framework for embedding best practice with regard to the exchanging of information proactively. All key health and social care organisations across Kent & Medway have signed into this agreement. It sets out a legal gateway making reference to key legislation such as the Data Protection Act 1998. It also contains the standard operating procedures (SOP) for the which the signatory partners have agreed in detail how and what information they are to share with each other, while ensuring compliance with legal and regulatory responsibilities.	Jamie Sheldrake Information Governance Lead Kent & Medway PCT Cluster	Completed
Completing Privacy Impact Assessments towards the development of Standard Operating	Between July to September 2012, the K & M Information Governance team along with KCC colleagues led the completion of the necessary PIAs and SOPs (involving weekly teleconferences) in the following key areas: 1. Acute trust and Community Health to view access to GP records using explicit patient consent. 2. The sharing and linking (with SUS or hospital data) of	Jamie Sheldrake Information Governance Lead Kent & Medway PCT Cluster Sally Smith Policy Officer Kent County Council	Completed except the SOP for sharing of social care data for combined

Procedures	pseudonymised primary care data for the purpose of risk stratification and population health intelligence with permission of data controller but explicit patient consent not required. 3. The sharing of care records by the Multi-Disciplinary / Integrated Care Team. This has been drafted primarily for the use of sharing of data between KCC and KCHT. Other agencies will be incorporated once the scope of the MIG has been widened to include them. 4. The sharing and linking (with SUS or hospital data) of pseudononymised social care data for the purpose of risk is on hold whilst clarification from NIGB/ICO is being sought on merging Health and Social Care data without consent.		health and social care intelligence including risk stratification
Agreement signing off by data controllers	GP practices in the East Kent Federation have been selected first to arrange necessary sign off of SOPs by their data controllers which should be completed by September / October 2012. It is expected that all 265 practices across K&M will have signed their agreements by the March 2013 along with consecutive roll out of the risk stratification tool. The LTC project managers have been specially delegated to ensure task completion. Parallel discussions are also taking place with respective Local Medical Committees to explore how they could facilitate this process.	Jenny Thomas AD Long Term Conditions Rob Stewart Co-medical Director Tony Obayori Programme Manager IM&T Kent & Medway Cluster	Ongoing
Piloting of 'Patients Know Best'	Patients Know Best is an national award winning approach towards virtual online solution for sharing patient care plan where the patient is the 'asset control manager'. It is currently the only product on the market that currently offers a set of critical and unique functionalities cpabale of the above. A agreement has made to pilot the use of Patients Know Best approach towards sharing of care records in the Swale and South Kent Coast CCG areas. This is expected to commence in October and will be mainly used for patients identified through risk stratification. Evaluation of patient experience will be one of the main outcome measures. If successful, the Patients Know Best will be adapted to provide an explicit patient consent model, built into	Jenny Thomas AD Long Term Conditions Rob Stewart Co-medical Director Tony Obayori Programme Manager IM&T Kent & Medway Cluster	To start in mid October 2012

	the Medical Interoperability Gateway once it is up and running, to facilitate the sharing of care records between different agencies.		
Caldicott Information Governance Review	Caldicott requirements have governed the way the NHS shares information; this is now being reviewed nationally. KCC have responded to an evidence gathering exercise, summarising the information sharing process across adult social care in Kent and how this will be altered as we move to closer integration with health providers. By sharing our experiences with the Review Panel we can actively contribute to the review of Information Governance at a national level and bring about a change in legislation so that our vision of integration can be achieved. KCC has been asked to take part in further discussions in September.	Anne Tidmarsh, Director of Older People and Physical Disability, Families and Social Care, KCC Anne.tidmarsh@kent.gov.uk Sally Smith, Families and Social Care Policy officer Sally.smith@kent.gov.uk	Comments submitted on 27 June 2012 Further discussions taking place in September

This page is intentionally left blank

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

To: Kent Shadow Health and Wellbeing Board – 19 September 2012

Subject: Update on the development of the Kent Joint Health and Wellbeing Strategy

Classification: Unrestricted

Summary: This report updates the Kent HWB on the development of the Joint Health and Wellbeing Strategy.

---

1. **Background.**

1.1. The Kent Health and Wellbeing Board received a draft of the JHWS at its meeting in July, alongside a report outlining the engagement process. The approaches to producing the JHWS and the engagement strategy were agreed by the Board.

1.2. In August, an updated draft of the Joint Health and Wellbeing Strategy was shared with key partners for comment, ahead of the wider engagement process scheduled for this autumn.

1.3. The closing date for initial comments is after the publication date for HWB papers, a verbal update will be given to the Board on comments received to date.

1.4. The comments received will then be added to the report, before undertaking wider consultation during the autumn of 2012 and the final version of the Strategy will be published in December 2012. The wider consultation on the JHWS will take place alongside the development of the CCG Commissioning plans for 2013/14.

2. Recommendation

The Board is asked to note the content of the report and verbal update to the meeting.

This page is intentionally left blank

KENT HEALTH AND WELLBEING BOARD (SHADOW)

COMMUNICATIONS AND ENGAGEMENT STRATEGY

Version 2
Author: Julie Van Ruyckevelt, Interim Head of Citizen Engagement for Health
Date: 31st August 2012

Contents

1. Executive summary

The Health and Social Care Act 2012 sets out the plans to transform health and care so that there is stronger democratic ownership and involvement, stronger relationships between health and social care, more integrated commissioning of services to achieve better health and wellbeing of the population.

Health and wellbeing boards (HWBs) are at the heart of these plans, providing a platform where leaders from the health and care system can collectively work to improve the health and wellbeing of their local population.

HWBs, which will take on their statutory functions from April 2013, will have strategic influence over commissioning decisions across health and social care. They will provide a forum for challenge, discussion, and the involvement of local people and other key stakeholders in the decisions it makes.

Strong leadership will be critical to realising this vision, as will involving people who use the services at every stage of its thinking, from planning to service evaluation, to ensure that local services truly meet local needs.

Kent County Council's Shadow HWB (SHWB) is committed to involving its people and communities from the outset. This strategy outlines that commitment and how we will work together with our local citizens, and other key stakeholders and partners, to build on the best in health and social care in Kent.

The strategy will need to meet the needs, and be owned by, the range of partners on the SHWB and will need to ensure that it forms the basis of a joint approach to communication and engagement that recognises and complements the partners' own duties to engage and involve, whilst reducing duplication.

The strategy will support and underpin the work of the SHWB in this period of transition and will inform the development of the joint communications and engagement strategy for the HWB as it establishes itself from April 2013.

