Collaborative notes

Health and wellbeing board action learning sets

National sharing event: Hammersmith, London, 24 April 2012

Collated contributions from;

- Catherine Mullins – Royal Borough of Windsor and Maidenhead Council
- Eddy McDowall – Health and Social Care Partnership
- Kieth Naylor – Bracknell Forest Council
- Martin Day – Southampton City Council
- Nazia Idries – Slough Borough Council
- Samantha Hudson – Hampshire County Council

Attendance at every workshop was not possible for individuals and breadth of information on each action learning set reflects this and not necessarily how much information was available

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Introduction

This was the third event in sharing products and thoughts from the 11 action learning sets (across 7 themes) for health and wellbeing boards.

Draft products are now available from: https://knowledgehub.local.gov.uk/group/nationallearningnetworkforhealthandwellbeingboards/forum?p_p_id=19&p_p_lifecycle=0&p_p_state=normal&p_p_mode=view&p_p_col_id=column-1&p_p_col_pos=1&p_p_col_count=2&_19_struts_action=%2Fmessage_boards%2Fview_thread&_19_categoryId=7583155. :

A: Improving the health of the population

B: Bringing collaborative leadership to major service configuration

C: Creating effective governance arrangements

D: How do we hard-wire public engagement into the work of the board?

E: Raising the bar on JSNA and JHWS

F: Making the best use of collective resources

G1: Improving services through more effective joint working – adults

G2: Improving services through more effective joint working – children and families

Please also see the webinars (video presentations) for each action learning set at:

https://knowledgehub.local.gov.uk/group/nationallearningnetworkforhealthandwellbeingboards/forum/-/message_boards/message/6814015

It appears that each locality is operating HWBs in the way that suits them best (in the spirit and intention of localism) and some are still at the forming stage. A recurring theme is that the wider determinants of health need to be included rather than just health, e.g.; Newcastle

stated their HWB was about wellbeing not just health. Some localities are more advanced (have had more meetings) and meet in public, and therefore there is some demand from other external agencies to be involved in HWBs, e.g.; opticians, dentists, etc.

An emerging question is how does the HWB ensure it includes all relevant stakeholders, but tight (light) enough to develop a clear, strategic direction as it begins to do business in the shadow year?

Speakers

John Wilderspin, National Transition Director, DH

Health and wellbeing boards are now looking at constructive challenge following 'phoney war'.

JW referenced the Kings Fund report *Health and wellbeing boards System leaders or talking shops, April 2012*:

Key words for the event:

- Enjoy
- Learn
- Reflect

David Behan, Director General for Social Care and Local Government, DH

- Key words for the event:
    - Lead
    - Collaborate
    - Engage
- Move from:
    - Relationship between health and local government defined by HOSC to transactional focus to strategic leadership across systems
- Transformational leadership needs to be driven by the vision and ambition of people sitting on HWBs.
- Transactional leadership driven by process and technical decisions
- HWB to support and challenge players in the system whilst supporting learning, growth and development.
- Key question: how do we get better care, better health, better value?
- HWB challenges:
    - Premature mortality
    - Independent lives and choices about dying at home
- Vital to HWB success:
    - High degrees of challenge *and* support
- People and pace:
    - Some HWBs into 8th or 9th meeting, some yet to start. [Sub-text: encourage late starters to finalise membership and settle local CCG structure]
    - Delay in introduction of key people means possible freezing out of new members – 'this is the way we do things around here' – effort is required to ensure that new members coming later in the year should do not feel marginalised (e.g. confirmed CCG leads and public voice/ local Healthwatch representative)
- How will HWBs know when they have delivered?
- Is governance in proper proportion to action?
- **HWBs not leading change in organisations, but leading change across systems**

Professor Steve Field, CBE and Chair of Future Forum

- HWB challenge: fair, open access to health in tune with NHS constitution
    - a duty on the Secretary of State to respond to health inequalities
    - Access to primary care is essential and it is important that most vulnerable people and hard to reach groups are not denied access.
    - Success references about working to support people who are not registered with a GP
- Embrace the general direction of Dilnot – even if figures need further clarity
- HWBs must recite the NHS outcomes framework - 5 national outcome goals
- Marmot summary document sets out the job the HWB is there to do
- Interventions should be:
    - Evidence based
    - Outcome oriented and performance managed
    - Systematically applied

