Local Government Association

Association of Democratic Services Officers

Health, adult social care and ageing

Health and wellbeing boards

A practical guide to governance and constitutional issues

Contents

1. Introduction

This guide is a joint publication by the Local Government Association (LGA) and the Association of Democratic Services Officers (ADSO). The content has been shared with the Department of Health (DH) and the Department for Communities and Local Government (DCLG). The purpose of this document is to provide a guide to governance and constitutional issues arising from the legislation, including the Health and Social Care Act 2012 and the regulations under section 194 of that Act.

This guide is intended to support councils in a practical way in interpreting and implementing constitutional and governance aspects of the legislation. It has no statutory standing, nor does it constitute non-statutory guidance. It is too soon in the development of health and wellbeing boards to reach a consensus on what best practice should look like. Rather, the examples we use in the guide are intended to cover a range of possible ways of addressing constitutional and other issues and to indicate some questions that councils and health and wellbeing board members will need to consider.

For the avoidance of doubt, this guide does not constitute legal advice. Councils will need to obtain their own legal advice on any matters of a legal nature arising in connection with the establishment and operation of health and wellbeing boards and the relevant legislation.

Underlying principles of boards

A number of principles underlie the creation of health and wellbeing boards. 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
- inclusiveness in the way it engages with patients, service users and the public.

The legislation was aimed at allowing considerable flexibility to councils and their partners on health and wellbeing boards to set up and run boards that conform to these principles in a way that suits local circumstances. This means that a range of options will be possible.

Functions of boards

The Health and Social Care Act 2012 gives health and wellbeing boards specific functions. These are a statutory minimum and further functions can be given to the boards in line with local circumstances. The statutory functions 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 (ie 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.
- Any other functions that may be delegated by the council 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.

In developing the governance, constitutional and other arrangements for boards, councils and boards should bear in mind these core functions and how they may best be facilitated in the context of existing local partnerships and the way in which the new local health improvement landscape is developing. Some shadow boards have been tightly focused on a small range of functions and specific priorities.

Others have taken on a wider brief, for example in relation to wellbeing generally. In some cases, the focus of shadow boards builds on the Local Strategic Partnerships (LSPs) or arrangements with which these have been replaced. For example, some areas have retained LSPs, which have been working well in drawing together partners across a number of sectors. In cases such as this, health and wellbeing boards may be focused on specific priorities deriving from their core functions. In other areas, health and wellbeing boards are now seen as the overarching local body which will take on at least part of the role of the LSP.

In these cases, boards are likely to have very widely drawn terms of reference, not confined to their core statutory functions.

In some areas, shadow health and wellbeing boards have decided to take an approach to issues such as joint commissioning which looks at the bigger picture and does not get involved in operational matters, believing that current local arrangements for detailed commissioning are sufficiently robust to undergo the transition to the new local NHS. In other areas, shadow health and wellbeing boards are taking the opportunity to prepare to strengthen joint commissioning arrangements and oversee their delivery through sub-structures of the board. A broad, strategic or a more 'hands-on' approach are both compatible with the regulations. (See the sections below on relationships and sub-committees and delegation for more detail.)

While the health and wellbeing board is required to discharge the council's and CCG's duties of undertaking JSNAs and developing JHWSs, it may be considered appropriate also to consult the full council. Doing so could improve the local transparency and accountability of the work of the health and wellbeing board. This could help to gain cross-party support of the strategies and the commissioning intentions on which they are based.

Ways of working

Councils and their partners on health and wellbeing boards can take advantage of the flexibility allowed by the regulations to develop ways of working that genuinely reflect the wishes of their members and the needs of the communities they serve. Boards should, of course, conduct their business in a way that is appropriate to their statutory role and is effective in fulfilling their functions. It is also important that their members and members of the public who attend meetings should understand what is happening and the issues being discussed and that they should feel able to participate where appropriate. For example, certain agenda items may lend themselves to a participatory style of discussion that could include members of the public or an opportunity for different board members to present and lead discussion of an issue.

Health and wellbeing boards are intended to be a genuinely new model of partnership working – it is in this spirit that the legislation will need to be implemented.