2. Introduction

HWBs will be the focal point for decision making about how best to improve health and wellbeing of local communities. They will play a key leadership role in bringing commissioners of health and care services together, alongside council members and Local Healthwatch – the independent public voice - to develop a shared understanding of the health and wellbeing needs of their local community.

Kent SHWB is leading and advising on work to improve the health and wellbeing of the people of Kent through joined up commissioning across health and social care, public health and other services (that the SHWB agrees are directly related to health and wellbeing), to secure better health and wellbeing outcomes in Kent and better quality of care for all patients and care users.

The SHWB has a primary responsibility to make sure that health and care services paid for by public monies are provided in a cost-effective manner. It is looking at the total resource for health and wellbeing across Kent and considering how and where investment in health improvement and prevention services could (overall) improve the health and wellbeing of Kent's residents.

It 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.

It is committed to deep and wide involvement to capture and use robust evidence and analysis of the needs of its local communities to inform its decisions.

The SHWB has developed this Communications and Engagement Strategy to outline how its work will reflect patient, public and other stakeholders' views and how it will discharge its specific consultation and engagement duties, working closely with LINks/Local Healthwatch and other patient/public/stakeholder engagement leads and groups across Kent.

3. Background

Local Authorities and CCGs have an equal and joint duty to prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS) through the HWB. JSNAs are local assessments of current and future health and social care needs. The JHWS is the strategy for meeting the needs identified in the JSNA

JSNAs and joint health and wellbeing strategies are a means to improve health and wellbeing outcomes through evidence based strategic commissioning and

positive action[1]. The quality of the process and the partnerships to support it are equally important. The JSNA and joint health and wellbeing strategy tell the community story, developing a joint approach, which focuses and drives local services to go beyond simply quantifying needs to addressing and meeting them. Through working with other local partners this can be enhanced to create a fuller picture of the needs of the community, and how to address them. The way JSNAs, joint health and wellbeing strategies and commissioning plans fit together is reflected in Appendix 1.

Core critical components of a HWB's work programme will be to refresh its local JSNA and develop a JHWS for how these needs can be best addressed – these are key agendas for putting localism into action.

Through the HWB agenda:

- Local communities will have a greater role in shaping and influencing services, supported by the involvement of democratically elected representatives and Local Healthwatch

- Local authorities and CCGs (who will be taking on the responsibility for commissioning the majority of health services) will plan and commission services in an integrated way so that health and care services better meet everyone's needs within the local community, including groups with the worst health outcomes

- HWBs will better understand and, with their partners, take action to tackle health and wellbeing inequalities

- The Board can promote better integration of service planning and provision, so that local authorities and the NHS can avoid duplication, make best use of resources and increase efficiency and quality of services for the local community

- The JSNA and JHWS will set and measure health outcomes for the local community so that improvements can be demonstrated

- Other services that impact on health and wellbeing, such as housing and education provision, will also be taken into account to consider how all future commissioning can be better joined up to improve the health and wellbeing of the community[2]

[1] Department of Health, 19 January 2012, Draft guidance on Joint Strategic Needs Assessments and joint health and wellbeing strategies
[2] Department of Health, 19 January 2012, Draft guidance on Joint Strategic Needs Assessments and joint health and wellbeing strategies

HWBs will take on their statutory functions from April 2013. They will bring together CCGs, democratically elected councilors, a representative from LINk/local Healthwatch, directors of children's and adult social services and the director of public health to have strategic influence over commissioning decisions about local health and social care (see Appendix 2).

4. Kent profile

Kent is one of the largest counties in England with a population of over 1.4 million. While almost three-quarters of the county is rural, most people live in the main 18 towns, the largest of which is Maidstone and the city of Canterbury.

People living in urban areas make up 71% of the Kent population, the remaining 29% of the population live in rural areas. Over the past 10 years Kent's population has grown faster than the national average. The population of Kent has grown by 7.8% between 2000 and 2010, above the average both for the South East (6.7%) and for England (6.1%). Kent's population is forecast to increase by a further 10.9% between 2010 and 2026.

Overall the age profile of Kent residents is similar to that of England, although Kent has a greater proportion of young people aged 5-19 and of people aged 45+ years than the England average. Just under a fifth of Kent's population is of retirement age (65+) and the number of 65+ year olds is forecast to increase by 43.4% between 2010 and 2026. The population aged under 65 is only forecast to increase by 3.8%. Life expectancy is higher than the England average for both men and women - men living for 79.1 years and women living for 82.7 years.

The health of people in Kent is mixed. 70% describe themselves as being in good health and 16.5% live with a limiting long term illness. Kent's ageing population will place significant pressures on health and social care services. Kent performs above the England average in terms of child development at age 5. Childhood obesity is lower than England average, infant deaths and early deaths from cancer and heart disease are all better than the England average.

Most of the population is white, but in areas such as Dartford and Ashford where the population is expanding rapidly, there are many more people from different countries and cultures. Overall the county is relatively affluent but is becoming more deprived with some large areas of deprivation - over 50,000 children live in poverty. Life expectancy is significantly lower in deprived areas, with a man living on average 8.2 years less, giving him a life expectancy of 70.9 years and a woman living on average 4.5 years less, with a life expectancy of 78.2 years.

Kent's performance on smoking in pregnancy, breast feeding initiation, healthy eating among adults and obesity in adults is worse than the national average. Continued poor performance in these areas will have a significant impact on the health of the population over the coming years with poor diet being a contributory

factor in cancer and heart disease and obesity in adults contributing to the increase in type 2 diabetes.

To improve people's long term health we will have to reduce unhealthy lifestyles, encourage healthy eating in adults, address the challenges of an ageing population, give every child the best start in life and enhance the quality of life for people with long term conditions and dementia.

We will need a real focus on differences in outcomes both within and between communities. In addition to this, we will need to look at how we improve people's knowledge of both the symptoms of various diseases and what they can do to prevent them e.g. encouraging physical activity. Engagement in self care/management will become a key agenda.

We will also need to address the wider determinants of ill health e.g. lifestyle, access to services, employment status and housing conditions. If tackled successfully these will have a significant long term impact on people's health.

5. Kent health and social care landscape

5.1. Social Care

KCC is responsible for the commissioning and provision of social care. At the beginning of April 2012 KCC Children's Social Care were dealing with 8,769 Children in need, of which 1,730 had a disability, and KCC Adult Social Care were dealing with over 30,000 clients, over 6,000 of whom were supported in residential or nursing care, 7,344 received domiciliary care and over 11,000 had personal budgets to manage their own care.