Dr Ruth Hussey OBE, Director of PHE Transition Team

Why health outcomes matter to all of us

- Consider:
    - People
    - Power – to make a difference
    - Place – to make it happen
    - Personal – we all have a role: it affects us all and we need to take responsibility ourselves
- Is there an understanding for the choices that people make, health behaviours, in the JSNA / JHWS to understand effective interventions?
- PH does not have to be a solely long term agenda, there are health improvements in short term, evaluation is key to demonstrate outcomes and health gains with economics, especially for healthy life expectancy.
- Where do we want to be in 3 years' time?
    - Why are people making certain health choices? A debate about what we are doing and why
    - Holistic services – prevention services will be wrapped around people's circumstances
    - Health and social care policy being made alongside economic and environmental policies
    - Results – real tangible change by being demanding and looking for results in:
        - Focus on 0-3 years
        - Breaking the cycle
        - Focus on families
        - Health at work
        - Chronic disease management
        - Creating health expectancy
    - Partnerships deeply embedded working on community objectives

- PHE development - next 3-6 months:
    - Local areas have submitted transition plans, they are being tuned and should have sign off by end of May.
    - Chief executive of PHE, Duncan Selby, starts in July 2012
    - Policy resolution
    - Transformational agenda
    - 1st April 2013 – lights on, doing what's needed
- Large scale change:
    - Narrative and numbers: the heart and the head to make JSNA / JHWS understood
    - Develop trust in ourselves, each other and in the system as we go forward
    - 5th wave of PH:
        - Housing and sanitation
        - Germ theory and vaccine development
        - Medicine and clinical interventions
        - Lifestyles
        - Interconnection and impact on wellbeing and public health
- Illness is solitary, wellness needs other people

Question about funding allocation: DH will look at figures again (November for final allocation) and a national formula will be published to show how funding totals have been reached.

Action learning set themes: draft products and notes from themed workshops

A: Improving the health of the population

Action learning set products:

- Assets-based approach – Cornwall
- Case studies on place shaping and health inequalities
- Health Impact Assessment – 1 page brief
- Video interview with Nottingham change makers (to be confirmed)

B: Bringing collaborative leadership to major service configuration

Action learning set products:

- Tips for councillors in understanding the NHS
- Tips for GPs in understanding local government

- Top tips for HWBs regarding service reconfiguration
- Top tips for GPS and elected members working together
- Case studies on reconfiguration and collaborative working
- Short best practice guide on fostering collective leadership based on literature review (to be confirmed)

Workshop notes: case study on Middlesbrough: unitary of 140,000 people, 2 CCGs

- HWB likened to a football team that hadn't played together before. HWB includes local acute hospital (main employers in the town and 1 mile from most deprived part of the locality)
- Looking at potentially pooling GP budgets
- Middlesbrough LINk: "an opportunity for a true partnership"
- HWB challenges:
  - Language of health and local government
  - Diary management
  - Familiarity of some HWB members, and unfamiliarity of others
  - Potential of tokenistic representation of the public voice
  - Thinking outside of the meetings culture
  - Understanding shared priorities
  - Empowering (operational) people closer to the delivery of care
  - Bringing in 3rd sector voices alongside patients/ service users
  - Systemic mis-matches, e.g.; finance, data collection
- Middlesbrough HWB role:
  - The 'day job': JSNA and JHWS
  - Commissioning principles: all to address key priorities that can be delivered and develop commissioning commonality
- Leadership lessons:
  - Relationships are key
  - Make the complex simple, without over-simplifying
  - You could write a book: it won't solve the problem

Lessons from Action Learning Set B:

- HWBs are about collaborative leadership not organisational survival
- HWBs need a clear strategy setting out the vision with actions and understanding at all levels
- Awareness of political sensitivities: (HWBs will take the bullet from local MP for closure of local hospital for eg)
- HWBs setting out with ongoing turbulence in national and local structures
- Tendency for health and social care to be distant partners – need a whole system approach

- Hospital is part of the system, not an end in itself – include providers
- Crucial to engage other elected members and GPs not on HWB
- Balancing integration with plurality in provider market
- Commissioning support service
- Public involvement/ engagement at an early stage: HWB is not a process for a set of suits
- Awareness and knowledge of leadership behaviours and their input

C: Creating effective governance arrangements

Action learning set products:

- Discussion paper on hard and soft wiring the board

Workshop notes: Presentation – IoW and Hinckley & Bosworth District Council

- Challenges for DH and government to be facilitative not directive
- Local systems need to work out for themselves how HWB fits in with and relates to HOSC/ LSP

