From:	Peter Oakford, Deputy Leader, Cabinet Member for Strategic Commissioning & Public Health and Chairman of the Kent Health and Wellbeing Board David Whittle, Director Strategy, Policy, Relationships and Corporate Assurance
To:	Health and Wellbeing Board – 20 September 2017
Subject:	Health and Wellbeing Board – future direction and fitness for purpose
Classification:	Unrestricted

Summary: This paper reports the findings of the review undertaken by the Chairman into the fitness for purpose and future focus of the Board in light of the development of the Kent and Medway STP.

Recommendations:

The Board is asked to:

a) **Note** findings of the review;
b) **Agree** that the Board should seek a role within the governance arrangements of the Kent and Medway STP;
c) **Agree** that the Chairman explore the creation of a joint Board with Medway Council to support the above recommendation.

1. Introduction:

1.1 At the last meeting of the Board it was agreed that the Chairman would undertake a review of the fitness for purpose and future direction of the Kent Health and Wellbeing Board (the Board) in light of the development of the Kent and Medway Sustainability and Transformation Plan (STP) and its impact. The Chairman agreed to visit/discuss the issue with each member of the Board to gauge their views and report back with findings and options. These visits/discussions took place throughout late July and August, and a list of those consulted is in Appendix A. This included current Board members, former Board members and other interested organisations/partners.

1.2 This report summarises the key issues raised during those discussions and sets out options for the Board to consider before agreeing next steps.

2. Background:

2.1 The Board is a formal committee of the County Council required by S.194 of the Health and Social Care Act 2012. The Board existed in shadow status from the summer of 2011, following Kent being given early implementer status by the Department of Health, and became fully operational on the 1st April 2013. The Act denotes the number of statutory members of the HWBB as:

- The Leader of the Council and/or their nominee
- Director of Adult Social Services for the local authority
- Director of Children's Services for the local authority
- Director of Public Health for the local authority
- A representative of the Local Healthwatch organisation
- A representative of each clinical commissioning group
- A general power of the local authority to appoint other persons as appropriate

2.2 S.197-199 establishes the Board as a forum for leaders from the local health and care system to jointly work to improve the health and well-being of the people in their area; reduce health inequalities, and promote the integration of services. It has a statutory duty to ensure the production of a joint strategic needs assessment and a joint health and wellbeing strategy, setting out priorities for local commissioning. It also needs to ensure the production of a Pharmaceutical Needs Assessment. These priorities then inform local authority and CCG commissioning plans.

2.3 Health and Wellbeing Boards have limited formal powers and were constituted as a partnership forum rather than an executive decision-making body, with executive authority for health and social care commissioning remaining with the CCG governing body or the local authority Cabinet. This reflects the intention of the Health and Social Care Act 2012 to create CCGs as the statutory vehicle for the commissioning of health services for their local population, and a clear statutory demarcation between commissioning and service provision within the health system. In only a limited number of examples, usually smaller unitary/metropolitan council area has a local authority Cabinet delegated executive decision-making authority to a Health and Wellbeing Board.

2.4 In Kent, the Board also created local Health and Wellbeing Boards (following Clinical Commissioning Group boundaries) as sub-committees of the main Board. This followed the Department of Health giving both the County Council and Dover District Council early implementer status in 2011 (although district councils held no formal role under the Act) and there was an appetite across CCGs and the District Councils for local Boards to support local planning, integration and engagement. It is worth noting that the other two-tier authorities given early implementer status (Hertfordshire & St Albans and Suffolk & Great Yarmouth) did not follow through to create a local Board structure. It was also agreed that three representatives from District Councils, nominated by the Kent Council Leaders group, would sit as members of the Board.

2.5 In March 2014, the Board also agreed to establish a Children's Health and Wellbeing Board as an informal working group reporting to the Board. The aim of the Children's Board is to ensure a clear link between the commissioning of children's services and the priorities set out in JSNA and the Health and Wellbeing Strategy as required under S.7 of the Children and Families Act 2014. It also supports the general duty on all partners for inter-agency cooperation to improve the welfare of children as set out in S.10 of the Children Act 2004.

2.6 It should be noted that while the statutory requirements as to membership and purpose of the Board is set out in the statute, there was an expectation from the Government that Health and Wellbeing Boards would develop beyond this limited statutory role as new partnership arrangements matured. As such, there is scope for variability in the focus and operation of the Board while still complying with the statutory limitations of the 2012 Act.