5.2. Public Health

As part of the reforms of the Health and Social Care Act, KCC will take on major responsibilities for Public Health from April 2013. Public health refers to the health needs of populations rather than individuals. The new arrangements will give KCC the main responsibility for improving the health of the people of Kent by commissioning health improvement services such as healthy eating and exercise. KCC will also have responsibilities towards health protection and ensuring services are of a good standard and will work in partnership with other contributors to the public health system.

5.3. Health commissioning

NHS Kent and Medway – a cluster of three Primary Care Trusts – is currently responsible for commissioning the majority of health services for people in Kent and Medway. From March 31st 2013 this organisation will cease to exist and the majority of their commissioning functions will be transferred to eight new CCGs: Medway; Dartford, Gravesham and Swanley; West Kent; Swale; Ashford; Canterbury and Coastal; South Kent Coast and Thanet. The seven Kent CCGs

are made up of 986 GPs in 216 practices. CCGs' Strategic Commissioning Plans and annual Operational Plans will be informed by the Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategy.

5.4. Health providers

Four Hospital Trusts deliver acute care to the people in Kent: East Kent Hospitals NHS University Foundation Trust, Maidstone and Tunbridge Wells NHS Trust, Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust. The last two Trusts are currently considering merging to form one Trust operating across two sites.

Kent Community Health NHS Trust (KCHT) provides a range of community health services including twelve 12 community hospitals, district nursing and health therapies. Kent Community Health Trust also has a number of contracts to deliver Health Improvement Services – for example, Stop Smoking, Sexual Health, Health Trainers.

Mental health services are mainly delivered by Kent and Medway NHS and Social Care Partnership Trust.

The 999 ambulance service is delivered by South East Coast Ambulance Service NHS Foundation Trust across Kent, Surrey and Sussex.

5.5. Other providers

The voluntary and community sector, also referred to as 'the third sector', is also a critical partner in supporting the health and care agenda. Kent's voluntary sector has the largest number of registered charities outside the Metropolitan districts and an extensive number of voluntary groups.

The Public Services (Social Value) Act 2012 reflects key policy changes about approaches to social value when considering how to provide public services. The Act, which became law in March 2012, aims to strengthen the social enterprise business sector by making 'social value' more relevant and important in the placement and provision of public services. Significant funding has been allocated to support existing and promote new social enterprises in Kent and these will become increasingly important players in future health and care provision.

6. Kent engagement landscape

6.1. LINks/Local Healthwatch

Local Involvement Networks (LINks), who provide citizens with the opportunity to influence how their health and social care services are delivered, will formally be replaced by Local Healthwatch (LHW) Organisations in 2013. LHW will also take

on additional responsibilities including signposting to services, possibly providing advocacy support, helping and supporting individuals as well as groups.

Localism is critical and each local authority is responsible for commissioning a LHW Organisation that most successfully meets local requirements. They therefore have flexibility and choice over the organisational form for LHW, to determine the most appropriate way to meet the needs of their communities.

The key requirements are that LHW organisations must be:

- corporate bodies carrying out statutory functions
- not-for-profit organisations
- able to employ staff and (if they choose) be able to sub-contract statutory functions.

LHW will be able to raise concerns about the quality of services with local CQC staff and will be able to request special reviews via Healthwatch England (HWE), which will be a statutory committee of the Care Quality Commission (CQC). HWE will be able to escalate concerns about health and social care services raised by local HealthWatch to CQC.

Kent LHW will be commissioned by and accountable to but operate independently to KCC The role of KCC is therefore complex as it will:

- fund and hold Kent LHW to account for its efficiency and effectiveness, in conjunction with Healthwatch England, where necessary
- have increasingly important influence on the health and wellbeing of its population
- continue to commission and provide services about which Kent LHW may wish to comment/challenge

(LHW) will have a statutory seat on the new Health and Wellbeing Boards, giving it influence at the decision-making table and ensuring public engagement is built into the strategic planning of health and care services early in the planning cycle. Its annual work programme will help shape and reflect the needs of the HWBB, the JSNA and the HWS. This will ensure the views and experiences of patients, carers and other service users are taken into account when local needs assessments and health and wellbeing strategies are developed. It will be supported by and need to demonstrate it is working to the emerging quality framework being produced by the Local Government Association and Healthwatch England.

LHW will develop and/or commission a range of tools and mechanisms for engaging widely and deeply with the diverse communities in Kent. It will analyse and provide authoritative, evidence-based feedback to organisations responsible for commissioning or delivering local health and social care services and will be able to alert Healthwatch England (HWE) to any concerns about specific providers and services, including those directly provided by local authorities.

LHW organisations will carry out statutory functions and service providers, such as local authorities and NHS bodies will be under a duty to respond to local Healthwatch reports and recommendations. Commissioners and providers will also have to have regard to the reports and recommendations and will have to be able to justify their decision if they do not intend to follow up on them[3].

For LHWs to be successful it will be vital for them to develop strong relationships – and credibility - with each of the key partners to understand their respective roles and to complement and build on their existing engagement functions. They will need to be recognised and trusted as a valuable resource – a critical friend - by all health and social care partners in order to successfully represent patients, carers and public in 'the strengthened system of strategic needs assessment and commissioning decision-making"[4]

6.2. Commissioners/providers duty to involve

6.2.1. Kent County Council

KCC has responsibility for engaging communities as part of the government's localism agenda. The Local Government Act 1999 introduced a duty for local authorities to consult in relation to Best Value. The Local Government and Public Involvement in Health Act 2007 imposes a duty on all local authorities to involve local representatives when carrying out "any of its functions" by providing information, consulting or "involving in another way".

KCC will take on the lead from the NHS for many public health functions, all of which will need significant communication and engagement campaigns.

KCC will also be responsible for commissioning Kent LHW and will hold it to account for operating effectively and providing value for money. However Kent LHW will hold KCC to account for the quality of social care and public health services: this will, therefore, be a complex relationship. To manage this, KCC will need to liaise, build and maintain strong relationships and positive working with the Local Government Association, Healthwatch England and other key national stakeholders. It will need to ensure that the health and wellbeing board supports Kent LHW in fulfilling its role on the board, so that it can contribute effectively and will need to mainstream patient and public engagement across all KCC health and social care activities/developments.