Issues to consider for your HWB

- Scope, extent and authority of HWB at local level – none of the HWBs in this ALS were decision-making bodies in their own right, but had to take Qs back or come prepared.
- Membership – number of people vs. pace of change
- Structures – integration
- Priorities – what will it do?
- Performance framework – how will account for itself?
- How to earn autonomy
- Future proof itself against political changes
- Number of players on their way – PCT cluster seen as nearest thing to NHS CB

Issues around relationships

- With new NHS architecture (PHE, HWE, NHSCB, DH) to be defined – moving feast
- With local partnerships
- With national agencies, e.g. DWP, etc
- Training and development across sectors – speaking same language
- Dealing with non-co-terminosity of CCGs/ HWBs
    - Leicestershire CCGs have aligned themselves with district boundaries
- Sustainability – policies, processes, dealing with political change and change in key players on Board

Integration

- with EIAs
- with decision making processes
- with other functions (UAs) or districts (County and districts)
- don't forget parishes and their local connection to communities

Accountability

- To each Board members
- Of the Board to the public and partners
- Consideration of hard accountability ditched early on by ALS as it will have to be done anyway
- Soft accountability:
    - Web of accountability
    - Shared values: transparency, inclusion, shard learning
    - Leadership behaviours: code of conduct
    - Example: Calderdale Assembly - http://calderdaleforward.org.uk/calderdale-assembly

Status and communication

- What is known about HWB and what do you need to say

Connection with other tiers of Government

- National
- Counties
- Districts: Leicestershire used section 256 to transfer funding from health to districts
- Parishes
- Neighbouring authorities (e.g. joint commissioning/ working)

Demonstrating value

- Locally determined e.g. reduction in GP visits, drugs prescribed, increase in early interventions and personal responsibility
- HWB pool funds, but what else can they leverage?
- What can partners bring that is not money, e.g. data, knowledge, capacity, asset-based approach?
- Agenda is now about public resilience

Questions from the floor

- HWB as the "community hub" – what does this mean and what does it do?
    - Strategic overview
    - Holding budgets
    - Co-ordinator of budget

- Leverage of funding
- Provide a single source of funding

- Leicestershire spoke of “co-location of public health services”, how did HWB do this?
  - A SLA agreement, split public health functions across geographic areas corresponding to area committees. Senior staff sprinkled across districts, housing, GP practices.
- How are LSCB and safeguarding arrangements incorporated?
  - The relationship needs to be sorted out locally
- How does the HWB work with other functions and CCGs?
  - There needs to be a cross-fertilisation of knowledge and a learning of other people’s languages
  - Sharing organisational charts and outlining the functions of each sector, organisation, agency is helpful
- LPNs (dental collaboratives) are not statutory bodies – how do dental practices get involved?
  - Dentists important to the community and for HWB to address

D: How do we hard-wire public engagement into the work of the board?

Action learning set products:

- Principles and top tips for public engagement
- Review of key policy documents

Workshop notes: Presentation – Case study on Coventry from NCF/ VODG and Coventry Council adult services

Strong focus on wellbeing at Coventry’s HWB – adoption of Marmot’s themes

HWB started with ‘what do we want HWB to do?’ leading to who should be on it – HWB has 20 members. VCS has 4 members: 2 x LINk (LHW), 1 national CS and 1 local VCS (chosen by direct approach). Coventry working on underlying public engagement structure, but needed VCS input now.

What is public engagement?

- Involvement in own care
- Engagement in service development and delivery

Involvement is micro not just macro – ensure involvement is person centred.

Public engagement is life-blood of HWB. Patient and public involvement is not just the responsibility of the HWB, each partner has statutory duties (responsibilities) placed on it to engage and involve.

Engagement should be a discussion throughout the process not a comment on the outputs / products of a process. Public need to *feel* engaged.

To ensure the widest views are heard, advocacy is essential, particularly for under-represented individuals and groups, but fears that advocacy for vulnerable and hard to rteach groups is ineffective.

Make sure representation on the Board is right for your area, put in place mechanisms to define representation, ensure a good balance of representatives, be clear on their roles and responsibilities (role descriptions are helpful) and be prepared to hold people to account if they do not deliver.

Access networks and lists of people, service users, and databases (subject to Data Protection). Opportunity for best practice and innovation.

Ensure providers have some representation in discussions – they are not the enemy.

A concern that LINk/ LHW is/ will not be diverse enough as a representative organisation – ensure VCS is represented in discussions. Benefits of VCS involvement provide national and local perspective with data and intelligence that covers a wider area/ groups.

Questions from the floor

How did you decide who from the VCS was on the HWB?

