John McElvaney
Solicitor
Director of Legal Services
County Hall
Matlock
Derbyshire
DE4 3AG

Tel: 01629 538324
Ask for: Gemma Duckworth
Ref:
Date: 15 September 2011

Members of the Shadow Health and Wellbeing Board

Dear Member

Shadow Health and Wellbeing Board

Please attend the meeting of the **Shadow Health and Wellbeing Board** to be held on **Thursday 22 September 2011** commencing at **10.00am** in **Committee Room No 1, County Hall, Matlock**

The agenda is set out below..

Yours faithfully

John McElvaney.

John McElvaney
Director of Legal Services

A G E N D A

1. Introductions and Apologies for Absence

2. To confirm the minutes of the meeting held on 7 July 2011

3. JSNA Priorities and Health Profiles

4. Stakeholder Forum Feedback

5. Health Visiting Implementation Plan

6. Family Literacy Strategy

7. Clinical Commissioning Groups – Progress (Report to follow)

8. PCT Transition – Progress (Report to follow)

9. Equality and Diversity

10. Early Implementer Network

11. Any Other Business

12. Date of Future Meetings :

    24 November 2011 – 10.00am –
    Committee Room 1, County Hall, Matlock

MINUTES of a meeting of the **SHADOW HEALTH AND WELLBEING BOARD** held on 7 July 2011 at County Hall, Matlock

PRESENT

Councillor A Lewer (in the Chair)

H Bowen	Chesterfield Borough Council
B Buckley	Derbyshire County Council
D Collins	North Derbyshire Clinical Commissioning Group
A Dow	NHS Tameside and Glossop
S Fuller	NHS Tameside and Glossop
Councillor C Hart	Derbyshire County Council
S King	High Peak Clinical Commissioning Group
B Laurence	Derbyshire County Council/Derbyshire County PCT
Councillor B Lewis	Derbyshire County Council
D Lowe	Derbyshire County Council
R Marwaha	NHS Erewash
A Mott	Southern Derbyshire Clinical Commissioning Group
B Robertson	Derbyshire County Council
S Savage	Derbyshire County Council/Derbyshire County PCT
W Sunney	Hardwick Health Clinical Commissioning Group
T Thompson	NHS PCT Cluster
T Wright	Derbyshire LINK

Also in Attendance – Councillors G Farrington and S Ellis, and L Tomes

Apologies for absence were submitted on behalf of Councillor J Burrows, A Layzell and Councillor B Wheeler

1/11 **INTRODUCTION** Councillor A Lewer welcomed members to the first meeting of the Shadow Health and Wellbeing Board, and provided some background information to its establishment.

2/11 **BACKGROUND AND TERMS OF REFERENCE** The Health and Social Care Bill required the County Council to establish a statutory Health and Wellbeing Board from April 2013. The Council had accepted an invitation from the Government to be an 'early implementer' for Health and Wellbeing Boards, and this had required the establishment of a shadow board, which would act as an advisory Board.

The core purpose of the Health and Wellbeing Board was to join up commissioning across the NHS, social care, public health and other services to improve health and wellbeing outcomes and better quality of care. The main functions of the Board were highlighted.

The shadow Board would operate within the framework of the Derbyshire Partnership Forum, and would drive the health and wellbeing theme within the Sustainable Community Strategy. Initial consultation with stakeholders at a Derbyshire Partnership Forum workshop had taken place in April 2011, with many organisations expressing a wish to engage with the Board. Supporting structures would need to be developed to ensure engagement from a wider range of organisations, including district and borough councils, providers, the voluntary and community sector, and patients and the wider public. The aim was to ensure that the Board could work with all in an effective way.

The draft Terms of Reference for the shadow Board were also presented, and these would be operational until 2013. Any comments from Board members would be welcomed, and it was stated that a somewhat flexible approach was required to allow changes to be made. With regard to membership, it was the intention to be as consistent as possible, but it was acknowledged that there could be changes due to developments. It was therefore agreed to be more explicit about membership once the shadow Board was more settled.

The Board appreciated that there could be a number of cross border issues, and there could be instances where the Board influenced a commissioning decision in a neighbouring county. It was therefore felt that communication between the different shadow Boards was essential, and the issue of co-terminosity and relationships with other Boards would be placed as an agenda item for the next meeting.

RESOLVED that the proposed Terms of Reference for the shadow Board be endorsed for approval by the County Council's Cabinet.

3/11 **TRANSITION PLANNING** Approval was sought to develop a scheme of delegation from the Derbyshire PCT Cluster supported by the development of a transition plan and assurance process to ensure progress towards the statutory establishment of a Health and Wellbeing Board.

A PCT could arrange for its functions to be undertaken by other NHS bodies and certain other non NHS organisations. This was commonly used in the NHS form of Lead Commissioning arrangements or pooled budgets. PCTs could not direct third parties to carry out statutory duties, and as such the PCT board had to retain accountability for commissioning health services. Until there was a change in legislation, PCTs could only delegate responsibilities for budgets to the Board within the current governance structure of the PCT. The accountability for use of budgets and associated outcomes would therefore remain with the statutory accountable PCT and would be assured through the Derbyshire PCT Cluster Board.

The Director of External Relations at the Derbyshire Cluster was to work with the County Council to develop a scheme of delegation. Appropriate amendments would be made to the Cluster Scheme of Delegation to reflect the role of the shadow Board. The Standing Financial Instructions and Standing Orders would also be amended to reflect the delegated authority to the Director of Public Health.

A detailed transition plan would be developed to ensure that the appropriate tasks were mapped out, and an assurance process would be developed to monitor progress.

RESOLVED to approve (1) the development of the scheme of delegation;

(2) the development of a transition plan;

(3) the development of an assurance framework; and

(4) to receive these at a future meeting.

4/11 PREVENTION SPEND – MOVING TOWARDS SHADOW BUDGETS IN TAMESIDE AND GLOSSOP In future, much of the accountability for delivering prevention would sit with the County Council, supported by Public Health England. Shadow budgets for 2012/13 and the actual budgets for 2013 onwards would be determined by Public Health England on the basis of 2010/11 spend, subject to a formula.

Details were given of the Tameside and Glossop preventive spend, along with proposed future commissioning arrangements. This would provide the Council with the best possible assurance that it would be in a position to deliver on new accountabilities for improving health and wellbeing, subject to the final funding formula developed by Public Health England.

Tameside and Glossop, as a health economy, had a strong history of partnership working on shared priority outcomes, and information was given as to how the prevention spend could be used as a basis for strengthening the approach and preparing for the establishment of shadow budgets for 2012/13. Although it was not possible to state the final preventive spend allocation on the basis of the 2010/11 prevention spend audit, the process would support a range of issues, and these were highlighted.

The first step in determining the size of councils' local prevention budgets was to ascertain baseline spend for a range of activities. PCTs had been asked to include spend on public health activity as part of the 2010/11 year end accounts, and this was known as the preventive spend audit, the results of which were presented. The audit covered public health activity,

along with a number of commissioning lead areas. The figures from the audit would be used as the basis for establishing the council's ring-fenced preventive spend budget.

In terms of Glossopdale, the prevention spend in 2013 would be allocated to Derbyshire County Council, which would then be responsible for delivering public health commissioned services into Glossopdale. This amounted to 14% of the currently available resource from NHS Tameside and Glossop identified in the audit. Derbyshire was currently working with NHS Tameside and Glossop to achieve a collaborative approach to the preventive spend, and this could potentially bring increased resources for prevention in Glossopdale. A number of principles had so far been agreed for transition, including that NHS Tameside and Glossop and NHS Derbyshire County would share information on public health and commissioning intentions from April 2011 until after transition.

Details of identifying the preventive spend were stated, along with developing a more integrated approach to commissioning the preventive spend. The first stage was to identify a shared set of priority outcomes agreed through the governance systems of the stakeholder organisations and the Health and Wellbeing Board. For each agreed priority area, the model described required that relevant partners agreed a range of measures.

It was proposed that, subject to the content of the command paper on public health to be issued from Public Health England, the approach be applied to the areas of alcohol, sexual health, health improvement, nutrition, obesity and physical activity and tobacco. These were all high spend areas, and were already underpinned by strong partnership working. To support this, a number of actions would be required:-

- Agree the principle of an integrated approach to the preventive spend
- Pilot this in partnership with public health, Tameside and Glossop shadow Clinical Commissioning Group and Derbyshire and Tameside Councils in areas with strong existing integrated working – health improvement including nutrition, physical activity and tobacco control, substance misuse and sexual health
- Support work to establish the totality of the resource for prevention – both for programmes and the supporting management resource
- Set out action plans for delivering outcome based commissioning using the model described and building on existing work
- Develop arrangements for the preventive spend for lead or joint commissioning as appropriate, which may include pooled budget arrangements
- On the basis of agreed plans develop supporting arrangements for the preventive spend shadow budget for 2012/13

- Use this model to take forward other areas of prevention spend as future accountability is clarified through the public health command paper
- Establish shared governance arrangements for the preventive spend through the Health and Wellbeing Boards and the Joint Health and Wellbeing Strategy

RESOLVED that the Board (1) notes the contents of the report;

(2) supports an integrated partnership approach to commissioning for preventive spend; and

(3) agrees the proposals for the next steps in the process.

5/11 JOINT STRATEGIC NEEDS ASSESSMENT The Local Government and Public Involvement in Health Act (2007) had originally set the requirement for Directors of Adult Care, Public Health and Children's Services to carry out regular assessments of the current and future health and wellbeing needs of their local communities. The knowledge that the Joint Strategic Needs Assessment (JSNA) gathered should be used to shape health and wellbeing commissioning decisions.