6.2.2. Clinical Commissioning Groups

Involving patients and the public in planning, monitoring and developing of health services is not only good practice but also a legal duty for all NHS organisations. Section 242 of the NHS Act 2006 which came into force in November 2008, strengthened the statutory duty on all NHS organisations to make arrangements to consult and involve patients and the public in:

[3] DH, March 2012, Local Healthwatch: A strong voice for people – the policy explained
[4] DH, 2 March 2012, Local Healthwatch: A strong voice for people – the policy explained

- The planning and provision of services commissioned
- The development and consideration of proposals for changes in the way those services are provided
- Decisions that affect the operation of those services

The Health and Social Care Act 2012 reinforces these legislative requirements and requires all CCGs to seek outcomes which deliver a positive patient experience.

The Revision to the Operating Framework for the NHS in England 2010/11 introduced four tests for all proposals for service reconfiguration which requires all proposals to demonstrate:

- Support from GP commissioners
- Strengthened public and patient engagement
- Clarity on the clinical evidence base
- Consistency with current and prospective patient choice

Substantial variations require a formal consultation to be conducted, which need to last a minimum of 12 weeks and will adopt a range of methods to gather feedback.

7. Current engagement on health and wellbeing

7.1. Joint Strategic Needs Assessment

The JSNA is an on-going process by which a range of data, information and analysis about the health and wellbeing of Kent is collated, assessed and compared in order to present an understanding of the issues impacting on the population of Kent.

A JSNA has been produced in Kent since 2006, broadly divided into two documents, adults and children, both updated in July and December 2011 respectively. The JSNA includes many health needs assessments which are undertaken each year on specific topics such as mental health, children in care, housing, and carers. More than 40 needs assessment have been carried out in Kent since 2008 exploring in-depth the health and social care needs, gaps in service provision and levels of un-met need.

Users, voluntary sector and carers views are sought as part of the gathering of data in all needs assessments. There has been considerable input from carers in the carers' needs assessment and mental health users in the mental health needs assessment. The commissioning document that followed the JSNA process for mental health is the 'Live it Well' strategy for Kent and Medway. This was developed with extensive involvement of local people and service users in particular. A number of methods of involvement were used from engaging with service users via the local planning meetings and in invited workshops. All the key issues the service users highlighted are reflected in this strategy, notably

better outcomes for people needing dual diagnosis services and better mental health treatment for offenders.

Focused engagement took place earlier this year on 'burning issues' within the JSNA:

- Breastfeeding: 4 listening groups were held (deprived areas, Thanet and Swale, young white mums)
- Smoking: 2 listening groups in schools (teenagers 13 – 16 years) and 2 in the Margate area with Further Education college age students (17 – 18 years)
- Long term conditions: 10 1:1 interviews about out of hospital care with men and women over 65 years with one or more long term condition.
- End of life care): 6 1:1 interviews with spouses/partners about access to services, signposting to support, choice of place of death.

7.2. Joint Health and Wellbeing Strategy

The Health and Wellbeing Strategy will inform commissioning decisions made by local partners especially GP Commissioning Groups (CCGs) so that they focus on the needs of service users and communities, tackle factors that impact on health and wellbeing across service boundaries and influence local services beyond health and care to make a real impact on the wider determinants of health (e.g. employment, housing and environment).

Initial development of Kent's JHWS took into account the key themes from the JSNA, a range of national and local related information as well as discussions at Kent Health and Wellbeing Board meetings and other forums where strategic discussions, particularly on health services, are being held - for example the NHS Chairs and Chief Executive forum.

The emerging HWB strategy reflects the health and wellbeing challenges facing Kent and focuses on five overarching outcomes identified as the most important for the population of Kent:

- Every child has the best start in life
- People are taking greater responsibility for their health and wellbeing
- The quality of life for people with long term conditions is enhanced and they have access to good quality care and support
- People with mental ill health are supported to live well
- People with dementia are assessed and treated earlier.

These will be achieved by:

- Engaging with the community via HealthWatch and other engagement mechanisms

- Halting the widening of health inequality gaps both within and between communities and improving healthy life expectancy.
- Focus on prevention and the individual taking more responsibility for own health and care.
- Providing good quality joined up support and care to people with long term conditions and dementia, preventing unnecessary hospital admissions. By care we mean both health and social care.
- Reducing premature deaths by the key killers including: Cancers and respiratory diseases
- Integrating commissioning of health and social care services as well as integrating how those services are provided.
- . Ensure cost effectiveness/efficiency are not achieved at the cost of quality.

It is important that local communities have a greater role in shaping and influencing services and improving health and wellbeing in communities. There is a statutory duty to involve certain groups and organisations in the development of a JSNA and the resultant JHWS[5]. These include people who live or work in the area, local Healthwatch and if applicable district councils. There should also be wider engagement, for instance with other agencies, the voluntary sector and health and social care providers. This involvement should be continuous, from early development onwards.

The draft JHWS was discussed by the SHWB in July and engagement with key stakeholders (CCGs, KCC, district councils) started in August. Feedback from this first stage of engagement will be presented to the SHWB in September and wider public engagement on the revised draft will then start, going through to November. This will tie into parallel work taking place in the CCGs on the development of the 2013 – 2014 Annual Operating Plans.

A range of engagement methods will be used in the wider engagement stage, including:

- Draft JHWS and questionnaire published both in paper form and online on KCC, PCT and LINk websites
- Paper documents placed in public places, such as libraries, leisure facilities, town halls
- Attendance at existing forums with particular interest/focus groups on one or more of the four outcomes
- Discussions with GP Patient Participation Groups, LINk/Local Healthwatch and other service user/participation groups, ensuring inclusion of diverse groups.

Feedback will be used to inform and develop the final version of the JHWS. This will be published at the end of 2012 and will demonstrate how public and stakeholder engagement has influenced its development.

[5] DH January 2012 Draft guidance on Joint Strategic Needs Assessments and joint health and wellbeing strategies

8. Future engagement on health and wellbeing

8.1. The role of the HWB

The HWB provides a real opportunity to join up our approach to communicating and engaging with the people of Kent, so that it is systematically embedded across the whole of Kent's health and social care system.

In September 2011 work was carried out (telephone discussions and web based research) to identify the communication challenges and opportunities the HWB might face in carrying out its statutory duties and this helped inform the development of the strategy and action plan (the full report can be found at: https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=706&MId=4086&Ver=4).

The HWB will play a central role in planning and delivering future health and social care services and will need to ensure the public are informed of these discussions. The HWB will have a duty to involve users and the public in the development of both the JSNA and the HWBS and pay due regard to the Public Sector Equality Duty, which came into effect 5th April 2011.