3. The development and focus of the Board

3.1 Many of those interviewed commented on the success of the previous Chairman in personally driving the development of the Board from the early implementer stage. In particular, there was a consensus that this had allowed members to forge cross-sector relationships that had not previously existed, and develop a pan-Kent view of the health and social care system. There was agreement that these 'softer' benefits should neither be underplayed nor lost in any reforms, as effective relationships across the different sectors are critical.

3.2 In particular, the advantage of the Board was particularly felt by clinical leads who found its broader consideration of health and well-being to be important. Discussions on the wider determinants of health such as social care, public health, housing, leisure etc. were seen as critical to supporting primary care, given the increasing demand for primary care can only be met through greater social prescribing and signposting to services provided by wider public services.

3.3 However, there was a broad degree of frustration from Board members regarding its limited role and in particular its lack of decision-making powers (beyond approving the JSNA, HWB

Strategy and PNA). There was agreement that this led to items being ‘show and tell’ narratives, where different partners in the system would inform other partners of their plans and strategies but with only limited reference to the wider pan-Kent issues, and limited scope for board members to influence those plans and activities. As such, members felt the Board wasn’t adding value in the way it could or should do. Non-members interviewed expressed frustration that the influence of the Board wasn’t felt across the wider health and social care system or the wider Kent public service landscape.

3.4 Some interviewees expressed the view that the Health and Wellbeing Board should be a mechanism for collectively holding the health and social care system to account for delivery. However, a counter view put forward by some was that as a committee of the County Council, which is meeting in public and with elected politicians as members, such collective peer challenge was unrealistic. They feel the Board is not a suitable forum for ‘difficult discussions’ on system performance, and that such conversations take place through better alternative forums.

3.5 There is consensus from all Board members that the emergence of the STP is a game changer. At a practical level, the STP governance arrangements and programme delivery are now driving the day-to-day activity of Board members, both CCG and KCC, as well as a requiring a significant degree of capacity and capability of the resources from their respective organisations. As a consequence, this is leading to meeting fatigue and prioritisation of effort more carefully. Given this, many Board members feel that they cannot prioritise engagement with the Health and Wellbeing Board while the STP is so resource intensive.

3.6 Moreover, in responding to the policy direction set by NHS England through the *Five Year Forward View,* the STP is blurring the demarcation between health commissioners and providers in favour of an integrated planning framework across the health and social care system. As such, the operating environment set for the Board through the 2012 Act is being radically transformed, even if the legal framework lags behind. It is felt that the Board must respond to this changing operating environment if it is to remain relevant.

3.7 There was broad agreement that it was the right time to review the role and fitness for the purpose of the Board. However, given the fluid nature of the health and social care system as a result of the STP, it was felt that any new arrangements would need to be revisited again in 18-24 months to ensure that they were still appropriate.

4. The role of the Board vis-à-vis the STP

4.1 Given the current prominence of the STP, there was agreement that its successful development and delivery is the short-term (1-2 years) priority for the health and social care system in Kent. There was also agreement that as a statutory committee with a remit covering health and social care, a membership drawn from across both sectors and a role in promoting integration, that the Board should play a significant role within the STP. There was also a strong view expressed by the majority of interviewees that if the HWBB were to have a more formal role within the STP, then it should be at a Kent and Medway geography, as this is the spatial scale of the STP. This would require the creation of a joint Health and Wellbeing Board between KCC and Medway Council.

4.2 The difficulty is that while there was a substantial degree of consensus that the Board *should* have a role within the STP, there was limited clarity about *what* that role should be and how it could be discharged in practice. Presuming that a joint Kent and Medway joint Board is possible, options put forward included:

a) **Strategic oversight:** Given national political and media interest in STP development, and the requirement of NHS England for all STPs to have local public and partner support, some interviewees suggested that the Board could have a strategic oversight role over STP development and delivery. As such, the Board might consider the STP a ‘third pillar’ of its responsibilities alongside the JSNA and the Health and Wellbeing Strategy. This was particularly

supported by those who expressed concern about the opaque and unclear accountability arrangements for the STP. However, it can be argued that given the number of STP updates considered by the Board already this year, it already acts as a form of strategic oversight. Moreover, this option is limited by the fact that even within the STP, there is no single decision-making authority and any proposals for change currently require sign off by each CCG governing body and, if necessary, local authority Cabinet. Without knowing what strategic oversight means beyond what the Board is already doing, this option risks the new joint Board with Medway merely becoming a talking shop sitting above the STP. Also, as some decisions emanating from the STP will likely be significant service changes, there is a risk that a 'strategic oversight' role duplicates the statutory role of Health Overview and Scrutiny Committees in considering service reconfiguration proposals.

