KENT COUNTY COUNCIL

HEALTH AND WELLBEING BOARD (SHADOW)

MINUTES of a meeting of the Health and Wellbeing Board (Shadow) held in the Pendragon Room, Invicta House, County Hall, Maidstone on Wednesday, 19 September 2012.

PRESENT: Mr R W Gough (Chairman), Dr B Bowes, Ms H Buckingham (Substitute for Ms A Sutton), Mr P B Carter, Dr S Chaudhuri, Cllr J Cunningham, Mr G K Gibbens, Cllr L Ingham, Mr A Ireland (Corporate Director, Families and Social Care), Ms M Peachey (Kent Director of Public Health) Mr R Kendall, Cllr M Lyons, Dr T Martin, Dr R Pinnock, Cllr P Watkins and Mrs J Whittle

IN ATTENDANCE: Mrs S Adams (Staff Officer to the Cabinet Member for Families and Social Care) Ms D Benton (Staff Officer to the Cabinet Member for Business, Strategy, Performance and Health Reform), Ms C Davis (Strategic Business Advisor), Ms M Farrow (Leadership Support and Corporate Communication Manager, Dover District Council) Mr A Scott-Clark (Deputy Director of Public Health, NHS Eastern & Coastal Kent), Ms P Southern (Director of Learning Disability and Mental Health) and Mr P Wickenden (Democratic Services Transition Manager)

UNRESTRICTED ITEMS

58. 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.

59. Substitutes
(Item 2)

The following apologies were received and noted:

Mr Mark Lobban
Dr Fiona Armstrong

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

(1) Dr S Chaudhuri declared that he had a role within the Kent and Medway Social Care and Partnership Trust.

(2) Helen Buckingham indicated that the workshop session was not specifically dedicated to Mental Health; rather it was a case study which would help with the table discussions.

61. Minutes of the Meeting held on 18 July 2012
(Item 4)

(1) The Board agreed that the Minutes of the meeting held on 18 July 2012 were a correct record and that they be signed by the Chairman.

Matters Arising

(2) Further to Minute 54 of the 18 July Shadow Health and Wellbeing Board, Meradin Peachey and Helen Buckingham informed the Board that the Provider sub-group was meeting on the 1 October. The purpose of the meeting will be to consider what a Kent model for engagement with stakeholders should look like.

(3) Engagement would initially be with the major providers followed by the smaller providers and the voluntary sector.

(4) This engagement activity would help to inform the Joint Strategic Needs Assessment.

62. Establishing Local Healthwatch in Kent
(Item 5)

(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 users' voice is the creation of a new consumer champion – Healthwatch.

(2) The report outlined for the Shadow Board the progress on the programme of work being undertaken to ensure the successful establishment of Local Healthwatch (LHW) in Kent by 1 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.

(3) The Board noted the ongoing engagement with stakeholders in moving forward to the establishment of Local Healthwatch on 1 April 2013 and acknowledged that it would be in procurement mode between January and March. The Local Healthwatch Shadow Board was scheduled to meet shortly.

(4) Several Members of the Board spoke of the importance of the "patient voice" which is crucial in the development of Local Healthwatch.

(5) Mr Watkins and others were keen to ensure that the tender specification acknowledged the flexibility and strength of local areas in the commissioning arrangements.

(6) Dr Pinnock said that Local Healthwatch was not very local. He said that it was important that there was some kind of federated structure. He informed the Board that all Clinical Commissioning Groups (CCGs) had to have a lay Member on their Board.

(7) Mr Kendall stressed the importance of the “local voice” being included in the organisations where they exist.

(8) RESOLVED that the Shadow Health and Wellbeing Board note the work currently underway in developing the Local Healthwatch for Kent and acknowledge the importance of taking the local dimension into account. A further update would be brought back to the Board early next year.

63. Options for the development of the sub-architecture for the Kent Health and Wellbeing Board
(Item 6)

(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.

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

(3) The report before the Board focused on the development of the sub-architecture for Health and Wellbeing Board 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.

(4) 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.

(5) The Shadow Health and Wellbeing Board noted that whilst the County Council 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 this Board, that any sub committee will need to focus on a number of key areas to add value. These areas are:

(a) CCG level Integrated Commissioning Strategy and Plan;
(b) Ensure effective local engagement; and
(c) Local monitoring of outcomes

(6) It was also noted by the Board that the focus of any sub-architecture will need to be the 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 arrangements. In Kent, there are three options to consider:

(a) Option 1: Sub Committees based on CCG boundaries
(b) Option 2: Sub Committees based on District Council boundaries
(c) Option 3: Locality Boards

(7) The Shadow Board noted that there was widespread support for the establishment of CCG level Health and Wellbeing Boards as sub-committees of the Shadow Kent HWB. The CCG level Boards would retain local flexibility and would be developed in an informal way, with KCC officers meeting each CCG and local representatives to help establish these. It was noted that secondary regulations would be available in the autumn and the legislation itself is due to be laid in January 2013.