The Equality Duty supports good decision-making – it encourages public bodies to understand how different people will be affected by their activities so that policies and services are appropriate and accessible to all and meet different people's needs. By understanding the effect of their activities on different people, and how inclusive public services can support and open up people's opportunities, public bodies are better placed to deliver policies and services that are efficient and effective. The Equality Duty therefore helps public bodies to deliver the Government's overall objectives for public services[6].

The involvement of the public is central to everything the Board does and there is a commitment to ensure effective communication and engagement takes place using existing and planned networks within LINks/LHW, Council, PCTs/CCGs and the voluntary sector. The public will have a stronger voice and will be kept informed on the areas being discussed taking place at the board.

Engagement on both the JSNA and the JHWS will be a continuous and iterative process and will include:

- Mapping any existing/current engagement, feedback and formal consultation related to any of the priorities within the JHWS
- capturing additional insights from the local population about their perceived health needs and priorities
- gaining information about what else is available within the community, for the community
- identification of gaps in service and information

[6] Government Equalities Office, June 201, Equality Act 2010:Public Sector Equality Duty What do I need to know?

8.2. Principles of engagement

In communicating and engaging with our community we will:

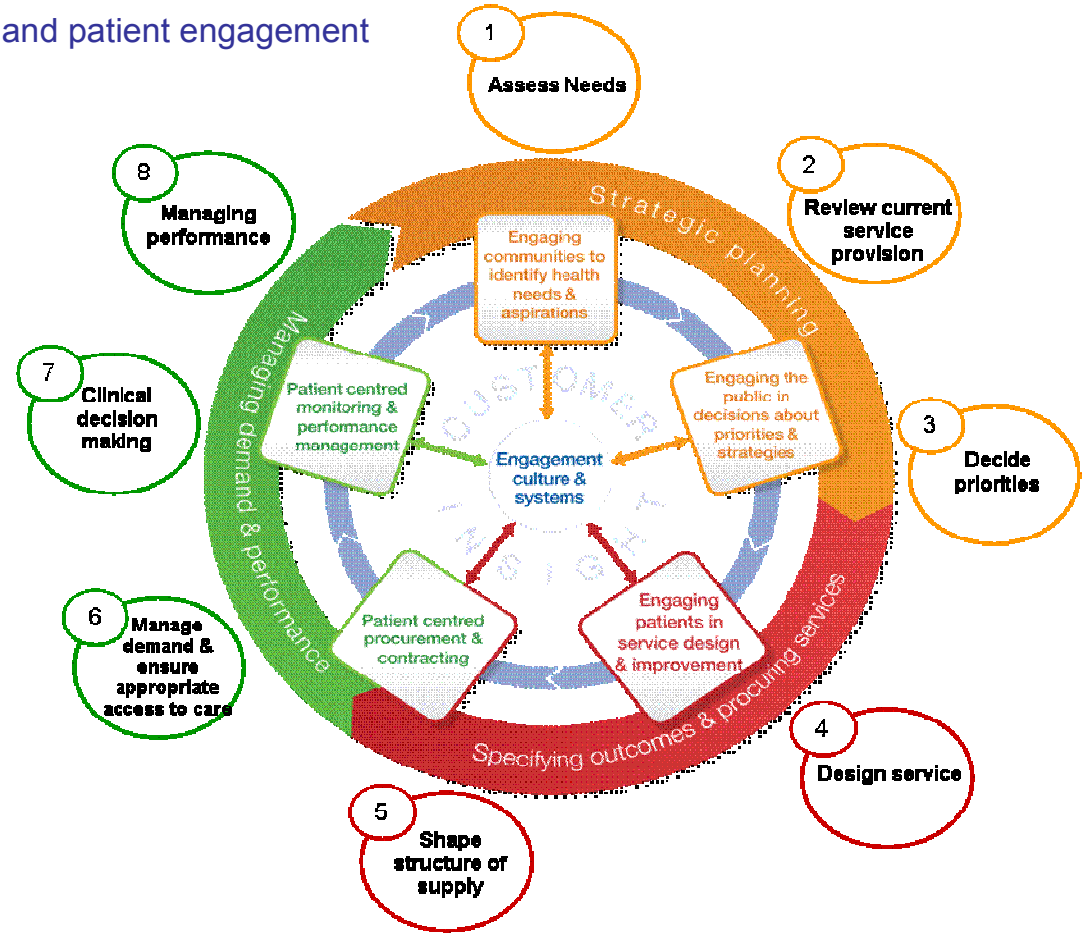
- build on what already exists, drawing on and using best practice from all the relevant organisations
- ensure communication and engagement underpins the work of the Health and Wellbeing Board so that it becomes part of its culture
- be open and transparent in how we engage and how we analyse and use engagement feedback and insights
- be inclusive and representative – ensuring that we reach diverse and seldom heard groups, either directly or through established networks
- work to establish and maintain robust relationships with all key stakeholders
- use a range of techniques to ensure wide and deep engagement
- use a wide range of communications channels (media, web, twitter etc) to ensure people have the relevant and most up-to-date information
- foster a culture of co-design with patients, public, key stakeholders and organisations
- adopt a 'whole system' approach to engagement, to make best use of resources and avoid duplication

8.3. Engaging in commissioning decisions

Proactively engaging patients, partners and other stakeholders ensures that services are shaped around local need and moves commissioning to the heart of the community, improving health outcomes, access and patient satisfaction. It also ensures that the needs of seldom heard groups are listened to and addressed, reducing health inequalities

The NHS Engagement Cycle, below, demonstrates how both public engagement and patient engagement activity should be reflected in all of the key stages in the commissioning cycle. Although this is NHS-focused, the principles can be adopted across health and social care and will be used as a framework for Kent HWB engagement.

Citizen and patient engagement



8.4. Using existing information/feedback

We will aim to build on what is already known, rather than reinvent the wheel, and will work together in identifying what is already known about the key issues within the JSNA, the priorities within the JHWS and related health and social care issues. We will work with all key organisations – commissioners, providers, voluntary organisations, LINks/LHW – to identify what information is already available.