The JSNA was an existing statutory requirement, but it was also central to new policy. Under the Health and Social Care Bill, the JSNA would set out the priorities to be in the Health and Wellbeing Strategy. Following the Government's recent approach to health and wellbeing, the JSNA now sat at the heart of local health and wellbeing improvement.

Under the new arrangements, the local authority and clinical consortia would have an equal obligation to prepare the JSNA and to do so through the Health and Wellbeing Board. This recognised that health and wellbeing promotion required the combined efforts of public health, local health services and local government, together with partners in the business, community and voluntary sectors.

Derbyshire's JSNA existed within the Derbyshire Observatory, which was a web based information system which held the various datasets required for the JSNA. Summaries of the Derbyshire JSNA had been published in 2008 and 2009, and had provided an overview of Derbyshire's main health and wellbeing issues along with more detailed information on a small number of topics. For 2011/12, the JSNA had identified a number of additional priorities.

There had been considerable progress across the PCTs and County Council in linking the JSNA across strategic planning cycles. The JSNA had been fully embedded in the PCTs' strategic plans, and had also informed the

prioritisation and budget processes for adult care and health. Under the new national policy proposals, Clinical Commissioning Consortia and local authorities would each have an equal obligation to prepare the JSNA, and the arrangements for how this would be accomplished would be within the remit of the Health and Wellbeing Board.

The expectation was for the JSNA to be the overarching framework for all health and wellbeing needs assessments, and this would help to ensure that the development of the Health and Wellbeing Strategy would reflect the wider evidence base that was available through other statutory processes. The JSNA needed to be re-focused to meet the needs of the new users of the JSNA, principally the Health and Wellbeing Board and Clinical Consortia.

It was proposed that new terms of reference for the JSNA Board be prepared with membership supplemented to include representatives from the Clinical Commissioning Consortia. The new terms of reference for the JSNA Board would need to be agreed by the Health and Wellbeing Board. It was agreed that the current terms of reference should be circulated to members for ratification and to inform any comments on the new terms of reference. Members were also asked to submit any comments in terms of membership, and the new terms of reference would be presented to a future meeting of the Board.

RESOLVED that the Health and Wellbeing Board (1) be the accountable body for the JSNA Board;

(2) supports the development of revised terms of reference and membership for the JSNA Board, which would be considered at a future Health and Wellbeing Board;

(3) receives regular progress reports from the JSNA Steering Board and monitors the progress against the agreed workplan; and

(4) receives regular reports on JSNA priority issues for discussion and consideration.

6/11 FRAMEWORK FOR HEALTH AND WELLBEING STRATEGY

On 30 November 2010, the Government had published a White Paper entitled 'Healthy Lives, Healthy People: Our strategy for public health in England'. The paper had specified that one of the main responsibilities of the Board was to devise joint health and wellbeing strategies. These would be informed by the local JSNA and would be prepared by local authorities and GP consortia.

This would be a first opportunity to develop a strategy that covered all the influences on the health and wellbeing of the whole population, and it also enabled a more in-depth look at how the widest range of public services could

be focused to improve the health and wellbeing of the population. The development of the strategy would allow a greater discussion about which priorities were most pressing, and a health and wellbeing strategy would be a public statement of the intention to work together across public services and of agreed priorities for action and improvement.

The County's JSNA would continue to be developed, which would bring together all information about indicators of health and wellbeing available to health services, local authorities and other agencies. The assessment would form the basis for any strategy. In order to progress the strategy in line with the development of the Health and Wellbeing Board, it was possible that the initial strategy would capture existing pressures and priorities within the system and reflect the current intelligence within the JSNA process.

It was stated that strategies needed to be focused on outcomes rather than actions, and the activities that underpinned outcomes should be those for which there was the best evidence of likely success. It would be important in implementing the strategy to incorporate a process of engaging at local level with people, voluntary and community partner organisations and other key statutory bodies in identifying local priorities. It was essential to ensure ownership of the strategy by all concerned, and for the strategy to reflect a local approach.

The general framework proposed adopted the life course approach identified in the Public Health White Paper, which was:

- START WELL To optimise children's health at the start to life and before school
- DEVELOP WELL Children attain potential and make successful transition to adulthood
- LIVE AND WORK WELL People are enabled to live healthy independent productive lives of their choosing
- AGE WELL People are enabled to age in optimal health with dignity and independently in settings of their choice.

A key question to consider was to what degree the Health and Wellbeing Strategy should reflect a wide set of priorities covering most or all of the main population groups and services, or a very narrow set of areas in which it was agreed particular progress was needed. It was generally felt that it would be beneficial to work with all groups within the limited resources available.

Essential to the successful delivery and achievement of the outcomes within the health and wellbeing strategy would be a number of cross cutting issues, including workforce planning and development, communication systems, public engagement, intelligence, equality and quality assurance.

The Board was informed how individual outcomes formed the relevant frameworks integrated into a life course approach, and it also aimed to identify the partnerships already in place in Derbyshire.

It was agreed that further work was required on the development of the framework for the strategy, and a more detailed report would be presented to a future meeting. A timescale for development and implementation of the strategy would also need to be agreed.

7/11 CHILDREN'S SERVICES INTEGRATED COMMISSIONING TASK GROUP The Board was informed of the establishment of a time limited group to oversee and provide strategic leadership to the development of a proposed model for integrated commissioning of children's services, and was presented with the proposed terms of reference. The task group had a number of aims, which were detailed, and it was stated that the group would work with Derby City to maximise the potential of joint delivery of the aims.

The task group would report to the Derbyshire Children's Trust Board, and had a number of outputs. The suggested membership of the group was reported. It was the intention that the work of the group would be completed by October 2011, after which a report would be presented to the Board.

8/11 LOCAL HEALTHWATCH AND TRANSITION ARRANGEMENTS FOR LINKS LINks had been established through the Local Government and Public Involvement in Health Act 2007, and the Derbyshire LINk had been funded through a central government ring-fenced grant for three years until 31 March 2011. The Government had required local authorities to continue to support the provision from 1 April 2011 whilst it provided guidance as to how a transition could be made to Local HealthWatch.

The original HealthWatch Transition Plan had included a timetable for a Pathfinder programme and action learning sets to be established during March/April 2011. However, there had been consultation on the NHS Reforms, entitled NHS Future Forum, and this had been conducted over an eight week period, and had been reported to the Secretary of State for Health in June. The NHS Future Forum report on 'Patient Involvement and Public Accountability' provided the detailed recommendations for Local HealthWatch. The Government response had recently been published, and included a number of proposals for HealthWatch, one of which was that LINks would evolve to become local HealthWatch.

A representative of local HealthWatch would sit on the Health and Wellbeing Board, and the Board would require the local HealthWatch to provide public and patient insight that would inform the assessment of needs and joint health and wellbeing strategy. Local HealthWatch would need to be established by October 2012, and local authorities and local HealthWatch

would take formal responsibility for commissioning NHS complaints advocacy from April 2013.

The East Midlands Public Health and Local Government Network had set up a workstream, which would be hosted by Derby City, to provide support to local authorities to ensure the successful transition of LINks into HealthWatch.

The HealthWatch Advisory Group had clarified the responsibilities for local authorities, and these included funding Local HealthWatch organisations, commissioning of HealthWatch and ensuring that the organisation was body corporate, and ensuring the accountability and value for money of the local HealthWatch. Derbyshire County Council would be the commissioners and funders of Local HealthWatch, and would be subject to scrutiny from it in respect of services for younger adults and adult care.

The Government was not stating the format of Local HealthWatch, but was encouraging local authorities to consider the transition from LINk to HealthWatch. The major challenge for LINk and the County Council would be how to manage the transition to a body corporate. Discussions would take place with the LINk Steering Group, LINk officers and the current HOST to explore the opportunity of developing into a suitable social enterprise. A further progress report would be presented to a future meeting.

RESOLVED that a work stream be developed that will focus on establishing the future role of HealthWatch and exploring how the current LINk can be supported to evolve into HealthWatch.

9/11 **FORMAT AND TIMING OF FUTURE MEETINGS** The Board was asked to consider the format for future meetings of the Board. It was proposed that meetings be held on a bi-monthly basis, at a time and venue to be advised.

10/11 **DEVELOPMENT NEEDS** It was felt that, over the coming months, there would be a lot of new information for members, and it was therefore an ideal opportunity to provide training and presentations where necessary. The Board was asked to submit any suggestions.

11/11 **FUTURE MEETINGS** It was suggested that evidence of what had been achieved between meetings would be useful information, involving a wider range of stakeholders.

12/11 **DATE OF FUTURE MEETINGS** **RESOLVED** that the next meeting of the Board be held in September, on a date and time to be advised.

Report Author – Liam Flynn Agenda Item No. 3

DERBYSHIRE HEALTH AND WELLBEING BOARD 2011

22 September 2011

JOINT STRATEGIC NEEDS ASSESSMENT 2011

Purpose of the Report

This report summarises the key health and wellbeing priorities for Derbyshire that have been identified by the Joint Strategic Needs Assessment (JSNA). It summarises these priorities and explains why each one has been identified. The report also addresses differences in need by district.

Actions to address these priorities will be considered in the development of the Health and Wellbeing Strategy.

Information and Analysis

The JSNA is a systematic gathering and analysis of Derbyshire's health and wellbeing needs. It is the result of work between Adult Care, Children and Younger Adults, Policy & Community Safety and the PCTs. The JSNA gathers and analyses over 100 data items that form the core JSNA dataset.

There are three types of data that make up the JSNA. First of all there is contextual data that will have a significant influence on health and wellbeing over the next few years. The best example of this is the unprecedented ageing of the population. Secondly, there is data that relates to specific health conditions (eg strokes) that may be unusually higher than in other parts of the country. Thirdly there are key performance indicators which have been systematically measured and which tell us very precisely how Derbyshire compares with other areas, and in particular to its "family" of similar authorities.