- Elect (if you have time, use role descriptions to make expectation clear)
- Select (on the basis of assets, if you know your VCS well and the sector will allow this)
- Balance the number of "people to pace" of how you want the HWB to work

What is the role of LHW on the Board?

- LINks model is not always a fair substitute for the tasks required of the Board but this will depend on local circumstances and effectiveness
- Role of LHW is to be determined, but we know more than we did before the legislation was passed. Possible to make reasonable assumptions based on the functions set out in law.
- What happens in the shadow year, what is determined by shadow operation will inform the specification for LHW

E: Raising the bar on JSNA and JHWS

Action learning set products:

- Making JSNA and JHWS a success

Workshop notes: Presentation – DH Policy Lead & Kent County Council

Existing JSNA must be tested for "fit for purpose" - clinical and public health JSNA is of limited use and need to be enhanced to consider the wider determinants of health.

A model JSNA might have three versions:

- Disease groups, etc. which are most relevant to GPs
- Wider determinants, etc. for LAs
- Prevention and Population Issues for the public

A good JSNA will also map assets – physical assets in the community (how can schools be used for the community in evenings and holidays? As well as people assets – a register of people, skills, networks, resources held in the community at large through the community and voluntary sectors.

Process just as important as product, as localities need to engage all of the way through to get the right information to appeal to audiences. Suggestions on process:

1. Review and learn from previous JSNA, peer review of similar locality's JSNA
2. Agree the vision and scope
3. Have a comprehensive picture of needs **and** assets (broken down into A Data; B Community Assets and C; Stakeholders Views)
4. Enable stakeholders involvement
5. Identify strategic priorities
6. Make it happen (A – through commissioning plans and B – strategic influences)

No two areas are the same and local health profiles are particularly helpful, both to commissioners and to elected representatives.

Priorities should be set on the basis of evidence and these should be returned to the community for their views and input.

The JHWS should set out strategic priorities where the most impact, biggest gains can be made for joint and/or independent commissioning.

Good questions to ask about your JSNA:

- Is it relevant / fit for purpose
- Does it map assets
- Are there gaps in services
- Can it shift resources
- How will it help GPs, LAs, CCGs, community partners
- Is there any comparability with other areas?
- How do we incorporate the views of the community
- Is it in plain English?
- Connection with outcomes frameworks, or Data Inventory
- Timescales (possible conflict with DH expectations, SHA expectations and understanding the sign off process for HWB, councils and health partners)

Where are we now?	Where do we want to be?	How are we going to get there?
JSNA	JHWS	Commissioning Plans

Questions from the floor

How can priorities on a geographical / parish / ward level be delivered?

- Encourage the taking of responsibility and ownership. Ask the question of those communities: what can be done at that level by the assets in that area?

How and where do Equality Impact Assessments fit in?

- EIAs should be started at the beginning of the process and the process itself will help make them comprehensive

Where is the VCS in the process – they should be part of the conversation that takes place in development

- The VCS is not always a good proxy of the community - Mechanisms should be in place to ensure that not just the VCS but everyone has a voice and can participate
- The JSNA and JHWS are processes and not products – don't leave consultation to the end build in a conversation
- 12 week compact standards need to be flexible, it is impractical to have a 12 week window at each stage of development, having a conversation in the development should mean that the product should be perfect and takes in the widest views. Anyway, public involvement is no longer just at macro-level (organisational level) it micro (at individual level)
- Ensure that all partners, including the VCS are held to account – if they make a promise, they should deliver if they are to remain credible partners
- Don't be afraid to ask difficult questions of the community and the voluntary sector, i.e., given the choices, how would YOU prioritise to take into account everyone's needs – it not only builds ownership, it builds a mature and responsible discussion where everyone appreciates the enormity of the task
- Speak to geographic communities – build local profiles based on evidence and seen what communities recognise and would prioritise as a result
- Manage expectation - ensure that people know that not everything can go into the JHWS but know of the prioritisation process. Its about deliverable, strategic priorities – just because it is not in the JHWS, does not mean it won't get delivered – push back: what, for example, will local assets contribute to the solution to reduce a problem?
- Include case studies in JHWS to "make it real"

F: Making the best use of collective resources

Action learning set products:

- Summary guide and case studies:
    1. Joint commissioning in Knowsley
    2. Welfare advice in GP surgeries in Gloucester
    3. Health and social care transformation programme (Leeds)
- Full guide and case studies (as above)

G1: Improving services through more effective joint working – adults

Action learning set products:

- Guide including key questions on effective integration of services for adults and older people
- Briefing paper on levers and drivers
- Aligning the outcomes frameworks
- Case study – Integration in North Yorkshire

Workshop: Presentation: North Yorkshire Council and Cheshire East

What does joint working mean?