Key sources will include:

- Kent LINk/Kent LHW
- Public Health Observatory
- National and local surveys/research/audits
- JSNA existing engagement
- JHWS engagement
- Provider services' Patient Advice and Liaison Services (PALS) and Patient Experience Groups
- Complaints and compliments received by commissioners and providers

- Patient experience and public engagement forums
- Specific interest patient/service user groups
- Carers groups
- Voluntary groups
- Patient Participation Groups in GP Practices
- Commissioner and provider websites – public facing information

8.5. Methods of engagement

There are many different approaches to engaging with patients, carers, public and stakeholders. The following is a list of methods used to gather information and views from patients and the public. Methods are not either/or, they each have different advantages and disadvantages. Application, however, requires a high level of specialist skill, knowledge and expertise to ensure that the engagement activity delivers what is required (for example, designing a questionnaire is seen to be quite a simple task but designing a successful questionnaire that delivers the desired results is a skill). It will be important to identify and adopt the most appropriate approach according to the required outcome.

8.5.1. Quantitative Methods:

- *Questionnaire surveys* –used to measure attitudes and motivations, emotions, behaviour and self-perception. Carried out one to one, by post, via the internet or distributed via local publications

- *Satisfaction surveys* – used to measure service users' satisfaction with a particular service or product – for example, a care home or an information leaflet

8.5.2. Qualitative Methods:

- *Interviews* – used to gather information about a particular subject, for example personal experience of a service. Can be administered in person or over the telephone

- *Focus Groups* – involve bringing together a group of people to explore their experiences/views or understanding of a particular service or health condition. Questions are asked in an interactive group setting and the conversation is recorded, transcribed and analysed for recurring themes and issues

- *Workshops* –used to bring people together to discuss, explore and identify potential solutions to an issue/area of interest/concern

- *Citizen panels* –recruiting volunteers (patients, carers, public) to give their views, as a panel, on a particular topic, concept or idea: for example hospital service changes, services provided in the community. Involvement in the patient panel may be through meetings, workshops or questionnaire

completion and participants should be provided with some background information

- *Citizens' juries* – 'jury members' – between 12 to 50 members of the public - consider a particular issue in great detail and make informed recommendations, following presentation of evidence, to service providers. This approach is useful in clarifying, identifying and drilling down into issues

- *Special interest groups* – designed to focus on specific areas of interest, such as a particular health condition, and can be short or long term depending on the expected outcomes from the group.

We will ensure that we adopt the right approach for the best outcomes when conducting any health and wellbeing engagement activity

8.6. Governance

It is proposed that a multi-organisational communications and engagement group be established to focus on providing a joint approach to communications and engagement and to contribute to and oversee all health and wellbeing communications and engagement work. The group to comprise communications and engagement leads from KCC, NHS Kent & Medway/Kent and Medway Commissioning Support Unit (KMCS) LINk/Local Healthwatch and nominated representatives from the SHWB.

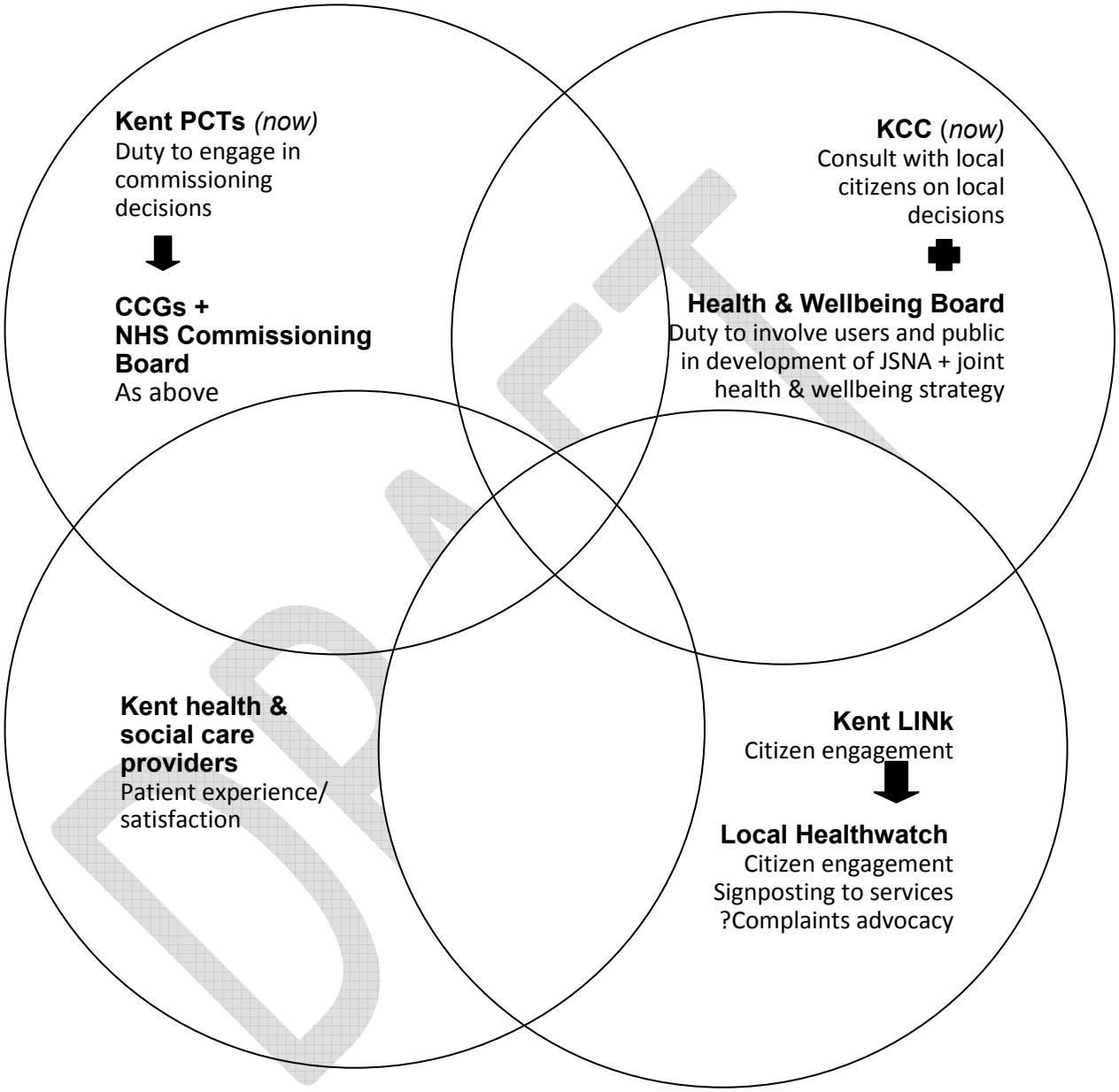
The remit of the group will be to:

- Share intelligence regarding insights/feedback on relevant health and wellbeing issues and priorities
- Plan communications and engagement programmes for JSNA 'refresh' and development/implementation of the JHWS
- Maximise the use of resources and opportunities to conduct joint communications and engagement activities
- Reduce duplication and engagement overload.

