Appendix 2

Wiltshire Council

Wiltshire Shadow Health and Wellbeing Board

2 April 2013

FORMAL ESTABLISHMENT OF THE HEALTH AND WELLBEING BOARD

Introduction and Purpose

1. The Health and Social Care Act 2012 introduces a requirement on all upper tier Councils (Unitaries and Counties) to establish a Health and Wellbeing Board by 1 April 2013.

2. This report outlines the key issues for consideration by the Board to enable it to make recommendations to the Council in May for the establishment of the Board.

Background

3. A number of principles underlie the creation of Health and Wellbeing Boards and the spirit in which the legislation has been drafted – these include:-

    - shared leadership of a strategic approach to the health and wellbeing of communities that reaches across all relevant organisations;
    - a commitment to driving real action and change to improve services and outcomes;
    - parity between board members in terms of their opportunity to contribute to the board's deliberations, strategies and activities;
    - shared ownership of the board by all its members (with commitment from their nominating organisations) and accountability to the communities it serves;
    - openness and transparency in the way that the board carries out its work;

4. The statutory functions of the Health and Wellbeing Board contained within the Act are:-

    - to prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), which is a duty of local authorities and clinical commissioning groups (CCGs).

- a duty to encourage integrated working between health and social care commissioners, including providing advice, assistance or other support to encourage arrangements under Section 75 of the National Health Service Act 2006 (i.e. lead commissioning, pooled budgets and/or integrated provision) in connection with the provision of health and social care services.
- a power to encourage close working between commissioners of health related services and the board itself.
- a power to encourage close working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services

5. The Act also provides for Councils to delegate any other functions under section 196(2) of the Health and Social Care Act 2012. For example, this could include certain public health functions and/or functions relating to the joint commissioning of services and the operation of pooled budgets between the NHS and the council. Such delegated functions need not be confined to public health and social care. Where appropriate, they could also, for example, include housing, planning, work on deprivation and poverty, leisure and cultural services, all of which have an impact on health, wellbeing and health inequalities.

6. It is suggested that for the meantime the Board concentrates on its core functions and does not seek further delegations from Council.

Status and Nature of the Board

7. It is fair to say that this issue has caused some concerns nationally. The Act requires that the Board be treated as if it was a committee established in accordance with the Local Government Act 1972. However the regulations – referred to in detail in the next section of this report – then amend/modify or disapply the provisions of the 1972 Act in some key areas.

8. This means that councils are being asked to treat Boards as a completely new and unique body, one which has had its functions (as set out in para 4 above) conferred on it directly by statute.

9. The legislation and regulations have been drafted with the deliberate intention of allowing considerable flexibility to councils and their partners in the way that the boards are established. The intention is that Boards should be set up and run with the underlying principles in mind but in a way that suits local circumstances. This means that a wide range of options is available to councils. These issues are dealt with in more detail in the paragraphs 15 - 29 below.

10. All of the modifications and disapplications of current legislative provisions apply to any sub committee structures that the Board may wish to establish.

Regulations

11. These were due to be laid in the House of Commons in the autumn of last year but there has been a delay. These have now been laid on 8 February 2013.

12. This delay has meant that it has not been possible to establish the Board by the date of 1 April 2013. Discussions have taken place with the Department of Health and they are not overly concerned with this indeed many councils are taking the logical step of formally appointing the Board at the annual meeting of their Council in May. Indeed with elections in May 2013 there were no scheduled meetings of the Board during April and so the proposal is to appoint the Board at the first meeting of council following the elections.

13. The key areas of legislation that are modified are as follows:-

    - The requirements of political proportionality are disapplied in relation to boards
    - To allow officers to be represented on the Board
    - To enable all members of the Board (including officers, CCG representatives etc) to vote

Membership and Voting

14. These are the first two key issues. As opposed to ordinary committees of the council the Social Care Act lays down the statutory membership of the Board as follows:-

    - at least one councillor from the relevant council
    - the director of adult social services
    - the director of children's services
    - the director of public health
    - a representative of the Local Healthwatch organisation (which will come into being on a statutory footing on 1 April 2013)
    - a representative of each relevant clinical commissioning group (CCG)

15. The Act also requires that the councillor membership is nominated by the Leader of the Council in councils which are operating executive arrangements. Representatives of the CCG's and Healthwatch are to be appointed by those respective organisations.

16. Councils are also permitted to include other councillors as appropriate but must do so in consultation with the Board. Likewise the Board may agree to add additional members such as representatives of other stakeholders or partner organisations such as the voluntary sector or providers.

17. In addition the NHS Commissioning Board must appoint a representative for the purposes of participating in the preparation of the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy and will join the Board when it is considering these matters.

18. Whilst the Act is silent in relation to the issue of members of the Board voting, the regulations specifically enable all members of the Board to vote (unless the council directs otherwise) and the Act encourages councils to treat all members of the board with parity of esteem.

19. Whilst it is very early to be searching for best practice on membership and voting guidance about to be issued by the LGA indicates from the case studies contained therein, that most councils are appointing executive members including the leader or mayor to chair the Board along with the most relevant cabinet members. There is also a clear preference towards consensual voting with majority voting only being exercised where consensual agreement cannot be reached.