2. The regulations

The regulations relating to health and wellbeing boards are published as Statutory Instrument 2013 No. 218 entitled, The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 http://www.legislation.gov.uk/uksi/2013/218/contents/made

The regulations modify certain legislation as it applies to health and wellbeing boards and disapply certain legislation in relation to the boards. The provisions which are modified or disapplied are in the Local Government Act 1972 and the Local Government and Housing Act 1989.

Under section 194 of the Health and Social Care Act 2012, a health and wellbeing board is a committee of the council which established it and for the purposes of any enactment is to be treated as if appointed under section 102 of the Local Government Act 1972. It is therefore a 'section 102 committee', as it is sometimes called within local government. However, the regulations modify and disapply certain provisions of section 102 and other sections of the Local Government Act 1972 and also provisions of the Local Government and Housing Act 1989 in relation to health and wellbeing boards.

This means that it is best not to think of health and wellbeing boards according to the strict model of other section 102 committees, but to think of them as a basic section 102 committee with some differences. The sections below discuss the characteristics shared by health and wellbeing boards with other council committees and where they do or may diverge under the new regulations.

The modifications and disapplications which apply to health and wellbeing boards within the regulations generally also apply to sub-committees and joint sub-committees of boards.

3. Establishment of health and wellbeing boards and carrying out of functions

What the legislation says

Under the Health and Social Care Act 2012, upper-tier and unitary councils in England must establish a health and wellbeing board. Its functions should include the statutory functions outlined above and any other functions that the council wishes to delegate to it. Additional functions may be added by the council at later dates and this will need to be allowed for in a health and wellbeing board's terms of reference. Constitutional matters such as terms of reference will also need to be discussed with the whole council.

The functions of encouraging integrated and close working are conferred directly on health and wellbeing boards. The Health and Social Care Act 2012 also requires that councils and CCGs discharge their functions of developing JSNAs and JHWSs through health and wellbeing boards, ie that the boards discharge these functions of local authorities and CCGs. The council and CCG will want to retain oversight to ensure the functions are discharged properly. They will also need to provide input, for example as to the scope of the functions, through evidence to inform JSNAs; and by taking actions to meet the identified needs.

Options

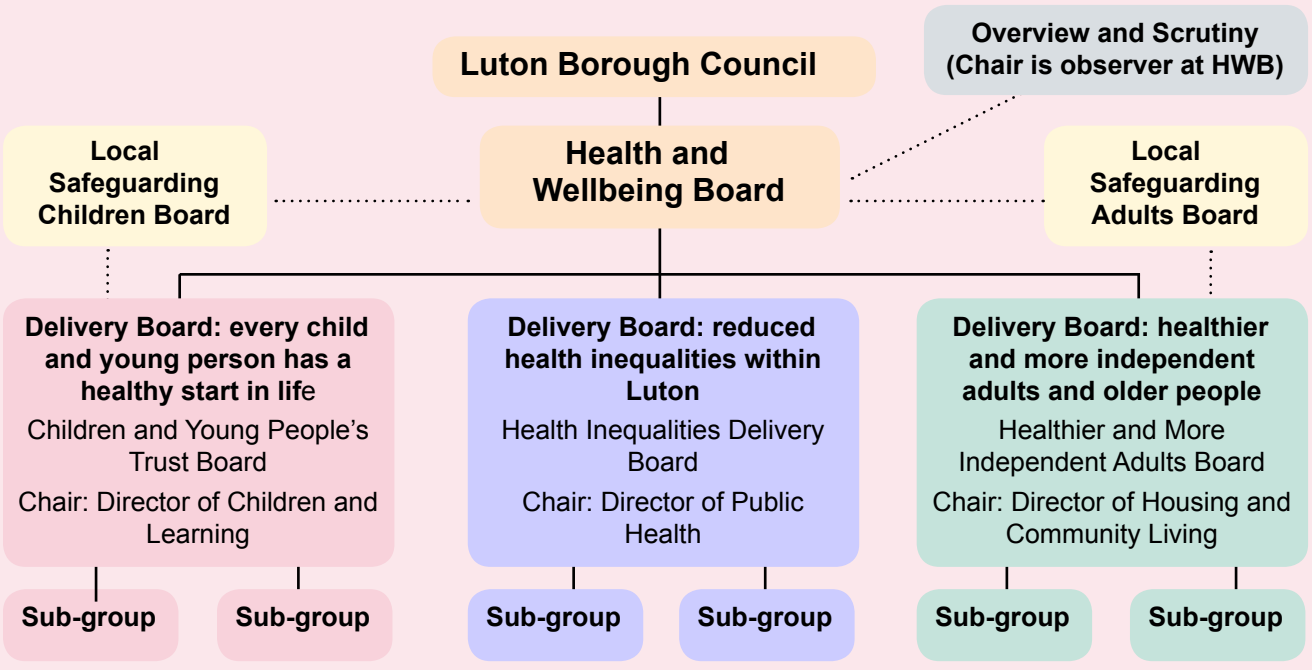
Health and wellbeing boards can choose a variety of methods to develop their JSNAs and JHWSs. Many shadow boards have held informal seminars or public engagement conferences to involve a wide range of participants in initial brainstorming about priorities. Many have also set up a strategy group to oversee the development of these assessments and strategies and to ensure that they are fit for purpose. Such groups are likely to include CCG representatives and either Directors of Public Health, Adult Social Services and Children's Services or their nominees ie officers in their departments. They could also include district councillors or councillors with responsibilities for these portfolio areas. Strategy groups or task groups could also include representatives of the voluntary sector and/or local Healthwatch and, for example, researchers from local universities or regional public health networks who are helping develop and interpret demographic information.