The group will report to the Health and Wellbeing Board and ensure reports are published demonstrating how the agreed activity has influenced the work of the Board.

8.7. Areas of discrete and complementary engagement responsibilities

Kent HWB provides a real opportunity for council, CCGs and LINk/LHW to underpin joint health and wellbeing planning and development with joint communications and engagement. The HWB will need to understand and work with health and social care commissioners' and providers' own engagement activities and responsibilities in order to successfully contribute to wide, deep and meaningful engagement.



A high level communications and engagement plan has been developed (Appendix 3) to ensure that the infrastructure is put in place over the next 6 months to deliver the engagement and communication requirements of the Health and Well-being Board from April 2013.

Communications and engagement resources in all partner organisations are limited, both in financial and human terms. These resources can be maximised by identifying and agreeing where engagement work can be conducted collectively (and agreeing where it needs to be done by an individual organisation to meet its statutory duties).

Patients, carers and public have also, in the past, expressed concern about the many requests for feedback on seemingly similar issues. By working collectively local people will experience a more coherent and systematic approach to engagement and involvement.

9. Conclusion

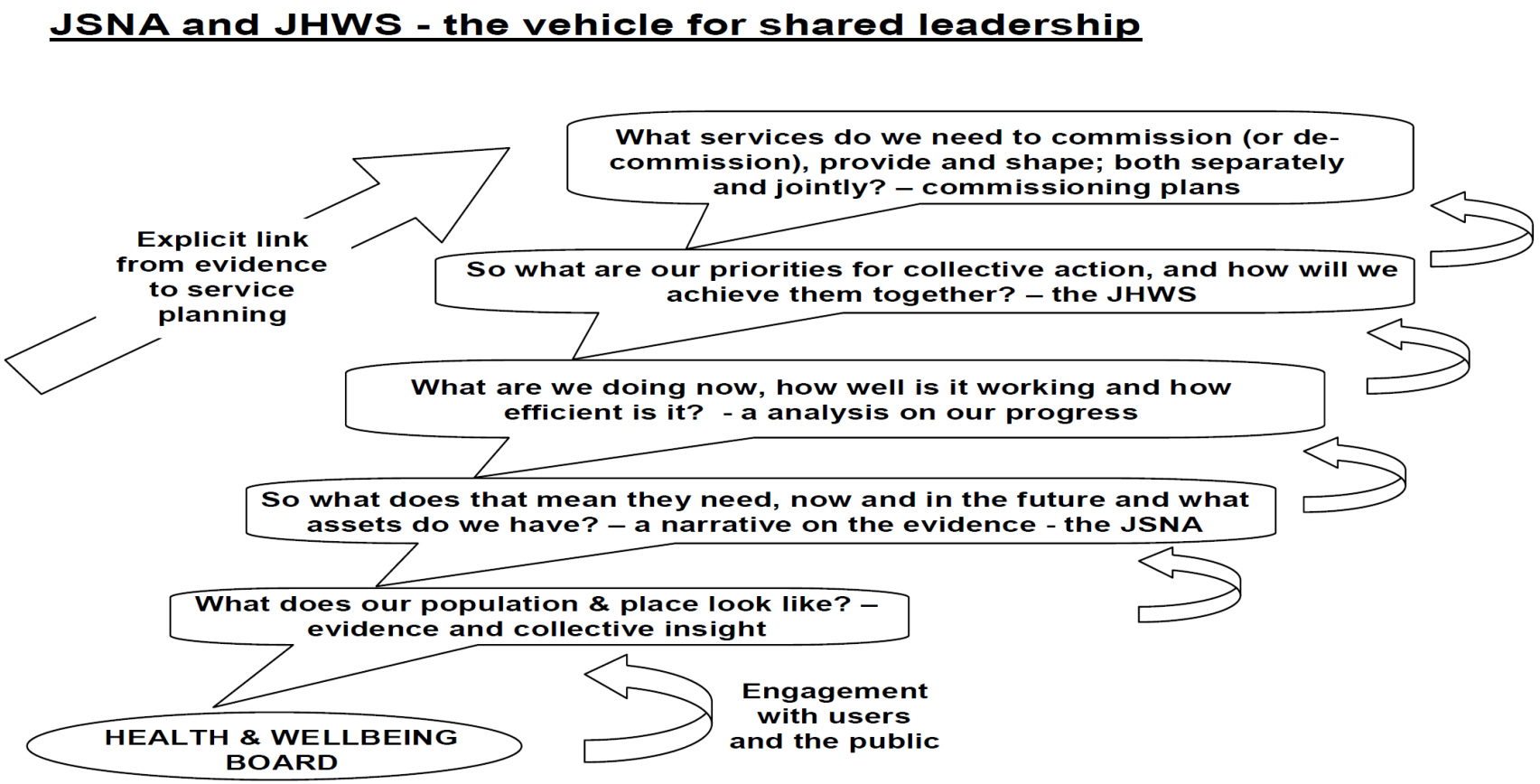
The HWB must operate in a transparent way that fully engages patients, service users, carers, communities and stakeholders enabling them to influence its work. This includes – but is not only - the JSNA and the development and implementation of the JHWS.

The SHWB is committed to involving patients, carers, public and a wide range of stakeholders in early and on-going discussions about all health and well-being plans, with a particular focus on health and health improvement and how we can work together to improve on these areas. We need to work with our communities to work towards better health and reduced health inequalities. This will be based on wide and deep engagement to capture feedback from a range of different people and groups on both our plans for and people's experiences of health and social care services.

