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.

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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.

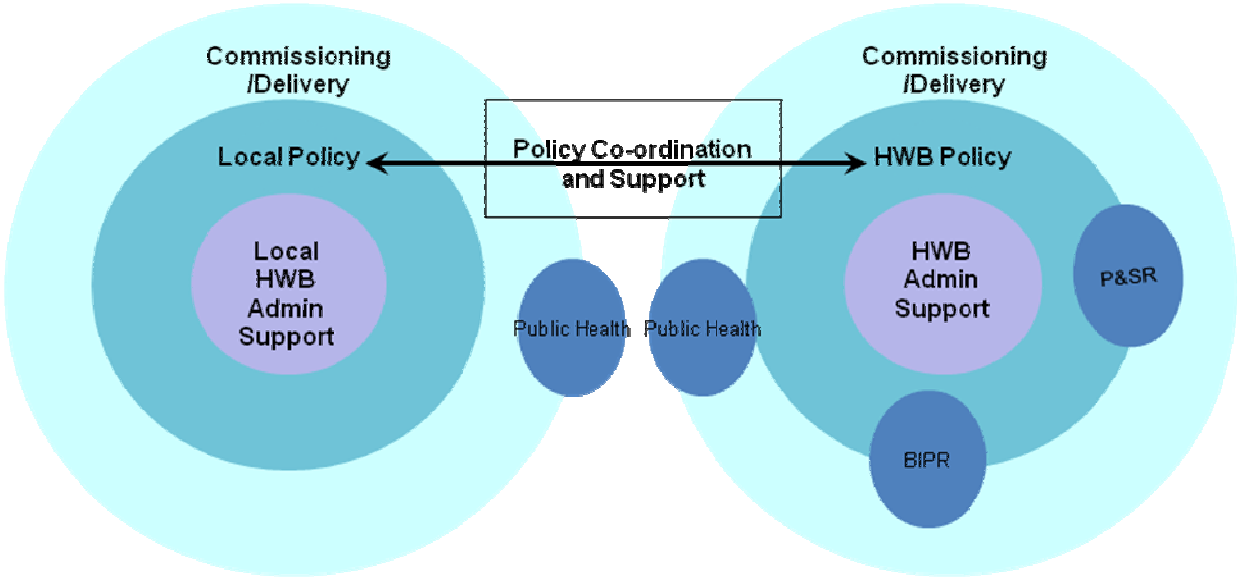
4.2. Irrespective of the type of sub architecture established for the Health and Wellbeing Board, KCC will need to ensure that it is confident that it has the knowledge and capacity to support the policy requirements of the Health and Wellbeing Board and the wider health and social care policy agenda. 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

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