Bristol shadow Health and Wellbeing Board hosted a stakeholder conference involving board members and other stakeholders such as local universities and third sector representatives who are not members of the board, to discuss priorities for the board's first JHWS. Voluntary and community sector organisations in Bristol also organised an event to feed into the development of the strategy. The priorities identified are now being developed by a small strategy group chaired by a GP member of the Health and Wellbeing Board, supported by officers and reporting regularly to the board. A draft strategy will be published for formal public consultation before being finalised.

Contact: **Kathy Eastwood,** Service Manager, Health Strategy
Kathy.Eastwood@bristol.gov.uk

Integrated working between health and social care will need close oversight during the transition from PCTs to CCGs and beyond. Commissioners in councils and PCTs are likely to have joint commissioning activities for which successor arrangements will need to be made. Some shadow health and wellbeing boards are proposing to subsume these joint commissioning structures as sub-committees of the board. This will require formal delegation of functions by the council executive (or full council, for councils not operating executive arrangements) to the board. Lead commissioning by social care or the NHS on behalf of both parties, pooling of budgets and integrated commissioning are all permitted under section 75 of the National Health Service Act 2006.

Luton has used the establishment of its shadow Health and Wellbeing Board to develop new structures across the council and its partners to support a wide range of activities on health and wellbeing. The diagram below shows the intended structures from April 2013. The delivery boards sitting under the Health and Wellbeing Board are not formal sub-committees, but groups set up by the lead officers to support the implementation of JHWSs. Any budgets are those which are already delegated to officers for services.



Contact: **Bren McGowan**, Partnership Manager: Bren.Mcgowan@luton.gov.uk

Key issues to consider

- ✓ Have you timetabled an item in your council's schedule of forthcoming meetings to discuss the establishment of your health and wellbeing board?
- ✓ Is there a common understanding in your council and among health and wellbeing board members of the board's status as a committee and its core functions? How will the core functions and provision for the delegation of additional functions be included in the board's constitution and terms of reference?
- ✓ Is there appropriate provision for the board's structures, for example through sub-committees or working groups, to support its core functions eg to develop JSNAs and JHWSs and to encourage integrated working?
- ✓ Has there been discussion of what the role of the board will be in relation to joint commissioning? Will any part of this role require delegation from the executive/ mayor/council to the board?
- ✓ Is your council and its executive aware of the option to delegate additional functions to the board? Have there been or will there be opportunities for discussion of what, if any, these might be?