- Integration? Collaboration? Pooling budgets? Co-location?
- In the context of interface with NHS CB, PHE and localism?
- In context of 2012 CSR (28% less funding?) that might force mergers?
- Is integration the real goal in terms of outcomes for the end user? Services may feel better and really work better, but what difference is this making to Kathy (aka Mrs Smith)
- Funding mechanisms not yet in place to make this happen
- See Jon Glasby's work on integration (integration shouldn't be an end in itself): http://www.ijic.org/index.php/ijic/article/view/246/490
- N Yorks identified:
    - People going into residential care too early
    - People going into care straight from hospital
    - A rule that no-one was to go into residential care over a certain period, which opened up discussions about other possibilities

G2: Improving services through more effective joint working – children and families

Action learning set products:

- Poster outlining principles and key success factors for improving children's health
- Review of key policy documents relating to children and young people's health
- Case studies on improving children's services through health and wellbeing boards:
    1. East Riding of Yorkshire – health and wellbeing board and children's trust links
    2. South Tyneside – Health and wellbeing board and youth unemployment
    3. Nottinghamshire – Health and wellbeing board and children's trust
    4. Rotherham – Health and wellbeing board and children's trust
    5. Milton Keynes – Health and wellbeing board and children's partnership

Workshop: Presentation: National Children's Bureau

Success factors

3 essentials to develop good joint working:

1. HWB leadership

2. Align with the three outcomes frameworks

3. Understand the levers and drivers and incentives for the partners.

Clear governance arrangements must link Children's Trust and LSCB arrangements to the HWB and changes in respective terms of reference must be made

There must be a focus on early intervention and the early health intervention must be defined – the Marmot policy framework is a good place to start.

Links must be made to clinical commissioning such that commissioning is holistic and not parallel.

An asset-based approach must be taken so everyone understands who is involved, what resources are available (beyond money, e.g. information, capacity, knowledge, skills) and an awareness of what each partner can bring to the party – do CCGs know what their offer is?

Mapping social determinants of health locally is helpful and priority should be given to that which is proven to work, e.g. clusters of fast food outlets are perceived to be a planning issue, but have an impact on youth health, crime and disorder, issues of citizenship (e.g. littering and noise pollution). The HWB could work with planning to assess and approve planning applications.

The involvement of young people in the development of the JSNA and the JHWS are essential.

Work on relations for an effective HWB, communications, aims & objectives, trust & respect, professionalism, behaviours and attitudes, leadership and ownership, all need work don't just assume all have this, needs work. Ensure that all members understand the drivers and

Can follow a proper change management model.

Questions from the floor

"Joint Commissioning" – the physical separation of ASC and CYP commissioning hinders life-course commissioning. Joining the two does not seem, in practice, to end the separation.

- The HWB is the best place to align commissioning to ensure that it is connected not just within the local authority, but across sectors.

"CYP" what does this mean?

- CYP does not just mean children and young people, it should encapsulate their families too.

What does the DfE say about Children's Trust and LCSB arrangements?

- the legislation for CT arrangements is still in place and there is no plan to remove it. CYP Plan is no longer statutory but it is to be encouraged because of its value. LCSB are also still in place. Localities have been given local discretion on how they use the Children Act 2004 and therefore flexibility as to how they integrate with the HWB.

What about CAF, where does this sit in the HWB?

- Integrated solutions suggest that the HWB has some role, but the scope and extent if for localities to determine.

Is there going to be a children's outcome framework?

- The Child Health Outcomes Strategy went out to consultation in March and will end in April. A long list of outcomes is being defined and process of rationalisation will need to take place. A short list of children's indicators will be integrated into the existing frameworks from June 2012.

<u>Criminal Justice System: virtual workshop (rather than action learning)</u>

Three elements for needs assessments:

- Offenders
- Witnesses

- Victims

90% of prisoners have a psychiatric disorder and alcohol is the cause of 44% of violent crime

Previously criminal justice process driven, not outcomes and people.

Health partners have a statutory duty to help cut crime (Crime and Disorder Act 1998), the PCT or equivalent local body is a responsible partner of the Community Safety Partnership) so this will be passed to the CCG's

Is there a prison / offenders need assessment for the local area, population profiles for offenders and their needs, including young offenders.

Police and crime plan? How much of criminal justice is in the JSNA's, are the police / community safety on the HWB. Consider whole family as offenders families have higher rates of offending if parent(s) through the criminal justice system.