To ensure successful and robust engagement in the future the Health and Wellbeing Board will need to:

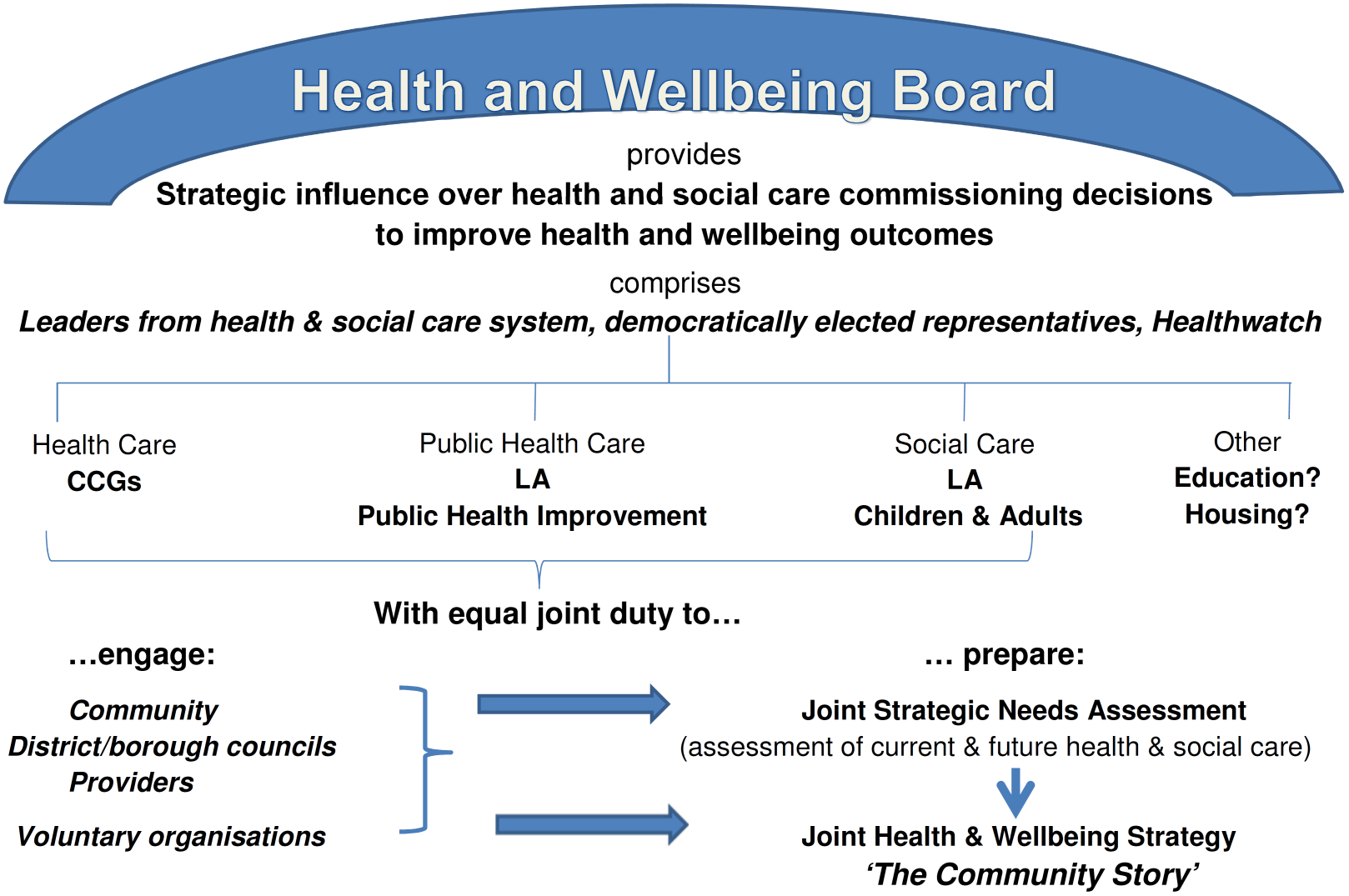
- take into account the specialist skills and technical knowledge needed to engage in health and social care engagement
- agree how the Board, collectively and individually, ensures deep and wide engagement with all the diverse communities within Kent
- identify what resources will be needed to meet the burgeoning engagement activity and to ensure the duty to involve is met
- draw upon the wide range of existing and future good practice to create a 'spider web' of feedback intelligence, avoid duplication and build on what is already known about our local services
- demonstrate how engagement has influenced the decisions it makes.

Appendix 1 – JSNA and JHWS leadership and engagement[7]



[7] Department of Health, 19 January 2012, Draft guidance on Joint Strategic Needs Assessments and joint health and wellbeing strategies

Appendix 2: Health and Wellbeing Board - overview



Appendix 3: Communications and Engagement Plan to April 2013

Milestones	Actions	Timescale	Lead(s)
Identify and develop effective engagement mechanisms to support the work of the SHWB	Agree proposed governance structure and membership of the Communications and Engagement Group (CEG)	September 2012	SHWB
	Review engagement requirements and scope engagement activity from April 2013	September – December 2012	SHWB/CEG
	Identify and agree the overall (and specialist) resource required to successfully complete the agreed programme of engagement activity	September-December 2012	SHWB/CEG
	Map and review current arrangements for consultation/ engagement covering health and social care	September/October 2012	CEG
	Identify how engagement/insights can be shared within and across organisations	September/October 2012	CEG
	Identify opportunities to streamline activities and develop proposals for joint engagement against JSNA and JHWS, particularly at 'refresh' points, and other HWB work programmes	September/October 2012	CEG – engagement leads
	Conduct a stakeholder mapping exercise to ensure appropriate engagement on SHWB programmes of work	September/October 2012	CEG
	Review and develop options for building an on-line presence for health and social care engagement related to the work of the HWBB	October/November 2012	CEG
	Agree engagement programme for JHWS priorities, once agreed	November/December 2012	CEG – engagement leads

	Agree and publish information materials to support the above	December 2012 – March 2013	CEG
Develop joint communication approaches regarding the work of the Health and Wellbeing Board	Raise awareness of the SHWB and its remit by agreeing and putting in place joint communication approaches	December 2012 – March 2013	CEG - Communications Leads
	Agree programme of key messages to be shared from the SHWB		SHWB
Work with local media to ensure understanding of the changes in the roles of the NHS and local authorities	Develop and manage a communication process, using appropriate media to effectively communicate key messages re local health priorities and developments to support the SHWB	September 2012	CEG – communications leads
	Produce and agree joint protocols for managing media and public messages, and resolving conflict.	September 2012	Working Group
Support the development of Healthwatch Kent	Work with Healthwatch development lead to ensure Healthwatch is actively engaged in the work of the HWB	September 2012- March 2013	Working Group
	Identify how Healthwatch Kent will contribute to HWB communications and engagement	September – December 2012	Working Group
Ensure SHWB members understand and value the engagement /involvement process and that it is a fundamental part of the Board's work	Develop a toolkit and provide learning opportunities to support SHWB's understanding of the requirements to engage/involve in service planning, development and monitoring	December 2012	Working Group