(8) Paul Carter, whilst supportive of the general thrust of the report, had some concerns over the re-configuration of Public Health. He was concerned that if the Board was not careful there would be another layer of meetings. He was keen to see a rationalisation of bodies to ensure that what was created were not just another opportunity to talk about issues without contributing to the health and wellbeing of the local population.

(9) Mr Watkins raised a concern that the report was silent about the issue of financial subsidiarity.

(10) Dr Pinnock agreed that there should be Local Health and Wellbeing Boards and its membership should include representatives of Public Health, Children's Centres, and the voluntary sector etc. He asked what functions will be devolved to the proposed local Health and Wellbeing Boards. How will issues such as "minding the gap" or equity be dealt with by these Local Boards. He concluded that for the CCG he represented to have a Local Health and Wellbeing Board was fine as the CCG boundaries were co-terminous with that of the Borough Council except for one village out and one village in, and the same could be said for Thanet. However, he added that if you look at West Kent the picture was very different.

(11) Dr Chaudhuri said the local Health and Wellbeing Boards were not accountable bodies. Dover and Shepway had already gone ahead and created their own local Health and Wellbeing Board.

(12) Paul Carter said in his view the Board should develop a model of what good looks like. Roger Pinnock added that he felt that Ashford Borough Council would probably welcome some support in establishing the Ashford CCG local Board and what functions would be devolved to the local HWB Board. Caroline Davis offered to meet with Ashford BC to take forward the development of the local board bilaterally.

(13) Meradin Peachey advised the Board that it would be important for the local Health and Wellbeing Boards to look at the Inequalities Gap particularly in looking at different parts of Public Health. She added the importance of building the Children's Trust into the model and said that the National Commissioning Board should not be overlooked.

(14) RESOLVED that the Kent Health and Wellbeing Board and Kent County Council working in partnership with the District Councils and Clinical Commissioning Groups develop a sub-architecture based on CCG boundaries.

64. Information Governance - an update

(Item 7)

(1) Following previous discussions at Board meetings on the issues of Information Governance, the Board noted the work carried out to date around the development of Information Governance arrangements for the implementation of the Kent and Medway Long Term Conditions Programme.

(2) 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. The sharing of coded data is critical for effective commissioning and the JSNA.

(3) 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 areas:

(a) the linking and sharing of health and social care data for robust population intelligence including risk stratification; and

(b) sharing of care records for effective real time patient care management by the multi-disciplinary health and social care integrated teams

(4) Roger Pinnock welcomed the report. He did however refer to the political dimension and the whole issue of confidentiality of data and the culture of different organisations. He spoke about the absurdity of being allowed to send handwritten confidential data in the post but not being allowed to transmit the same information electronically.

(5) Mr Watkins expressed the view that the bigger problem/barrier was within the local authorities. This was an issue where the local authorities should reach a collective agreement.

(6) Dr Chaudhuri said that "Patient Knows Best" tackles the issue of patient confidentiality and data sharing. Helen Buckingham said that the NHS constitution is also being updated to state that it will be assumed that the patient is happy for their data to be shared unless they clearly state otherwise.

(7) Mr Ireland advised the Board that he had particular concerns around the issue of "safeguarding". At the present time there was no way that this information could be transmitted securely using the existing technology

(8) Paul Carter suggested that one of the CCGs might want to tackle the issue and develop a model of what would work well and what "good" will look like. Helen Buckingham informed the Board that the CCGs were very actively involved in this issue.

(9) RESOLVED: that

(a) the report be noted and a further report be made to the Board early in the New Year, with a particular focus on "Patient Knows Best"; and

(b) the Chairman make representations to the Government on the Health and Wellbeing Boards behalf to tackle this important issue of data sharing. It was agreed that Abraham George, Helen Buckingham and Caroline Davis would prepare a joint statement.

65. Update on the development of the Kent Joint Health and Wellbeing Strategy
(Item 8)

(1) The Shadow Health and Wellbeing Board noted the comments of key partners on the updated draft of the Joint Health and Wellbeing Strategy (JHWS) ahead of the wider engagement process scheduled this autumn.

(2) The Board noted that the final version of the strategy will be published in December 2012. The wider consultations on the JHWS will take place alongside the development of the CCG Commissioning Plans for 2013/14.

(3) Dr Bowes said the Strategy needs to clearly state expectations and targets around "numbers for improvement". The document was fine but highly aspirational – it needed to reflect what could be achieved by the CCG. Each CGC needs to look at the Strategy and make it relevant to their area and evolve locally.