Further information

Health and Social Care Act 2012 and explanatory notes: http://tinyurl.com/c9dpdp5

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013: http://www.legislation.gov.uk/uksi/2013/218/contents/made

LGA, 'Get in on the Act: Health and Social Care Act 2012': http://tinyurl.com/d3z2tzm

Products from the National Learning Network for health and wellbeing boards: 'Support and resources for Health and wellbeing boards': http://tinyurl.com/by7oc8c

'A guide to governance for health and wellbeing boards': http://tinyurl.com/at7dyon

'Operating principles for Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies': http://tinyurl.com/azthskh

Department of Health, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies – draft guidance: http://tinyurl.com/atktxlu

4. Membership and voting

What the legislation says

It is clear from the Health and Social Care Act 2012 that health and wellbeing boards are different to other section 102 committees, in particular in relation to the appointment of members. Specifically, the Act:

- sets a core membership that health and wellbeing boards must include:
  - 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)
  - any other members considered appropriate by the council
- requires that the councillor membership is nominated by the executive leader or elected mayor (in councils operating executive arrangements) or by the council (where executive arrangements are not in operation) with powers for the mayor/ leader to be a member of the board in addition to or instead of nominating another councillor
- under the regulations (Regulation 7) modifies sections 15 to 16 and Schedule 1 of the Local Government and Housing Act 1989 to disapply the political proportionality requirements for section 102 committees in respect of health and wellbeing boards – this means that councils can decide the approach to councillor membership of health and wellbeing boards
- requires that the CCG and local Healthwatch organisation appoint persons to represent them on the board
- enables the council to include other members as it thinks appropriate but requires the authority to consult the health and wellbeing board if doing so any time after a board is established
- the NHS Commissioning Board must appoint a representative for the purpose of participating in the preparation of JSNAs and the development of JHWSs and to join the health and wellbeing board when it is considering a matter relating to the exercise, or proposed exercise, of the NHS Commissioning Board's commissioning functions in relation to the area and it is requested to do so by the board.

The Local Government Act 1972 does not allow officers to be members of local authority committees. Regulation 5(1) removes this restriction in relation to health and wellbeing boards by disapplying section 104(1) of the 1972 Act to enable the local authority directors specified in the 2012 Act to become members of health and wellbeing boards.

Regulation 6 modifies the Local Government and Housing Act 1989 (section 13(1)) to enable all members of health and wellbeing boards or their sub-committees to vote unless the council decides otherwise. This means that the council is free to decide, in consultation with the health and wellbeing board which members of the health and wellbeing board should be voting members.

Voting arrangements would need to be agreed by the whole council. In considering whether to make any variation to the provision that all members of the board, including non-councillor members, may vote, the council will wish to bear in mind the aim of giving parity of esteem to all members of the board.

Options

Membership

The regulations disapply the requirement for political proportionality. However, cross-party engagement in health and wellbeing boards is clearly going to be important in achieving health improvement and wellbeing objectives for the whole population. There is no restriction on the number of councillor members boards may have under the core membership specified in the legislation. However, membership of boards is only one option among many for engaging a range of councillors from different parties.

Many shadow boards have wanted to stay small and focused and have therefore not included additional members. This may be an issue especially in two-tier areas where councils might wish to appoint district councillors but do not want the board to become unmanageably large. Nonetheless, in the spirit of inclusiveness and shared ownership of boards, a number of upper-tier and unitary councils are appointing councillors from across the political spectrum, including opposition parties, to shadow boards.

Some boards are finding different ways to involve councillors beyond the core statutory membership, for example, by offering opportunities for the whole council to discuss JSNAs and JHWSs or by asking scrutiny committees to look at different aspects of health and wellbeing and make recommendations to the board.

In some areas, the role of providers of services is highly controversial and political, particularly where big changes in the NHS landscape are taking place or are likely in the future. In other areas, long-established providers are seen as having an essential contribution to make to the deliberations of health and wellbeing boards. The options of restricting voting rights to certain categories of board member should assist councils to developing an approach to voting that is appropriate to local circumstances. See the publication from the National Learning Network on engaging with providers (referenced below) for more discussion of this issue.

The terms of reference for Cheshire East's shadow Health and Wellbeing Board include the potential for board members to exercise their voting rights and, subject to the board's approval, for 'associate' members (ie non councillor members) to vote when appropriate. However, the board believes that resorting to voting rights could indicate that there are difficulties in collaborative working and in understanding each other's viewpoints. Therefore, the board's emphasis throughout is that its decisions and recommendations should ideally be determined through open debate and consensus.

Contact: **Diane Taylor**, Partnerships and Planning Manager, Children, Families and Adult Services
Diane.Taylor@cheshireeast.gov.uk

Durham Health and Wellbeing Board's terms of reference include a quorum of five members. Decisions will be reached by consensus. If a consensus cannot be reached the Chair will then call for a vote and a simple majority will prevail. The Chair will have a second casting vote if a simple majority is not reached.