Two approaches we have used in identifying something as a priority for attention in the JSNA is if the condition is significantly above or below the national average. Being different from the average is a strong indicator that it should receive attention. Secondly, a condition may become a priority because it has been historically overlooked and not enough is known about it.

Some of the priorities for improving health and wellbeing depend upon the ability to change people's behaviour, for example to reduce smoking and alcohol consumption, and to encourage people to eat a more healthy diet and take more regular exercise. This fits in with the new national strategy of prevention.

<u>Health Inequalities</u>

In the JSNA we have looked at both countywide priorities and those linked to specific places. So whilst life expectancy in general for both men and women

in Derbyshire is similar to the national average, life expectancy is 7.6 years lower for men and 5.4 years lower for women in the most deprived areas of Derbyshire than in the least deprived areas.

Older People

The latest population projections show that between 2011 and 2016 Derbyshire's population will grow by 2.7%. This projected increase is the net result of some age groups increasing and some decreasing. There is also the additional effect of inward migration; Rural Derbyshire is a popular place to retire to. For the younger age groups (eg 0-19 years) there is either a decrease or at least no change (eg 20-64 years). It is the older age groups that show consistent growth as the post-war baby boomer generation reaches beyond retirement age. The 65-89 year age-group will increase by almost 16% and the very oldest (ie 90 years or older) by 26%. There will be fewer younger people who will have to support more older people. This is referred to as the increasing "Dependency Ratio".

There are clear ramifications following from an increasingly older population: there will be many more people affected by conditions associated with increasing age, and who therefore may require health and care services. For example, we know from Planning4Care, our social care statistical modelling tool that there are just over 57,000 older people with social care needs in 2011. By 2016, the number of people with social care needs will have grown to over 65,600. In addition, there were just under 3000 older people predicted to require hospitalisation during 2011 as a result of a fall. By 2014, this figure will rise to just fewer than 3,240, an increase of 8%. Also during 2011 there are over 23,700 people with a continence problem in Derbyshire. The number of people so affected by this condition is expected to grow to 26,100 by 2014.

Additionally, there are more older people than ever before who are likely to provide daily care to a spouse or family member, and who will need support themselves in order to sustain their caring role.

The rise in older people is a very significant contextual factor that will put increasing pressure on a range of public services including in particular health and social care services.

Dementia

There are just over 9,900 people affected by dementia in Derbyshire in 2011. By 2014, the number is projected to increase by 9.4% to just under 10,950. Derbyshire's Dementia Strategy puts in place a new pathway that will help people affected to receive better care and support.

Carers

The 2001 Census demonstrated that there are about 20,000 people in Derbyshire who provide 50 hours or more per week caring. When the 2011 Census data is published next year, it is expected to show a large increase in

the number of carers. It is very important that we continue to build the amount of support that carers receive so that they continue in their caring role.

Obesity

The Health Survey for England 2006-08 shows that the rate of obesity among Derbyshire adults is significantly worse at 25.3% than comparative figures for England. Chronic obesity is a precursor to a number of related health problems so it is important that campaigns to help people change their lifestyle behaviours are targeted accordingly.

Diabetes

There were 37,200 people on GP registers with a recorded diagnosis of diabetes in 2009/10, representing 6% of all Derbyshire GP registrations. The numbers are on the increase and are currently significantly higher than the average for England. It is thought that the increase is related to poor diet and exercise and rising alcohol consumption.

Hospital Stays for Alcohol related harm

Derbyshire has a rate of 1797 per 100,000 population hospital stays for alcohol related harm. This is significantly higher than the England average. Alcohol consumption has been increasing for a number of years now and it is very important that the trend is reversed through concerted partnership working.

Autism

There are estimated to be over 7,100 adults and over 1500 children with Autism in Derbyshire. Autism is a condition that is not widely understood and often goes undiagnosed. As a consequence, people with autism often lead isolated lives and are not able to access public services to help them to lead more fulfilling lives. The failure to provide the right services at the right time means that people with autism need greater levels of support in later life because the lack of earlier care has resulted in the person having greater needs subsequently.

Long-term Conditions

In England in 2005 33% of all people had one or more long term condition (eg chronic heart disease, mental health conditions, liver disease), including some 60% of those aged 65 or over.

There is currently a pilot project being jointly undertaken by the Derbyshire County PCT and Adult Care to combine primary care and secondary care data in respect of people with long term conditions. If successful this is likely to be undertaken Countywide in order to provide local data on the number of people with (multiple) long term conditions to inform strategies, commissioning and joint working.

Children's Health and Wellbeing

The Early Identification of vulnerable children and families

Recent studies show that early identification, a universal offer of early support and targeted support for the most vulnerable children and families can make a real difference in breaking the cycle of disruptive and antisocial behaviour as well as protecting children from harm.

Neglect

Derbyshire has seen a rise in cases of neglect, across the age range of children and young people, resulting in rising numbers of children in care and subject to child protection plans. Integrated family support, based on evidence based programmes, can help to reduce neglect and the harm caused by it.

Reduction of alcohol and substance misuse

In line with national trends, excessive consumption of alcohol by young people continues to be a significant problem. Alcohol mis-use is often a factor in anti-social behaviour, youth crime and teenage pregnancy and is often a significant factor in cases where children are abused or neglected.

Increase breastfeeding at 6/8 weeks

Research shows that breastfed children are healthier and are less likely to experience social and emotional difficulties in adolescence. In Derbyshire, the prevalence of breastfeeding at 6/8 weeks is 36% with significant variations by district (eg Bolsover 29%). Breastfeeding Initiation is 72.2, significantly worse than the national average.

Reduction of childhood obesity

It is estimated that over 33,000 Derbyshire children are clinically obese and many more children are overweight. It is very important to tackle obesity because it is a condition that is associated with additional health problems (eg Type 2 diabetes, heart disease). Slight decreases have been achieved since 2008 but more progress needs to be made.

Reducing Teenage pregnancy.

Between 1998 and 2009 (the latest year for which figures are available) there was a 20% fall in the rate of under 18 conceptions. However, teenage pregnancy rates are still too high in Derbyshire with a rate of 33.3 conceptions per 1000 females aged under 18.

Emotional and Psychological Wellbeing

One in ten children aged between 5 and 16 years has a mental health problem, and many continue to have mental health problems into adulthood. A far greater number experience emotional and psychological difficulties that significantly affect their everyday lives and make achieving good outcomes more difficult.

The above priorities are not meant to be an exhaustive or exclusive list of the health and wellbeing issues affecting Derbyshire. They are the priority areas identified by the JSNA.

RECOMMENDATIONS

It is recommended that:

1. the Health and Wellbeing Board notes the health and wellbeing priorities identified
2. Consideration be given to address these priorities as part of the development of the new Health and Wellbeing Strategy.

2011 Health Profiles for NHS Derbyshire and Derbyshire Local Authorities

Significantly worse than England average	
Nott significantly worse than England average	
Significantly better than England average	

Domain		Indicator	AV	BL	CH	DD	EW	HP	NE	SD	NHS DC
Our Communities	1	Deprivation									
	2	Proportion of children in poverty									
	3	Statutory homelessness									
	4	GCSE achieved (5A*-C maths & eng)									
	5	Violent crime									
	6	Long term unemployment									
Children & young people's health	7	Smoking in pregnancy									
	8	Breast feeding initiation									
	9	Physically active children									
	10	Obese children									
	11	Children's tooth decay (at age 12)									
	12	Teenage pregnancy (under 18)									
Adults' health & lifestyle	13	Adults smoking									
	14	Increasing higher risk driving									
	15	Healthy eating adults									
	16	Physically active adults									
	17	Obese adults									
Disease and poor health	18	Incidence of malignant melanoma									
	19	Hospital stays for self-harm									
	20	Hospital stays for alcohol related harm									
	21	Drug misuse									
	22	People diagnosed with diabetes									
	23	New cases of tuberculosis									
	24	Hip fracture in 65's and over									
Life expectancy	25	Excess winter deaths									
	26	Life expectancy male									
	27	Life expectancy female									
	28	Infant deaths									
	29	Smoking related deaths									
	30	Early deaths: heart disease and stroke									
	31	Early deaths: cancer									
	32	Road injuries and death									

.

Source:

Author Sally Savage
Assistant Director Commissioning, Derbyshire County Council and NHS Derbyshire

SHADOW HEALTH AND WELLBEING BOARD

22 SEPTEMBER 2011

Health Visiting Implementation Plan

Background and Context

The first few years of a child's life are fundamentally important. A strong focus on these years leads to huge economic, social and emotional benefits later on, both for individuals and society as a whole ((DH/DfE, 2011). A whole raft of new policy from the current Government is predicated on this principle: Supporting Families in the Foundation Years; Allen, G. (2011) Early Intervention: The Next Steps; Munro, E. (DfE 2011) A review of child protection; Field, F (Dec 2010) The Foundation Years: preventing poor children becoming poor adults; The report of the Independent Review on Poverty and Life Chances).

The Government is committed to making the best use of the opportunities presented during pregnancy and the first five years of a child's life through the effective integrated delivery of the Healthy Child Programme, increased early intervention and plans to increase the numbers of health visitors; to double the coverage of Family Nurse Partnerships (FNP); to provide 15 hours a week of free early years education for all 3 and 4 year olds with an extension of this to disadvantaged 2 year olds. The early-intervention agenda is in essence a joint Public Health and Local Authority strategy, effectively delivered and coordinated through joined up services, maximising the resources and targeting services to those who need it the most.

The Health Visiting Implementation Plan - A Call to Action (DH 2011) sets out the Government's commitment to a larger, re-energised health visiting service in order to deliver a new model of support for families through integrated working and the delivery of the Healthy Child Programme in partnership with Primary Care, Sure Start Children's Centres, Multi-agency Teams, and other local services. The NHS Operating Framework 2011/12 sets targets for individual health communities to increase the number of health visitors over the next 5 years. NHS Derbyshire County and NHS Derby City are working together to maximise the potential of these delivering targets and NHS Derbyshire County are one of two "Early Implementer" sites across the region.