b) **Act as the STP Programme Board:** Some suggested that given many members on the Board also sit on the STP Programme Board, the Health and Wellbeing Board could take on that responsibility. While possible, it needs to be remembered that there are organisations on the Programme Board that are not on the Health and Wellbeing Board, in particular, some health providers and other representative bodies (such as the Local Medical Committee). There is also the added complexity that the Programme Board is in the process of recruiting an independent Chairman, and is supported by external consultancy given the demands of the STP and the need for frequent Programme Board meetings. Transposing Programme Board responsibilities to a joint Health and Wellbeing Board is not straightforward.

c) **Work stream lead responsibility:** Another option suggested by a number of interviewees was that a joint Board should take a greater responsibility and accountability for the development of specific work streams within the STP, in particular, those work streams where local government and social care have a particular interest because of the potential impact on local authority social care and public health budgets, staffing and commissioning arrangements. The two work streams most frequently suggested where the 'Local Care' and 'Prevention'. It was broadly felt that while these were essential to the delivery of a new health and social care model, the STPs immediate focus on acute service sustainability meant they are not as prominent in the STP as they could be. It was felt that placing them under the auspices of a joint Board would give them the necessary ownership to be developed at a greater pace.

4.3 It was widely recognised that if there was an appetite for a greater role within the STP, then this would drive business and agenda in the short-term bar any continued statutory responsibilities for the JSNA, Strategy and Pharmaceutical Needs Assessment. This did raise some words of caution, particularly from clinicians, that the important focus on the wider determinants of health should not be lost given that post-STP, these issues will still be fundamental to dealing with future demand pressures.

4.4 Indeed, when asked what the Board should focus on if it were *not* able to integrate with the STP or form a joint Board with Medway, the majority of interviewees suggested that a sharper focus on the wider determinants of health, particularly on a smaller number of priorities identified through the forthcoming refresh of the Health and Wellbeing Strategy. This would, however, have to be achieved through fewer Board meetings as the resource demands of the STP would remain.

5. Membership

5.1 The issue of the membership of the Board was the area of least agreement amongst those interviewed. Whilst there was an acceptance that if the Board took on a formal role in the STP its membership would have to change to discharge that role, on the general principle of membership there was little agreement, and a general concern that changing the membership of the Board would change the nature of discussions and detrimentally impact on meeting management.

5.2 Although the Kent Board chose to establish itself as a board of commissioners, there are a number of examples of Health and Wellbeing Boards including health providers on the Board itself

(normally as non-voting members) or creating specific mechanisms to engage health providers. Some interviewees expressed support for inviting representatives from acute, primary and community providers in Kent onto the Board on the basis that the STP and wider policy agenda for health is removing the absolute demarcation between commissioning and provision, and there was no logic for the Board in keeping it. Others expressed sympathy for this view but were concerned about the practical implications of inviting more members onto a Board that already has a large membership.

5.3 Others thought that inviting providers onto the Board was not only impractical but would have unintended consequences. In particular, there was concern that a focus from providers on short-term delivery would skew discussions away from the strategic issues that is the remit of the Board. Unsurprisingly, the providers interviewed thought that they should be represented on the Board, as the Board is better served by having as much input from clinicians as possible, and provider organisations were more clinically focussed. In particular, they argued they would be able to support the delivery of the Boards objectives more directly by being members, and that the Board would provide an appropriate vehicle currently for providers to engage in strategic planning conversations.

5.4 The issue of broadening the membership to wider public service partners was also considered during interviews. Whilst it was felt that this would not be appropriate if the Board was focussed on a role within the STP, if focussed on wider determinants, there was general agreement that would be beneficial, although some concern as to the impact on the management of the meetings. The Police and Crime Commissioner would like to be included as a member of the Board, given the strong link between demand on police services and mental health.