Contact: **Peter Appleton**, Head of Policy, Planning and Performance, Adults, Wellbeing and Health
Peter.Appleton@durham.gov.uk

In Plymouth, partners on the shadow Health and Wellbeing Board have signed up to the principle that decisions and recommendations will be reached on a consensus basis.

In exceptional circumstances and where decisions cannot be reached by a consensus of opinion and/or there is a need to provide absolute clarity to executive bodies, voting will take place and decisions will be agreed by a simple of all members (councillors and co-opted members) present.

Contact: **Ross Jago**, Democratic Support Officer
Ross.Jago@plymouth.gov.uk

Key issues to consider

- ✓ Do all health and wellbeing board members understand the principles that underpin the board's membership and voting arrangements?
- ✓ Do councils and health and wellbeing board members understand the regulations and what the options are for councils in respect of board membership and voting?
- ✓ Do non-council board members understand the complexities of the councillor/officer relationship and why councils need to give some thought to developing a new kind of relationship through health and wellbeing boards?
- ✓ Do non-council board members understand the meaning of and principles underlying democratic accountability?
- ✓ Have you made provision for your leader/elected mayor to nominate and for your council to formally appoint councillor members to your health and wellbeing board?
- ✓ Have you considered issues of cross-party engagement in the health and wellbeing board's work and have you come to a clear decision?
- ✓ Has there been any discussion of whether to include providers as board members and, if so, any voting issues that may arise?
- ✓ In two-tier areas, has there been any discussion of whether/how to include district councillors as members of the board?
- ✓ Have councillors and shadow board members discussed the issue of whether boards should have voting and non-voting members?

Further information

Department of Health, 'The general duties and powers of health and wellbeing boards': http://tinyurl.com/a284982

From the National Learning Network for health and wellbeing boards:
'Stronger together: how health and wellbeing boards can work effectively with local providers': http://tinyurl.com/bark38s

5. Codes of conduct and conflicts of interest

What the legislation says

The regulations under section 194 of the Health and Social Care Act 2012 do not modify or disapply any legislation relating to codes of conduct and conflicts of interest. This means that legislation in relation to these issues will apply to health and wellbeing boards.

All councillors and co-opted members of council committees are required to comply with a code of conduct. Under the Localism Act 2011(section 27 (4)), all non-councillor members of health and wellbeing boards who are entitled to vote on any question that fails to be decided at any meeting of the board would be 'co-opted members' for these purposes. This means that all voting members of health and wellbeing boards will be governed by the local authority's code of conduct. The code of conduct for each council sets out the conduct expected of members and co-opted members when they are acting in that capacity.

Section 28(6) of the Localism Act 2011 requires those codes of conduct to be consistent with the Seven Principles of Public Life. Within these rules, it is for individual councils to decide what their codes of conduct say. The legislation requires councils (other than parish councils) to have in place arrrangements to investigate, and take decisions on, allegations of a failure to comply with the authority's code of conduct.

Codes of conduct must also contain the provisions the council considers appropriate in respect of the registration and disclosure of pecuniary and other interests.

Section 29 of the Localism Act 2011 requires the monitoring officer of a relevant authority to establish and maintain a register of interests of members and co-opted members of the authority. Section 30 requires a member or co-opted member to notify council's monitoring officer of disclosable pecuniary interests on taking office.

Section 31 requires a member or co-opted member of a relevant council to disclose a disclosable pecuniary interest that they are aware of (apart from a sensitive interest — see section 32), at a meeting or if acting alone, where any matter to be considered relates to their interest. It prohibits a member from participating in discussion or voting on any matter relating to their interest or, if acting alone, from taking any steps in relation to the matter (subject to any dispensations — see section 33).

This will apply to members of health and wellbeing boards and might, for example be relevant in relation to members' financial interests in matters on which the boards will be deliberating, such as contracts with providers of services.

Section 34 makes it a criminal offence if a member or co-opted member fails, without reasonable excuse, to comply with requirements under section 30 or 31 to register or declare disclosable pecuniary interests, or take part in the local authority's business at meetings or when acting alone when prevented from doing so.