Health Visiting Services are currently commissioned by the NHS. The draft Health and Social Care Bill anticipates that in future these services will be

commissioned via the Local Authority as a crucial part of the delivery of improved health and wellbeing.

Purpose of the Report

Following the agreement of the Children's Trust Board to invest in developing the Family Nurse Partnership in year one of the five year programme, this paper is presented to update members of the Shadow Health and Wellbeing Board on the wider delivery of the Health Visiting Implementation Plan (HVIP). It also highlights the strategic importance of the HVIP and seeks to gain engagement in securing the on-going commitment and investment required.

This paper was presented to the Children's Trust Board on 15th September 2011.

Key matters for consideration

1. On-going commitment to support vulnerable families through investment in health visiting and FNP

It has been made clear that early intervention and specifically increasing the number of health visitors is the highest priority for the Department of Health at present (NHS Operating Framework 2011/12, SHA letter to Chief Executives 27th June 2011) and this has lead Derbyshire to become one of two early implementer sites for the HVIP in the East Midlands. The Department of Health has been clear about the numbers of health visitors we are expected to recruit and Derbyshire is required to recruit an additional 5.8 health visitors each year until 2015.

As part of this recruitment programme FNP has been jointly commissioned by NHS Derbyshire County and Derbyshire County Council and will be ready to start delivery of the programme to young mothers in early 2012 in targeted areas.

This will assist in meeting part of the Healthy Child Programme; gaps remain in achieving the ante-natal visits in the early stages of pregnancy and this area has been prioritised for the increased investment required by the HVIP in subsequent years.

The outcomes expected from this investment are

Use of effective validated screening tools to enable the early identification of vulnerable families with effective joint working strategies in place to provide early intervention through integrated working, appropriate to need resulting in:

- Early identification of poor attachment

- Promotion at an early stage of the importance of early neurological development leading to improved emotional wellbeing.
- Early identification of mothers/fathers with low literacy levels and opportunities to promote family literacy
- Early understanding of the importance of language development and its contribution to improving literacy
- Increased rates of breastfeeding
- Improved uptake of immunisations
- Reduction in health inequalities
- Improvements in women's ante-natal health and behaviour
- Improved early engagement with families resulting in increased uptake of support and social networks.
- Increase in health and well-being and lifestyle to nurture babies and young children.
- Decrease in number of families reaching crisis and subsequent safeguarding processes.
- Fewer subsequent pregnancies in young people
- Improved earlier parenting support
- Early identification of those more at risk of post-natal depression
- Active promotion and engagement of fathers

Long-term Outcomes

- Reduction in the number of school entry children with unidentified health and social care needs who are less able to participate in school and achieve their potential.
- Decreased involvement in crime and anti-social behaviour in later life
- Decrease in early substance misuse initiation.

Clearly partnership working is critical in delivering these outcomes and it is essential that we develop effective integrated working with other early years services including those in the voluntary sector and local communities but most notably Children's Centres.

2. Engagement with commissioners of health visiting services and the Healthy Child Programme via Clinical Commissioning Groups and the Local Authority

Additional investment is required in order to meet the target of 5.8 additional health visitors per annum until 2015.

In order to meet the strategic objectives of "Supporting Families in the Foundation Years" and the early intervention agenda, the HVIP steering group is aiming to prioritise the ante-natal home visit as a key strand in early identification of vulnerable families and will utilise additional health visitor

resource in implementing this important target. But this can only be achieved through a combination of the Health Visitor Implementation Programme, and improved delivery of early intervention, alongside the targeted approach of the Family Nurse Partnership.

In partnership with the aligned strategies to reduce teenage pregnancy, and respond to areas of higher need, public health are undertaking an analysis of areas where there are pockets of higher teenage conception and pregnancy rates with a view to extending the FNP to Swadlincote (2012) where GPs have highlighted a need. This provision will also possibly be extended to the Fairfield Estate in Buxton and Hurst Farm in Matlock (2013) in recognition of the higher levels of health inequalities and teenage pregnancy rates should the data demonstrate sufficient numbers of teenage pregnancies to sustain a programme.

The Shadow Health and Wellbeing Board is requested to support the engagement of commissioners in order to prioritise the investment required. Investment of £450,000 has already been committed for the current financial year and this is delivering the FNP in targeted areas. Scoping work is underway to identify the resource required. It is envisaged that a recurrent investment in the region of £300,000 is required each year until 2015 providing an accumulative additional investment of £1.3m in total. This will provide an additional 24 health visitors working across the Family Nurse Partnership and health visiting service.

Recommendations

1. Members recognise the importance of the delivery of the Healthy Child Programme and the governments' drive to prioritise this area by securing additional health visitors, and endorse this work becoming part of a wider strategy for early intervention.
2. Members support and promote the on-going commitment to vulnerable families through the investment in the HVIP and FNP as a key part of future commissioning plans of the Health and Wellbeing Board.
3. Members support the providers to further improve the delivery of integrated services to improve outcomes for children and families.

Agenda Item No: 6

Health and Wellbeing Board

22 September 2011

FAMILY LITERACY STRATEGY

Reading works: pass it on

Derbyshire Family Reading Homes Strategy

‘Action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken.’
Fair Society, Healthy lives, The Marmot Review 2010

‘If some one would just tell us what to do we’d get on and do it.’
‘Harder to reach’ mother, interview for Partners in Literacy, Derbyshire 2010

Literacy = listening and speaking, reading and writing, problem solving.

Background

Between 2009 and 2011, 'Read On Write Away!' (ROWA!), led a study into a strategic partnership approach to support literacy in family homes. The study was led by a partnership advisory group and chaired by the Strategic Director for Culture and Communities, also known as, the Family Reading Champion. This study was part of a national pilot led by the National Literacy Trust; four authorities took part in the first year and a further five authorities took part in the second year.

The National Literacy Trust wanted to test the premise that if literacy challenges were could be addressed through a strategic and partnership approach the, 'achievement gap', which characterises the difference in school achievement between deprived and less deprived communities, could be significantly reduced.

In year one, in Derbyshire, we asked,

- harder to reach parents about their views concerning their children's language and reading and their role in this, and
- non-literacy colleagues about their views clients' literacy and the impact this had on the achievement of their objectives.

We learned that many parents do not even know that they have a role in language development and that many of those who thought they had a role, but who lacked confidence, do not access existing support. Many non-literacy colleagues who have access to these families want to be part of the solution but lack the experience or confidence to offer language and literacy support to their clients.

In year two, we experimented with pilot studies to redefine and redesign literacy support to make it more available and accessible through a range of support services including volunteers. We also identified a wide range of partnership services which had 'synergy' with these pilots and which could become part of a broad, sustainable, shared goal to eliminate the effects of disadvantage in the development of children's language and literacy.

This study is available at http://www.rowa.org.uk/pil_research.html
The Derbyshire Family Reading Homes Strategy is available at
rowa.org.uk /what we do / Derbyshire Family Reading Homes Strategy.

Derbyshire: the evidence

Derbyshire's statistics are typical of the national statistics. Low levels of literacy are significantly correlated to a range of lower housing, employment, income, unplanned pregnancy, health and well-being outcomes. The evidence in the Marmot report describes the complex but reliable conditions which give rise to shorter life expectancy and higher levels of disabling illness.

Other national reports, 'Grasping the nettle', and 'The Foundation years; preventing poor children becoming poor adults',[1] outline the conditions which apply to Derbyshire. 'Early Intervention: The Next Steps' (Allen, 2011) also promotes the essential nature of early intervention (0-3 years) as "a social and emotional bedrock" for current and future generations, and the key to preventing social, health and learning problems being passed from one generation of families to the next. The report calls for an increased awareness of the importance of early intervention, effective working from staff and processes, better information for parents, and more effective data and tools to measure progress and identify children in need. All three of these reports point to the wealth of research which demonstrates the importance of the parent's role in early education.

National statistics show that around 16.5% of all adults in the UK have literacy skills limited to those of an 'average' 11 year old. The people who have limited skills are over represented in areas of socio–economic disadvantage, unemployment figures and offender figures. Last year 17% of all young men who left school at age 16 had similar literacy skills to those of an 11 year old.

In Derbyshire the literacy achievements of children who are eligible for free school meals (FSM) and those who are not eligible is startling. Table 1 shows the widening gap in achievement from Key Stage 1 to Key Stage 4. The gap between non free school meals and those eligible for FSM is the same for boys and girls but boys lag behind girls overall.

2010	All pupils	Boys	Girls	Non FSM	Free School Meals
KS1 % achieve level 2	88.8% n=7384	84.1%	94.1%	91.2%	78.7% n=1097
KS2: % achieve level 4	85.9% n=6777	83.6%	88.2%	88.3%	70.7% n=928
KS4 An A*-C English GCSE	64.7%	57.2%	72.7%	67.9%	32.4% Boys 24% Girls 41.3%
5 A*- C GCSEs inc English+maths	54.3%	50.5%	58.3%	57.5%	22.7% Boys 18.9% Girls 26.7%
	All pupils n=8877				FSM pupils n= 802

Table 1 % of Derbyshire pupil achievements at Key Stages 1,2, and 4 (2010) comparing results by gender and free school meal eligibility.

[1] Grasping the nettle; early intervention for children, families and communities. C4EO 2010 The Foundation Years: preventing poor children becoming poor adults Frank Field, HM Government December 2010.