(4) Roger Pinnock said that the Kent Health and Wellbeing Strategy would not be perfect as this was the first year it had been produced. He added that working with a Local Health and Wellbeing Board for Ashford he would like to develop a meaningful strategy for Ashford.

(5) The Chairman indicated that the Strategy would be refreshed on an annual basis.

(6) RESOLVED that the report be noted and a further update be presented to the Board at the November meeting, with a focus on activity over the coming year.

66. Health Engagement: Developing engagement for Health in Kent
(Item 9)

(1) Julie Van Ruyckevelt Interim Head of Citizen Engagement for Health made a presentation to the Board on a Communications and Engagement Strategy.

(2) In a workshop session the following questions were addressed:

(a) What is the Board's role in ensuring that engagement successfully informs and underpins its programme of work?

(b) How can the engagement landscape be joined up more successfully to create a two way dialogue between the Board and each part of the Health and social care system?

(3) A summary of the table discussions is set out below:

Table 1

- If you engage 36 different groups you receive 36 different answers
- How do we manage engagement and the risk of getting too many answers back
- Rather than traditional engagement should we ask the public to prioritise
- How do you balance the silent majority and the vocal few
- There are concerns about the language used in engagement. It is important to communicate with the public at the level they would understand

Table 2

- What is the role of CCGs and the Health and Wellbeing Board in engagement
- Important to avoid duplication
- Suggest delegating the function to the Local Health and Wellbeing Board

Table 3

- What is the function of the Health and Wellbeing Board
- The Health and Wellbeing Board should be about assurance
- How should the providers be engaged

Table 4

- What is the programme of work for the Health and Wellbeing Board
- The Board should assure itself that what it is doing is right
- If there are examples of good practice in one part of the County this should be cascaded across the County
- There needs to be proper community engagement on the Joint Strategic Needs Assessment.
- What could be done centrally to utilise the skills more effectively
- What message are we trying to deliver to the public? The message of the Board is critical
- When you ask the public what they want, they ask for every service close by and available immediately. Should the public be given a list of services to prioritise instead? The public are very informed about where to go if they are concerned by a local decision. Are you going to consult in a way where you end up with a forced decision rather than the other way round

(4) Hazel Carpenter asked what commissioning support should look like. Where could CCGs get the best expertise from?

(5) Dr Tony Martin said that a huge amount of local engagement was essential.

(6) RESOLVED that a communications and engagement group be established to take forward the development of the Communication and Engagement Strategy taking into account the views expressed during the workshop.

67. Mental Health Reconfiguration: Achieving Excellence in Mental Health Crisis Care
(Item 10)

(1) Helen Buckingham, Director of Whole System Commissioning and Deputy Chief Executive, NHS Kent and Medway made a presentation using the proposed changes in mental health services as an example in the future to ask the Board:

(a) How would the Board expect the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy to identify the need for such changes?
(b) How would the Health and Wellbeing Board expect CCGs to work together with Kent County Council to lead such change?
(c) Who leads on public engagement and consultation?
(d) Who actually takes the decisions required to implement change?
(e) What are the respective roles of the Kent Health and Wellbeing Board, CCG Boards, the National Commissioning Board, Local Health and Wellbeing Boards the Kent County Council Health Overview and Scrutiny Committee?

(2) The following is a summary of the workshop discussions:

Table 1

- Suggest an Informal Leadership Group of CCG Leaders to come together and come to some sensible decisions at a Kent wide level

Table 2

- The Health and Wellbeing Board should identify issues through the Joint Strategic Needs Assessment. They should identify the needs before commissioning decisions are made. The Board should assure themselves that the process is appropriate and the service delivered represents Value for Money. Should Value for Money feature in the JSNA?
- The Local Health and Wellbeing Boards should consider the practicalities and implementation of the commissioning decisions
- Health Overview and Scrutiny should, where appropriate, be asking relevant questions and challenging proposals/decisions

Table 3

- More Boards more confusion
- Need a central list of what consultation is underway and who is leading it

(3) Bob Bowes said that the local issues should be addressed by the CCGs. We need to agree what the common problems are which CCGs can get together to deal with. How do we identify what those issues are? The larger issues should be dealt with by the Specialist Commissioning Boards.

(4) The Chairman added that it was important that the Joint Strategic Needs Assessment identified those issues which cut across geographical areas. Other issues can be determined at the local level.

(5) Bob Bowes said that the PCI services were excellent and a good example of commissioning which has worked well. How is the next PCI going to be commissioned? The HWB should have a key role to play.

68. Date of Next Meeting – 21 November 2012
(Item 11)

The Board noted that Professor Chris Bentley was to be invited to the November meeting of the Board and that his workshop would focus on health inequalities.