5.5 Repeatedly throughout the review process, Board members thought a representative from the state education sector would be a positive step given the importance of schools, education and training to the future health and wellbeing of the population and reducing health inequalities. It was suggested that the Association of Kent Head teachers might be appropriate to become a member of the Board. Alongside education, the most frequently referenced wider public sector partner whom it was felt should be represented on the Board was housing. This representative could come from one of the housing associations operating in Kent or a representative from the Kent Housing Group, the officer group of district council housing officers that acts as a pan-Kent coordinating body.

6. Agenda planning and meeting management

6.1 Another issue that was frequently referenced by those interviewed were concerns about meeting management. In particular, numerous interviewees raised concerns that the Board frequently has too many agenda items to discharge, and that there was a tendency for the time available in meetings to be focussed on just a single (and often the first substantive) item, with other items having to effectively be rushed through without appropriate consideration.

6.2 It was generally recognised that this was a consequence of the Board having too greater scope and not focussing on more specific objectives and priorities. There has become a tendency to treat the Boards consideration of an item as a ‘tick box’ exercise that was adding unnecessary items to the agenda. Some health members felt that they had not done enough to support the local authority in developing an appropriate forward plan and ensure appropriate agendas were set for the Board.

7. Meeting arrangements

7.1 There was some concern about the meeting arrangements of the Board including the bi-monthly meeting schedule and timing the start of meetings in the early evenings. This is difficult for members who have to travel long distances home in the late evening from Maidstone. The meeting schedule necessary to support the STP has compounded this matter for some Board members.

7.2 The rationale for the evening meetings lies in the initial establishment of the Board at early implementer stage in 2011. At the time, clinical leads were combining their new CCG leadership roles with GP surgeries, and evening meetings were deemed the best way to allow clinical leads to attend. The bi-monthly meeting frequency was, again, set at early implementer stage as this was necessary to discharge the business of the Board. However, it is worth noting that the terms of reference for the Board only require it to meet quarterly.

8. Local Health and Wellbeing Boards

8.1 As noted in paragraph 2.4 the Board established local Health and Wellbeing Boards as a response to the concurrent early implementer status given to both KCC and Dover District Council in 2011. From the interviewees who had experience of local Boards (not all did) there were very mixed views about them. In some CCG areas the local Boards had found a niche role, and promoted wider engagement with partners at a local level, and as such were valued. In other areas, the Boards have fallen away and were no longer meeting. All respondents felt that the links between the main Board and the local Boards were weak, and the issue of lack of decision-making powers at the main Board was replicated in local Boards.

8.2 A number of respondents made the point that the future of local Boards couldn't be separated from the STP, as they also contributed to the feeling of meeting overload, but also because there is an emerging place based sub-structure for delivery of the STP. There is also widespread expectation that whatever new integrated health and social care arrangements might be created through the STP, these will have a local footprint (most likely through Accountable Care Systems) that would inevitably further challenge the purpose and role of local Boards.

8.3 It was broadly felt that trying to 'sort out' local Boards and bring them back to having some uniform, standardised role with stronger links back to the countywide Board would be both impractical and should not be an immediate priority given other pressures.

9. Children's Health and Wellbeing Board

9.1 Not all those interviewed as part of the review had experience of the Children's Health and Wellbeing Board. There was as mixed response about whether it should continue to sit as a informal subcommittee of the main Board. On the one hand, there was a strong view from some interviewees that if the aim of the Board was to impact on the wider determinants of health, such longitudinal change must start by a focus on children as part of the preventative agenda, and therefore children's issues should be a core focus of the main Board.

9.2 Conversely there was also a view put forward that the integration of health and children's social care in Kent is lagging behind the progress made in other areas of the country, and as such, a separate Children's Health and Wellbeing Board can provide a vehicle for progressing that agenda more quickly given it provides an appropriate, and specific, engagement vehicle. In the future, should the integration of children's health and social care progress, it was suggested that the Children's Board could exist as a decision-making committee in its own right. It was certainly felt by a number of interviewees that the current lack of a focus on children's issues in the STP made having a specific vehicle for engaging on children's issues necessary.