The ROWA! survey of 63 'harder to reach' families from three disadvantaged areas of Derbyshire, found that, although two thirds of parents said they wanted to help their children to succeed, far fewer knew how to do this. One of the figures from the survey report is shown below, figure 1, to illustrate this issue. This figure shows the responses from parents when asked what they did to help their children learn. The number of parents who gave a positive response to various suggestions is low. Critically only 11% felt that talk was important. We asked, mainly mums, what they did with their babies and toddlers and many said, 'walk (meaning baby in a buggy) to a park or to the shops' and, 'watch TV' (many thought that this was a better option than anything they could provide).

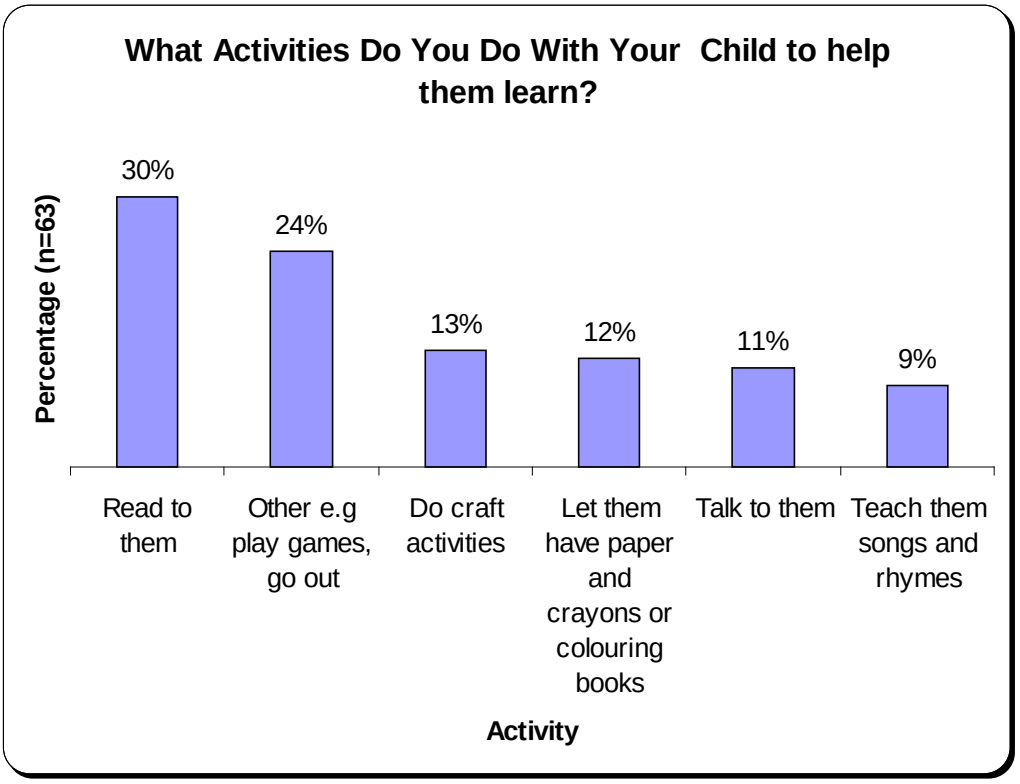

Figure 1

Literacy, by which we mean; communication, speaking and listening, reading and writing and problem solving, is a critical core skill which underpins all the outcomes which our services aim to help others achieve; figure 2 summarises these outcomes. The foundation for these skills is laid in early learning before age three and much of this learning takes place in family homes and local communities.

Helping children to achieve more: the five outcomes.	**Marmot**
Be Healthy	Ensure healthy standard of living for all Strengthen the role and impact of ill health prevention.
Make a positive contribution	Enable all children, young people and adults to maximise their capabilities and have control over their lives
Stay safe	
Achieve economic well being	Create fair employment and good work for all
Achieve and enjoy	Give every child the best start in life Create healthy and sustainable places and communities

Figure 2

The Derbyshire Family Reading Homes Strategy

This strategy is the result of this study and close collaboration between partners of the Derbyshire Strategic Partnership. It aims to develop a cohesive and holistic approach to supporting the development of language and literacy in early years by bringing together diverse but synergistic service to radically target and support families who need help.

This approach does not 'belong' in any one agency or service. Families and communities do not fit into adult, children's or health categories. The services most likely to identify problems may not be those which are most likely to provide the solution through inspiration and enthusiasm, such as community arts, outdoor learning, peer mentoring, recreation, culture and heritage, informal adult learning, basic skills support including 'workforce development' parenting and community groups. To radically address literacy we need to work in a different, collaborative and more inspired way.

What needs to change?

Many parents are not sure of their role in children's development, and many parents are not confident, or believe they are not sufficiently competent, to get involved with their children's learning. This is largely true of socio–economically disadvantaged parents but not restricted to this group. Parents need to know what they have to do; their task is not onerous, it could be described as having fun with your children and enjoying their development.

The available literacy support is not always visible, accessible or appropriate. The current service provision needs to be reviewed to meet the needs of the clients. Self

referral is the main method of ‘recruitment’ and many support systems do not run at capacity or fail to run because of insufficient ‘interest’.

Literacy support is disparate and not clearly labelled: it is ‘disguised’ in the community. Succession or progression between avenues of support are not often planned to build on acquired strengths.

Service providers with access to families are not sure how they can contribute to literacy. In our pilot study we demonstrated that everyone with access to families can be part of the solution. We need more people ‘on message’, talking about expectations, introducing the resources families need to homes, referring and signposting. Literacy can be built into a wide range of service to produce win:win effects.

We need more community members and champions willing to talk to parents about family reading and some to take a mentor role.

Support and advice does not start early enough – there is growing evidence that parents should talk to the bump! We need ante-natal services to begin to identify families who need additional support.

Schools engagement / partnership with parents – often starts too late, and schools can be poor communicators about their expectations of parents. Schools struggle to engage with ‘these’ parents, and are hampered by parents’ views and memories of schools.

Services need to radically re-think their literature to be more socially inclusive.

Appendix 1 suggests ways in which these issues could be addressed through a partnership approach. The suggestions only cover the ideas which came to light during the pilot phase and are not meant to be inclusive of a whole partnership offer.

The Derbyshire Family Homes Reading Strategy: aims, objectives and principles

Strategic aims:

1. for locality partners within the ‘Derbyshire Strategic Partnership’ to work to a shared strategic vision to eliminate the effects of disadvantage in the development of children’s communication and literacy by developing and delivering a process of support for Family Reading Homes

2. to find synergy between this strategy and others within the ‘Derbyshire Strategic Partnership’, and locality partners, to create a continuum for achieving better communication, language and learning outcomes through improved service provision and teaching especially in Family Learning, 'Early Years' and Key Stage 1.

Strategic objectives:

1. to develop at locality and community level, robust inter-agency processes for recognising families who need literacy support

2. to identify the range of literacy resources available in communities, especially those communities with higher 'achievement gap' records and to develop this into a comprehensive and accessible continuum of support including: volunteer family reading champions, first steps interventions delivered in the families' home, informal opportunities through the Voluntary, Community and Independent sector and libraries, promotion of parents' role in child development, family literacy resources and activities, Family Learning (both specialist literacy support sessions and courses and other opportunities for families to learn together) and adult education accessed by parents for their own pleasure through informal or formal learning

3. to prepare workforce development resources to support a multi-agency approach to delivering first steps literacy interventions and confident signposting to accessible literacy support.

4. to develop this package within the remit of Multi Agency Teams (MATs) and their extended networks

5. to deliver this targeted support within the context of a universal message to parents about the importance of family reading Marmot calls this 'proportionate universalism'.

6. to monitor the outcomes of this activity through outcomes in literacy and language at Early Years Foundation Stage and Key Stage 1. To monitor additional outcomes for parents through take up of adult education and to monitor the impact on library membership and sustained use.

Strategic Principles:

1. Partnership working, ambitious shared vision, shared goals with an understanding of each partner's different role within this process

2. To value reciprocal learning between partners so that joint effort towards shared outcomes can be achieved through transformation of the way service is offered and partners work together to create win:win outcomes.

3. Acknowledgement of the significant influence of parents, carers and wider families on the development of communication and literacy.

4. Focus on family units, parental involvement, exchange of information and support to parents to enable them to become partners in this process

5. Early identification of literacy challenges within families

6. Recognition of some parents' antipathy to education environments and, therefore, to develop an appropriate community response with a robust pathway to increased levels of support.

7. Clarity of easily identifiable step by step options within localities.

8. Monitoring and reporting through the Children's Trust

Appendix 2 lists the known synergies which could be brought together to create visible and planned service pathways for language and literacy

Implementation

The Children's Trust Board recently considered this strategy and asked for a paper to be resubmitted which combined an implementation plan for this strategy with that of the Derbyshire Family Support Strategy. When this work is completed it should be brought back to this Board.

At the same time Clinical Commissioning Groups are asked to consider how they and other operational services in the PCT can play a part in the delivery of this strategy. For example the children, young adults and maternity services commissioning group could consider how families could be identified and supported through various services designed to support the development of young children and their families.

The ongoing implementation of this strategy should be supported by the Family Reading Champion, currently Martin Molloy, DCC Strategic Director for Culture and Community Services, and a partnership strategic planning group.

The development and implementation of this strategy will require resources to further integrate this approach into partnership planning and pathway delivery, support workforce development, develop partnership monitoring and create a social marketing campaign.

Recommendations

1. **That the Derbyshire Family Homes Reading Strategy be adopted by the Health and Wellbeing Board.**

2. **That the Children's Trust and Clinical Commissioning Groups be asked to consider how the proposals can best be implemented and report back to the Health and Wellbeing Board.**

3. **That a 'Reading works: pass it on', strategic planning group, chaired by the Family Reading Champion is identified to share information and to identify cross partnership implementation methods.**

Sarah Burkinshaw, Director, Read On Write Away!