20. The Board needs to determine its recommendation to council in terms of:-

    (a) The membership of the Board outside of the core membership established by the Act;
    (b) The voting arrangements in terms of who can and who cannot vote;

21. Issues that the Board should consider before agreeing its recommendation on membership and voting arrangements:-

    (a) The principal role of officers has conventionally been to provide councillors with impartial advice. This role does not sit comfortably with the ability to vote.
    (b) All members of the board with a vote in effect become co-opted members of the council and therefore are subject to the requirements of the code of conduct in relation to declaration of interests etc;
    (c) The spirit of the Act which suggests parity of esteem between members of the board – this will be made more difficult if one group within the board has significantly more voting members than other groups;
    (d) Any inherent conflicts of interests for members of the Board – eg providers;
    (e) The ability to distinguish between groups of members (outside of the core membership) by classifying voting and non voting/observers.

Codes of Conduct and Conflicts of Interest

22. Neither the Health and Social Act nor the regulations made there under modify or disapply the legislation under the Localism Act in relation to the code of conduct and the declaration of interests. Therefore all voting members of the Health and Wellbeing Boards will be required to comply with that legislation and Wiltshire Council's code of conduct.

23. Non councillor representatives on the Board may also be subject to their own code of conduct and professional standards.

24. In order to better understand this position it is suggested that following formal appointment of the Board some awareness sessions be organised for all non-councillor representatives on the Board to explain in detail the provisions of the legislation and the code of conduct.

Transparency and Openness

25. The Health and Social Care Act does not modify or disapply the current legislative provisions relating to the access to information. So Boards will have to comply with the Local Government (Access to Information) Act 1985 so that the public have access to the meetings, the agenda and reports.

26. The Department of Health are very keen that whilst the Board is to be treated as if it is a traditional committee of the council, its proceedings should be conducted in such a way that both the non-councillor membership and the public feel able to engage and participate in an inclusive and welcoming forum.

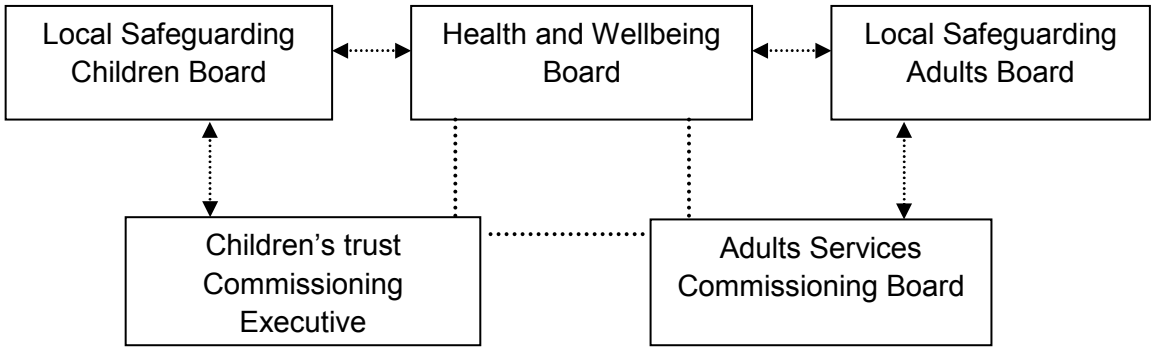
Accountability and Relationships with other Council structures

27. This in part relates back to the status of the Health and Wellbeing Board.

28. Health and Wellbeing Boards are to be treated as committees of the Council and therefore they should report to Council regularly on the business they transact. This should in part help to embed their business within the council and help with cross party ownership of the issues with which it is dealing. In particular the Boards are tasked with preparing the JSNA and JHWS and it will wish to consult partner organisations as part of this process. The Council should be regarded as one of those consultees and this again will help ensure cross party support for these two key documents.

29. Formally it is not considered that the Board operates executive functions and therefore its relationship with Overview and Scrutiny is one of partnership. Its decisions are not subject to call-in but it may wish to work with Overview and Scrutiny to develop particular areas of work that it is focussing on. Conversely the Overview and Scrutiny Committee may wish to scrutinise particular areas of work that the Board are looking at.

30. There are also broader relationships within the Council with other structures. Both the commissioning of services for adults and children will work as sub groups of the Board and whilst these are not accountable to the Board the commissioning arrangements will be brought together at Board level through joined up reporting arrangements. Likewise the safeguarding responsibilities of the Council are performed through the respective multi agency Safeguarding Boards for Adults and Children. Whilst again the governance of these Boards will be separate they will have a critical relationship with the Health and Wellbeing Board which will be both mutual and complementary. These relationships are described in the structure chart below.



QUESTIONS FOR THE BOARD

31. To enable the Council to formally appoint the Health and Wellbeing Board there are a number of issues that need to be determined. The working arrangements for the Board will evolve over time and indeed should be reviewed in due course.

32. The Board are asked to respond to the following questions:-

A. this report (para 14) outlines the statutory core membership for the Board, does the Board think that all the statutory members should have votes ?

B. is it acceptable that any of the key groups within the statutory membership should have a majority of votes on the Board ? ie be able to outvote all other groups ?

C. with this mind how many councillors should be elected onto the Board with votes ? and how many CCG reps should there be ?

D. Outside of the core statutory membership does the Board wish to appoint any other members ? and if so who are they ?

- Acute trusts ?
- Voluntary sector ?
- Other partner agencies ie the PCC
- Other councillors ?

E. And should they have votes ? or should they have observer status ?

F. Who should chair the Board – a Councillor or an independent chair ?

G. In order to encourage and facilitate cross party ownership of the Issues that the Board will be dealing with, should the minutes of the Board be submitted to the Council ? and should the Council be consulted formally on the JSNA and the JHW strategy ?

33. Following consideration of these views the Council will formally appoint the Board and the Director of Law and Governance will make any necessary consequential amendments to the Council's Constitution.

John Quinton, Head of Democratic Services, Wiltshire Council