10. Discussion and next steps

10.1 If we accept that form should follow function, then the fundamental decision, from which other issues and decisions (e.g. membership, agenda planning, sub-board arrangements) will flow, is what role, if any, the Board should seek to have within the STP?

10.2 It is important to recognise that the Board cannot unilaterally decide to integrate itself into the STP governance arrangements. The STP is a separate entity. It is developing its own governance and support arrangements. As a change programme it needs to be flexible and adaptable to both

local and national requirements. Its membership is broader than the Board's. If the Board does feel it should have a role within the STP, this needs to be negotiated and there must be consensus about what the role is to be, and how it should be discharged.

10.3 Moreover, if the Board is to have a role in the STP, the consensus is that it must operate at a Kent and Medway. The Kent Board cannot do this unilaterally as it would require the creation of a Joint Health and Wellbeing Board between Medway Council and Kent County Council. Both Councils would formally have to agree, and Medway Council are under no requirement or obligation to do so. If Medway Council did agree, then the Kent Board would likely need to delegate much of its functions to the new joint Board for the period it is in place.

10.4 If Medway Council does not agree, then we should not expend time and resource seeking to persuade. Instead, we should default to the option identified in para 4.4 and on which there was broad agreement through the review, to refocus the Kent Board on the wider determinants of health, agree fewer specific and actionable objectives, and pare down the forward agenda and meeting requirements accordingly.

10.5 Initial conversations with Medway Council leadership have taken place about the appetite to create a joint Health and Wellbeing Board. Medway Council are willing to explore the creation of a joint Board, on a without prejudice basis, and KCC and Medway officers have been tasked to prepare reports on the options and practicalities for the operation of a joint Board, to be considered by both Councils' senior leadership later this month. An update on those discussions will be provided to the next Board meeting.

11. Recommendations:

11.1 The Board is asked to:

a) Note findings of the review;
b) Agree that the Board should seek a role within the governance arrangements of the Kent and Medway STP;
c) Agree to explore the creation of a joint Board with Medway Council to support the above recommendation.

Background Documents:

- Terms of reference and governance arrangements for the Kent Health and Wellbeing Board, Kent County Council, 28 March 2013 available at: https://democracy.kent.gov.uk/documents/s38976/Appendix%20A%20-%20Delivering%20Better%20Healthcare%20for%20Kent.pdf

Appendix:

- Appendix 1: Persons consulted as part of the review

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Appendix A: Interviewees as part of the review:

- Felicity Cox, Director Commissioning Operations South (South East), NHS England
- Dr Fiona Armstrong, Swale CCG Chair
- Dr Elizabeth Lunt, Clinical Chair for Dartford, Gravesham & Swanley CCG
- Patricia Davies, Accountable Officer, Dartford, Gravesham & Swanley CCG and Swale CCG
- Simon Perks, Accountable Officer, Ashford CCG and Canterbury & Coastal CCG
- Simon Dunn, Clinical Chair - Canterbury & Coastal CCG
- Dr Bob Bowes, Chair of West Kent CCG
- Dave Holman, Head of Mental Health Commissioning for West Kent CCG
- Ian Ayres, Accountable Officer – West Kent CCG
- Dr Tony Martin, Clinical Chair, Thanet CCG
- Dr Jonathan Bryant, Clinical Chair, South Kent Coast CCG
- Dr Joe Chaudhuri, Governing Body Member, South Kent Coast CCG
- Hazel Carpenter, Accountable Officer – South Kent Coast CCG and Thanet CCG
- Steve Inett, Chief Executive – Healthwatch
- Paul Bentley, Chief Executive, Kent Community Health Foundation Trust
- Dr. Mike Parks, Kent Local Medical Committee
- Dr. Gaurav Gupta, Kent Local Medical committee
- Matthew Scott, Kent Police and Crime Commissioner
- Cllr Paul Watkins, Leader of Dover District Council
- Cllr Fay Gooch, Deputy Leader, Maidstone Borough Council
- Cllr Ken Pugh, Swale Borough Council
- William Benson, Chief Executive, Tunbridge Wells District Council
- Roger Gough, Cabinet Member for Children, Young People and Education, KCC
- Andrew Ireland, Corporate Director - Social Care, Health and Wellbeing, KCC
- Graham Gibbens, Cabinet Member for Adult Social Care and Health, KCC
- Andrew Scott-Clark, Director for Public Health, KCC