Appendix 1.. using only the information which came to light during the pilot phase, this table illustrates what could be done differently. The illustrations in this table are not exclusive and do not reflect the full offer which could be made through the Derbyshire Strategic partnership.

What would it look like	What are the synergistic opportunities to be developed or tweaked?
New partnerships linking access and reach to 'tweaked' services. New literacy collaborations.	e.g. linking parents of nursery children to library activities through a nursery project
Better identification and referral. Use CAF to identify family literacy challenge from before birth onwards	Pilot leaflet
Use 2 year old screen (Health Visitors) to identify delayed language	Screen being rolled out and support being identified through SLT or ELKLAN trained children centre workers.
A workforce with a shared and joint vision about telling parents what their role is and encouraging them to use support.	CAYA commissioning documents include sign up to this
People with access to families confident in supporting first step literacy intervention	Pilot training package .. half a day plus resources plus backroom support Workforce development
Peer support	Pilot Bookstart champion training Pilot 'Reading Works' mentor training
	Volunteering at Children's centres Volunteering at libraries Learning Champions (Bolsover) Volunteering in the Health Service
Community Support	'Bedtime reading' clubs VCI support e.g. literacy cafe
Trusted advice from: Health Visitors	4 month visit and Bookstart gift Follow up 9-12 month visit

	Healthy Child programme –may begin in maternity
Childminders and nursery staff talk to parents about activities they can do at home and why it's important.	Cards in place but cost £17 a pack Use of network meetings and Childcare Imp service to prepare staff
Support in my home	Package of Back packs and training for: Family Resource workers Family Intervention project workers Floating Support / Housing VCI signposting /support Follow on from SLC one:one (ELKLAN trained Children Centre workers) Family Nurse practitioners?
Support through an agency	Children's centres / PEEP Surestart librarian activities Library activities Some PCT Nursery nurse activities (Clay Cross)
Support through a group	Family Learning organised through Children's centre, health centre, nursery or school provided and funded by DACE Informal adult learning
Support on a course	Adult Education / qualification either through DACE, approved VCI or FE college Workplace learning
Early Years Education	Could nursery schools do more with parents if they partnered with someone with better access?
Compulsory Education	Could schools do more with parents if they partnered with someone with better access? E.g. outdoor activities, family days, clubs, adult education, community groups
Specific support for Teenage parents	Housing: Floating Support

Specific support for Children in Care	Social pedagogy 'Stick at it' Amber Valley pilot
Support in the wider environment	Museums, parks, heritage centres, Galleries, leisure centres, on message and offering inclusive support.

Appendix 2

Strategic Synergies:

This approach to family reading has close synergies with other strategic plans and operational systems. This list only covers those synergies which came to light during the pilot phase; it is not exclusive and does not represent all of the strategic plans or services which the Derbyshire Strategic Partnership could bring to bear on language and literacy.

1. **Helping children to achieve more:** the governments approach to improving outcomes for children. Literacy confidence affects: safety, health, achievement, economic well-being and participation, and continues to have an impact on outcomes throughout life.

2. **The Derbyshire Family Support Strategy:** this strategy sets guidelines and processes for early intervention and support for families. In terms of helping parents to purposively promote their child's education, workforce development, partnership working and monitoring, the two strategies are linked. This strategy fits within the Family Support Strategy where literacy is recognised as one of the differentiated layers of family support.

3. **Family Learning**: Derbyshire Adult and Community Education (DACE) is the lead partner on Family Learning. There is a universal offer on a wide range of DACE courses for families to learn together. Additionally there are targeted family learning opportunities and specific family learning literacy courses. Within the Family Learning Literacy offer there are introductory courses and courses leading to a basic skills qualification in literacy for the parent.

   The new Skills Funding Agency criteria for family learning will allow greater freedom to offer the support that families need in more accessible ways. The DACE family learning coordinator has considerable experience in Family Literacy and community based approaches to delivery. This element of the DACE programme is very well placed to be a key player and funder in the delivery options for this strategy.

4. **Every Child a Talker (ECAT)** this one year pilot has enhanced training for supporting communication in early years settings. ELKLAN training, to develop language rich environments for children, has been introduced as workforce development; some training for parents is also being offered. A 2 year old communication screening test has been developed for Health Visitors to use.

5. **Speech, Language, Communication Needs network**. This is a partnership planning and development group for those working with children who have SLCN. Increasingly the children referred to these specialists are children whose development is delayed by family practice. The information and support these parents require is a precursor to that required to support family literacy. Therefore similar reach and access issues apply. The SLCN group is responsible for service improvement in language and communication. There is a possibility of close monitoring and reporting links between communication, language and literacy, possibly to the Children's Trust.

   2011 is the **National Year of Communication** for children, known as 'Hello', and this provides another opportunity to begin to embed this work in 2011.

6. **Health Visitors**: play a key role in developing and disseminating information to parents. A piloted Partners in Literacy approach using the book gifted by Bookstart as a talking point could be rolled out through Health Visitor Locality Managers. Health Visitors also have a role in identifying delayed speech and language. PCT locality managers have a role in extending the learning from this pilot within health services. The **Healthy Child Programme** (in progress, Derbyshire PCT) will guide health visitors to supporting parents to help baby learn. Health Visitors will be more involved with signposting and referring to other language and literacy support.

7. **Bookstart**: a book gifting programme to children under one and in their third year. This is linked to the children and family offer in libraries. A Library / DACE partnership is developing a course for parents based on the book gifts to show parents how to use books with their children. The Bookstart programme and associated support needs to be made accessible to parents and delivered in communities in ways which are acceptable to them.

8. **Parenting Support**: 'Positive parenting', 'living with children', 'living with teenagers'. The ideas and skills encouraged in these courses have a lot of synergy with good family reading practice but reading is, so far, not used as a means to an end. The inclusion of literacy activities and parents' role in supporting literacy as a means to engage with children in a positive way is being trialled and evaluated.

9. **Children's Centres, PEEP:** these courses are designed to help parents better understand how they can support their children's learning and development.

10. **Culture and Communities, Libraries:** the library service makes a number of offers to support emergent adult readers and families. By working in closer

partnership with agencies which can identify target families, libraries are better able to focus services for these families with literacy need and adapt to their needs for information, guidance and support. The library service could also play a crucial part in making other resources available on loan and in working with family support agencies to ensure the best use of these loans.

11. **Culture and Communities**: **Museums, Art Galleries and Heritage sites:** these centres could offer a range of support on communication, participation and adult education matched to children's syllabus subjects.

12. **Family Resource Workers / Family Intervention Project key workers:** these workers can support literacy in families by working with them on first step interventions and signposting to supported participation. Colleagues using literacy resources have been impressed with the positive affect on bonding between family members.

13. **Volunteering:** there is a huge potential resource, at various levels, for literacy support through volunteering. Volunteers could be engaged as follows, to:
    - be community mentors and help encourage better reading in families
    - be buddies in schools or start a family reading project from a school
    - work with established volunteer services such as Home Start and CVS.
    - be encouraged to obtain the Derbyshire Trust Volunteer Passport

    Volunteering opportunities are provided though workforce development and could be created from within DCC workforce. Elsewhere literacy volunteering is sold as workforce development to the private sector. Through social housing and the VCI sector and Children's Centres literacy volunteering could be included in community development and confidence building programmes. There is the potential for volunteering programmes to be supported through the 'Big Society' policy as yet to be fully described by the government. DACE is currently developing a Community Learning Volunteer programme which could be explicitly linked to family literacy support.

Linked strategic synergies:

Adult education and skills for life: parents who become involved in family learning and skill development often address their own skills and are more likely to return to education or training.

In house workforce development: as part of public sector workforce development, sessions in family reading could be offered to parents of young children. This could be linked to the GO Award initiative. A volunteer programme could be developed as part of workforce development.

Regeneration and Worklessness: the communities which need the most intervention are those that are also affected by worklessness. Improving the literacy skills of parents in these areas could be linked to other forms of support for returning to work.

Health and Wellbeing: poor health and shorter lifespan are significantly correlated with low educational achievement. Furthermore problems with reading instructions and leaflets make it difficult for some families to understand health advice,

Report Author - Anita Thomas
Assistant Director - Equality, Inclusion and Human Rights NHS Derbyshire County / Derby City Cluster

Agenda Item No. 9

SHADOW HEALTH AND WELLBEING BOARD

22 September 2011

EQUALITY AND DIVERSITY

1. Purpose of the Report

The key purposes of this report are to brief Derbyshire County's Health and Well-Being Board on the recent launch of the Department of Health's Equality Delivery System (EDS) and to recommend that the Board agrees to receive and comment on the EDS performance reports of local NHS organisations.

2. Information and Analysis

2.1 The report's scope includes highlighting:

- The background to, and key requirements of, the new Equality Delivery System
- The proposed role of a recently convened Derbyshire Community Health Equality Panel (DCHEP) in assisting Derbyshire NHS organisations to effectively review their EDS performance
- How the Health and Well-Being Board could receive and consider EDS assurance information and performance reports from local NHS organisations
- How and when the EDS will be formally launched in Derbyshire

2.2 Department of Health Equality Delivery System

2.2.1 The Department of Health's Equality & Diversity Council, led by Sir David Nicholson, developed the Equality Delivery System, which is aimed at improving the equality performance of the NHS and embedding equality into mainstream business. The EDS is based on best practice, including the Equality Performance Improvement Toolkit that is operating successfully in the North West.

2.2.2 It is proposed that the EDS will focus on the things that matter the most for patients, communities and staff. It emphasises genuine engagement, transparency and the effective use of evidence.

2.2.3 The EDS applies to both current and planned NHS commissioning organisations, including Clinical Commissioning Groups (CCGs), and to NHS providers. By using the EDS, it is anticipated that organisations will not only improve their equality performance but also be better able to

meet the requirements of the Equality Act 2010 and the equality requirements relating to CQC registration (for providers) or authorisation (CCGs). It should be noted, however, that use of the EDS does not automatically lead to, or ensure, compliance.

2.2.4 During 2011/12, in full engagement with local interests, NHS organisations will be expected to develop four-year Equality Objectives and priorities, based on a grading of their equality performance against a set of EDS goals and outcomes. There are 18 outcomes (detailed in Appendix 1, EDS Outcomes and Goals), grouped under four goals:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and well-supported staff
- Inclusive leadership at all levels

2.2.5 Based on transparency and evidence, NHS organisations and local interests agree one of four grades for each outcome in the form of RAG ratings:

- Excellent (Purple)
- Achieving (Green)
- Developing (Amber)
- Undeveloped (Red)

The grades are published. The Care Quality Commission (CQC) will take account of concerns highlighted by the EDS through the Quality Risk Profiles it maintains on all registered NHS providers

2.2.6 Following the consideration and analysis of stakeholder views and relevant data and evidence, NHS organisations, again in discussion with local interests, will confirm their Equality Objectives for the coming business planning period (as required by the Equality Act) and agree the priority actions. Performance against the selected priorities should be annually reviewed as part of mainstream NHS business planning and review processes.

2.3 Pilot Derbyshire Community Health Equality Panel and the receipt of EDS Performance Reports by the Health and Well-Being Board

2.3.1 The Department of Health EDS guidance recommends that, once finalised, equality objectives and associated actions are formally reported to the local Health & Well-Being Board. The EDS guidance states that LINks and their successors, the new local Health Watch, could play a key role in facilitating this process. In this context, and also taking into account the key EDS requirement of ensuring that local interests are centrally involved in reviewing NHS organisations' equality performance, a pilot Derbyshire Community Health Equality Panel (DCHEP) has been set up.

2.3.2 DCHEP's key roles are to act as:

- A co-ordinating panel for the engagement and involvement of local interest groups in Derbyshire
- A moderation panel for local interests in analysing organisations' performance against the requirements of the EDS, identifying priorities and making grading recommendations for Derbyshire NHS Trusts and Clinical Commissioning Groups.

DCHEP's current draft Terms of Reference are included at Appendix 2.

2.3.3 It is proposed that the Health and Well-Being Board could receive, consider and comment on EDS assurance information and performance reports from local NHS organisations. The reports would either directly include, or be supported by, an overview statement from DCHEP on the key feedback from local interests on each organisation's EDS performance and equality priorities and objectives. This proposal is fully endorsed by the national EDS guidance which advises that: "The critical and independent support of these (HWB) boards can go a long way in helping the EDS to run successfully."

2.3.4 In order for the Board to assure itself that DCHEP has involved all relevant interest groups in the analysis of organisations' EDS performance, it may be appropriate for the Board to request that DCHEP provides at least one report annually which summarises the groups with which it has engaged, and its involvement methodology.

EDS Engagement and Launch Event

2.4.1 The Equality Delivery System encourages continuous improvement and the delivery of positive outcomes for protected groups*, using the best available evidence and good practice examples to inform service and workforce developments. It has a key enabling role in helping NHS organisations to identify and address health inequalities and commission/ deliver accessible equitable health services.

2.4.2 In the context of the EDS's potential value, a formal launch of the EDS, promoting community and stakeholder engagement, will take place on the 6th October 2011 which members of the Health and Well-Being are invited to attend. Further details on the event are attached in Appendix 3.

3. RECOMMENDATIONS

The Board is recommended to:

- Note the background to, and key requirements of, the new Equality Delivery System

- Approve the proposed role and Terms of Reference of the recently convened pilot Derbyshire Community Health Equality Panel
- Consider whether DCHEP should be formally requested to produce and submit, at least annually, a report which summarises the groups with which it has engaged, and its involvement methodology.
- Approve that it receives, considers and comments on EDS assurance information and performance reports from local NHS organisations
- Note the invitation to the Equality Delivery System launch event on the 6th October 2011

* The protected characteristics (listed in the Equality Act 2010) are: age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation

Appendix 1

Department of Health Equality Delivery System
Objectives and Outcomes

The analysis of the outcomes must cover each protected group, and be based on comprehensive engagement, using reliable evidence

Objective	Narrative	Outcome
1. Better health outcomes for all	The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results	1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities
		1.2 Patients' health needs are assessed, and resulting services provided, in appropriate and effective ways
		1.3 Changes across services are discussed with patients, and transitions are made smoothly
		1.4 The safety of patients is prioritised and assured
		1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups
2. Improved patient access and experience	The NHS should improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience	2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds
		2.2 Patients are informed and supported so that they can understand their diagnoses, consent to their treatments, and choose their places of treatment
		2.3 Patients and carers report positive experiences of the NHS, where they are listened to and respected and their privacy and dignity is prioritised
		2.4 Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently

3. Empowered, engaged and well-supported staff	The NHS should Increase the diversity and quality of the working lives of the paid and non-paid workforce, supporting all staff to better respond to patients' and communities' needs	3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades
		3.2 Levels of pay and related terms and conditions are fairly determined for all posts, with staff doing the same work in the same job being remunerated equally
		3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately
		3.4 Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all
		3.5 Flexible working options are made available to all staff, consistent with the needs of patients, and the way that people lead their lives
		3.6 The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population
4. Inclusive leadership at all levels	NHS organisations should ensure that equality is everyone's business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions	4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond
		4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination
		4.3 The organisation uses the NHS Equality & Diversity Competency Framework to recruit, develop and support strategic leaders to advance equality outcomes

Appendix 2

Derbyshire Community Health Equality Panel

(Equality Delivery System Governance Group)

Terms of Reference

1. Purpose

The Derbyshire Community Health Equality Panel (DCHEP) is a voluntary sector led strategic alliance jointly developed in partnership with local LINks (and their successor Health Watch), Derby and Derbyshire Race and Equality Commission and NHS organisations to support and monitor the implementation of the NHS Equality Delivery System (EDS). The purpose of DCHEP is to act as a co-ordinating and moderating panel for the engagement and analysis of Equality Delivery System (EDS) priorities from local interest groups in Derbyshire and to make grading recommendations on EDS outcomes for Derbyshire NHS Trusts and Clinical Commissioning Groups.

2. The panel's objectives :

- Derby/Derbyshire LINks (and their successor Health Watch) and Derby and Derbyshire Race and Equality Commission will jointly oversee the group and monitor compliance of EDS Standards as independent local organisations.
- To provide a coordinated representation of local interest groups from all protected characteristics.
- To coordinate engagement with local interest groups, particularly seldom heard groups and present aggregated analysis of recommended equality priorities
- To monitor and support all NHS organisations in Derbyshire in the delivery of the EDS standards by the dates set out within the NHS regional EDS Implementation plan and guidance.

- To undertake joint assessments with Derbyshire NHS organisations of their delivery against EDS outcomes and make annual recommendations of gradings.
- To enable the sharing of learning and best practice across Derbyshire and with the regional NHS neighbour(s) with regard to the implementation of the EDS.

3. Membership

Membership to the Group will include, but not be limited to:

Derby City and Derbyshire LINks
Derby and Derbyshire Race and Equality Commission
Patient/community representatives
Representatives from local interest groups representing all 9 protected characteristics (plus seldom heard groups)
Derbyshire Community Health Services NHS Trust
Derbyshire Health Care NHS Foundation Trust
East Midlands Ambulance Service
Derby Hospitals NHS Foundation Trust
Derby and Derbyshire NHS Cluster
Chesterfield Royal Hospital
Local Clinical Commissioning Groups
Derbyshire City Council Public Health representative
Derby City Health and Well-Being Board representative
Derbyshire County Council Public Health representative
Derbyshire County Health and Well-Being Board representative

4. Roles and Responsibilities of DCHEP Members:

- Ensure local champions on the panel have a strategic understanding of community, inequalities and broader issues impacting on health and well-being.

- Ensure effective engagement of local interests and community groups (particularly from protected characteristics, seldom heard and disadvantaged groups).

- Seek assurance that NHS organisations have undertaken effective engagement with local interest groups. This will include validating, confirming and challenging trusts with regards to effective and sustained engagement of local interests in EDS process and continuous feedback, offering support and advice as critical friends.

- Facilitating access to networks/groups to support organisations to effectively engage with diverse groups, particularly seldom heard and disadvantaged groups.

- Proactively work with Health and Well-Being Board and Health Watch to ensure views of diverse groups are represented and the effective use of resources.

- To ensure demographic and local community needs are taken into account in order to develop improved provision with regards to access to quality services, commissioning, effective consultation and feedback.

5. Governance arrangements

DCHEP is an independent voluntary sector led group. It will seek to receive EDS progress reporting from all NHS organisations in Derbyshire.

Reporting arrangements to both Derby City and Derbyshire Health and Wellbeing Boards to be agreed.

6. Frequency and structure of meeting

DCHEP will be chaired by a non NHS representative namely Derby/Derbyshire LINks (their successor Health Watch) and Derby and Derbyshire Race and Equality Commission (rotational basis).

Derbyshire Community Health Equality Panel

invites you to the launch event of

The Equality Delivery System for the NHS

Thursday 6 October 2011, 9.30am to **4pm**

Derby West Indian Community Association,
Carrington Street, Derby, DE1 2ND

- Come and learn about the Equality Delivery System and what it will mean to you.
- It is a means by which all NHS health services can meet the requirements of the Equality Act (2010), Human Rights Act (1998) and the NHS Constitution (2010)
- Help us to set the Equality Delivery System priorities in Derby and Derbyshire
- An opportunity for the community and local organisations to hold your local Health Service to account for delivery on Equality locally.
- Come and dialogue with local, regional and national stakeholders to ensure your voices are heard.

Lunch will be provided.

Booking is essential.

Contact: Kirit Mistry on **01332 372428** or email kiritmistry@derbyrec.org.uk

Derbyshire Healthcare NHS
NHS Foundation Trust

Derby Hospitals NHS
NHS Foundation Trust

East Midlands Ambulance Service NHS
NHS Trust

Derby & Derbyshire Race and Equality Commission

LINk MAKE IT HAPPEN!

NHS Derby City and NHS Derbyshire County

Derbyshire Community Health Services NHS
NHS Trust

Report Author – David Lowe Agenda Item No. 10

SHADOW HEALTH AND WELLBEING BOARD

22 SEPTEMBER 2011

HEALTH AND WELLBEING BOARD – LEARNING SETS

Purpose of the report

To update the Board about a series of Learning Sets being established as part of the Health and Wellbeing Board National Learning Network.

Information and Analysis

As an "early implementer" for Health and Wellbeing Boards, Derbyshire has now been asked to become involved in Learning Sets, currently being established as part of the Health and Wellbeing Board National Learning Network.

The Learning Network aims to enable Health and Wellbeing Board members to share their knowledge and experiences with peers. It will cover both practical and developmental issues that will ultimately improve outcomes for local people.

As a result of consultation, Learning Sets have been developed and incorporated as a key element of the Learning Network. They will enable groups of Health and Wellbeing Boards to work together on issues of mutual interest to share learning and best practice, find new approaches to delivering outcomes and produce a summary of the work of the set which will then be used as guidance for others.

The Learning Sets, further details of which can be found in Appendix A to this report, will cover a number of themes including:

- Improving services for the community
- Improving the health of the population
- Bringing collaborative leadership to major service change
- Creating accountable and effective structures
- Raising the bar in joint needs assessment and strategies
- Maximising opportunities for joint commissioning and integration across the NHS and local government
- Embedding engagement in the work of the Board

Membership of the sets will be based on the principle of co-production between the Department of Health, Local Government Group and Health and Wellbeing Board early implementers. While a core membership will deliver the

themes listed, a wider membership will be able to access the learning of the core and share their own experiences.

Designated Health and Wellbeing Board early implementers will work with a Department of Health sponsor to lead the initial design and development of the set, agree the terms of reference and deliver monthly progress updates. A 'sponsor' policy lead from the Department of Health will provide support for learning set members and help frame the issues they will explore to avoid duplication.

A maximum of 15 Health and Wellbeing Boards will make up the core membership of each Learning Set, with responsibility for active participation and the dissemination of learning across their Health and Wellbeing Boards. Once the Learning Set is established, a maximum of 140 associate members will be able to read and access relevant content and where appropriate, engage with the work of the set. Each early implementer has been asked to indicate their preferred Learning Sets, with a view to being selected as a core member for one of these issues.

At this stage in the development of the Shadow Board and given the current workload and future work programme, it may not be the most appropriate or beneficial time to become a core Learning Set member. However, the Board may wish to consider whether there are any priority issues where becoming an associate Learning Set member may be valuable to the Board's ongoing development. It is anticipated that the majority of meetings and discussions will take place online, therefore as an associate member the Board would still have access to the learning opportunities available.

Regardless of the Board's involvement in Learning Sets, ensuring that Board members are kept up to date of the latest developments and current issues, through ongoing communication and engagement with other early implementers, will remain a priority.

Recommendations

1. To note that the Board has been invited to become involved in a series of learning sets as part of the Health and Wellbeing Board National Learning Network.

2. To agree which, if any, Learning Sets the Board would wish to become an associate member.

Appendix A

DRAFT

Identifying the leaders and members of health and wellbeing board themed learning sets

The Health and Wellbeing Board National Learning Network

Health and wellbeing boards are a key element of the health and care reforms introduced in the NHS White Paper, and further strengthened following the NHS Future Forum listening process. Their role is to bring together the key decision makers across the NHS and local government, to set a clear direction for the commissioning of health care, social care and public health, and to drive the integration of services across communities. Strong relationships between health and wellbeing board members, driving a mutually agreed set of priorities, will be critical to their success.

The purpose of the Learning Network is to support health and wellbeing board members to develop knowledge and behaviours that will enable them to work effectively to deliver their shared purpose. In some places, shared leadership is already well established, and has been tested over time. In other places, there is a great willingness to work collaboratively, but recognition this will require new and different approaches.

By April 2012, health and wellbeing boards will need to be able to operate effectively in shadow form during 2012-13. Joint strategic needs assessments and joint health and wellbeing strategies will need to be in place by October 2012 to inform the first clinical commissioning group commissioning plans for 2013-14.

The Learning Network will enable the members of the emerging health and wellbeing boards to share their thinking and experiences with peers. It will cover very practical issues around, for example, agreeing health and wellbeing board membership, but also allow participants to work on the developmental issues that will make the real difference in creating a highly effective board, and ultimately to improve outcomes for local people.

The Learning Network comprises five main elements:

- learning sets based around themes of common interest
- an online “Community of Practice” to facilitate communication between network members
- two national events to stimulate new thinking and share learning
- elected member development, incorporating joint work with local NHS leaders, specifically clinical commissioners and Directors of Public Health
- engaging other stakeholders in the development of health and wellbeing boards and integrated working.

The Learning Set approach

Learning sets have been incorporated as a main element of the Learning Network after extensive consultation with early implementer health and wellbeing boards, stakeholders, and experts in learning and development. They will enable groups of health and wellbeing boards to work together on issues of mutual interest, which are likely to feature on their agendas in the run up to April 2013. The learning sets will:

- Share learning between participants, drawing on their own experience
- Draw on published evidence of good practice in their area of interest
- Enable boards to try out new approaches and share the comparative outcomes and learning

- Regularly update other members of the wider Learning Network on their learning to date
- Produce a summary of the work of the set, to be used as guidance by others

We anticipate that the majority of learning set meetings and discussions will take place online.

What themes will the learning sets cover?

The learning sets will cover the following themes:

- **Improving services for the community:** as a member this learning set, you will join a sub-group focusing on a key population group. You will develop understanding of how health and wellbeing boards can operate effectively across the NHS, local government and wider partners to improve outcomes for one of the following issues: children's health, mental health, long-term conditions, people with learning disabilities, dementia, older people, offender health.

- **Improving the health of the population:** as a member of this learning set you will develop understanding of how health and wellbeing boards can drive effective action by the NHS, local government and wider partners to improve the health of the population in your communities, maximising the health gains achieved by local public services.

- **Bringing collaborative leadership to major service change**: as a member of this learning set you will develop understanding and best practice in how health and wellbeing boards can embed collaborative leadership effective across the NHS, local government and wider partners in potential major reconfigurations in your communities.

- **Creating effective and accountable structures:** as a member of this learning set you will develop understanding and best practice of how the governance of health and wellbeing boards and other new (and existing) structures can bring about effective mechanisms for balancing national, local and democratic accountabilities in your communities.

- **Raising the bar in joint needs assessment and strategies:** as a member of this learning set you will help to develop understanding and best practice of how health and wellbeing boards can effectively align and integrate Joint Strategic Needs Assessments and joint health and wellbeing strategies with clinical commissioning, resulting in improved outcomes for your communities.

- **Maximising opportunities for joint commissioning and integration across the NHS and local government:** as a member of this learning set you will help to develop understanding of the role of health and wellbeing boards have in driving forward local priorities for joint commissioning and integration for your communities.

- **Making engagement rather than consultation with communities the norm:** as a member of this learning set you will develop understanding and best practice of how health and wellbeing boards can embed engagement with the public, patients, carers and citizens an integral part of their work, for the benefit of your communities. This set will operate through the HealthWatch pathfinders work.

Who will be members of the Learning sets?

Membership will be based on the principle of co-production between DH, Local Government Group and the health and wellbeing board early implementers themselves. It will also be flexed over time to allow:

- a core membership which will deliver the objectives set out above
- a wider membership which can access the learning of the core, and if core members wish, comment on and share their own experience to enrich the learning (associate membership).

On this basis, we propose:

- A lead health and wellbeing board early implementer to work with a DH sponsor to lead initial design and development of the set, agreement of a simple terms of reference, and delivery of monthly updates via the Community of Practice and final outputs to the wider Learning Network members.
- A "sponsor" policy lead from DH (including Deputy Regional Directors for social care and partnerships, and transition teams) with responsibility to support learning set members to access existing evidence of best practice, and help frame the issues they will explore to avoid duplication. By agreement with learning set members, they will also co-produce guidance.
- Core members, up to a maximum of 15 health and wellbeing boards, per set. Members will be responsible for active participation in the work of the set, and dissemination of learning across their health and wellbeing board. They will share responsibility with the lead health and wellbeing board early implementer for agreeing terms of reference, and delivering monthly updates and summary/guidance for other learning network members.
- Associate members (may be up to a maximum of 140 other members by agreement of the core), who will be able to read and access relevant content and/or opportunities to engage with the work (through online seminars, for example). Associate membership will be opened up once the set has had the opportunity to establish itself.

How will Lead Health and Wellbeing Board roles be determined?

We will invite all early implementers to express an interest in leading a learning set, indicating their preferred theme. Should more than one early implementer express an interest, we'll come together to agree a way forward.

How will core members be selected?

We will ask early implementers to express their preferred learning sets 1-3. We will aim to match as many as possible with their first choice, but will need to balance this with the need to have a good spread across the themes.

On joining a set, we will ask the health and wellbeing board to nominate a lead representative who will participate on their behalf, attending the meetings and ensuring the board is engaged in the learning set's work.

Where a health and wellbeing board does not get it's first preference, but still wants to be involved, we encourage they are involved in the work of the set through 'associate membership' arrangements.