The principles of these requirements are consistent with the requirement on CCGs in relation to conflicts of interest. CCGs are under duties in relation to registers of interests and conflicts of interest. The NHS Commissioning Board is under a duty to issue guidance to CCGs on the exercise of their functions in relation to conflicts of interests and CCGs must have regard to such guidance.

It should also be noted that the public law notions of predetermination and bias will also apply: non-council members may not be familiar with these concepts.

Options

Councils will need to make clear to health and wellbeing board members that the council's code of conduct and requirements on Disclosable Pecuniary Interests apply to them and what this means. Non-councillor members of boards may be bound by other codes of conduct and professional standards. For example, the General Medical Council (GMC) provides advice for members of the medical profession on standards of professional conduct for doctors and the Health and Care Professions Council (HCPC) sets standards for members of the social work profession and of health care professions.

Representatives of local Healthwatch may require support and guidance on how to get the best from their seat at the board. Building on the learning and experiences of others who have been involved with shadow boards, Healthwatch England will be providing guidance for the local Healthwatch member on the health and well being board. This will be linked to guidance on how to influence by building an evidence base.

Most people who have sat on public sector governing bodies will be familiar with the Seven Principles of Public Life, and health and wellbeing board members may already be bound by the principles in their other roles.

Newcomers to public sector governance may welcome a briefing on these issues as part of a health and wellbeing board development programme. It may also be helpful to offer members an opportunity to explain to each other what their own professional and any other accountability responsibilities are. For the purpose of transparency and openness, it will be important to publicise accountability responsibilities. Boards are encouraged to consider summarising these responsibilities for the public (for example, on a board or council website).

Councillors and others who have served on public bodies will also have experience of having to declare an interest, including pecuniary interests, in relation to the bodies on which they serve; and will be familiar with what is expected of them in relation to potential conflicts of interest when certain matters are under discussion.

Other members of health and wellbeing boards will be less familiar with such practices and will need to be briefed and perhaps also reassured that the responsibilities involved are not onerous, that agendas will be published in advance (so that they can take advice if necessary), and that council officers can advise about what does and does not need not be declared. Particular advice may be required in relation to CCG members of health and wellbeing boards who are also service providers and may be delivering or bidding for contracts to provide services which the board will be discussing. Council officers who are not used to having to register and declare interests may also need advice as to what they should declare, for example, in relation to voluntary sector organisations on whose governing bodies they may sit and which may be bidding for service contracts.

Warwickshire currently has a partners' code which is based on the existing members' code of conduct and requires the same standards of behaviour in relation to declaration of interests and participation in meetings.

Contact: **Paul Williams**, Democratic Services Team Leader
Paulwilliamscl@warwickshire.gov.uk

Key issues to consider

- ✓ Have your health and wellbeing board members been briefed (or do you have plans to brief them) on the council's code of conduct and do they understand that it applies to them?
- ✓ Do the individual members understand what they should register on the register of interests and when and how they should declare an interest in specific agenda items?
- ✓ Have board members been given contact details for an officer who can advise them on which interests to declare and how and when to do so?
- ✓ Have board members had (or will they have) an opportunity to understand each other's professional accountability and the standards to which they are answerable?
- ✓ Are there clear arrangements for deciding on agenda items and circulating agendas in advance (see the next section for more detail)?

Further information

The Localism Act Explanatory Notes: http://tinyurl.com/b37v2sp

The Committee on Standards in Public Life – seven principles of public life: http://tinyurl.com/cjg5uyg

Department of Communities and Local Government – illustrative text for a code of conduct: http://tinyurl.com/a7hwv9y

Department of Communities and Local Government, 'Openness and transparency on personal interests: a guide for councillors': http://tinyurl.com/a3x485d

NHS Commissioning Board, 'Managing conflicts of interest: Towards Establishment: Technical appendix 1' (for CCGs): http://tinyurl.com/aaym3hc

6. Transparency and openness

What the legislation says

The regulations under the Health and Social Care Act 2012 do not modify legislation in relation to transparency requirements in relation to health and wellbeing boards. This means that they are subject to the same requirements of openness and transparency as other section 102 committees:

- in addition to the requirements relating to codes of conduct under the Localism Act 2011 mentioned above, the Local Government Act 1972 imposes requirements on committees of certain councils in relation to making copies of agendas and reports of meetings open to inspection by the public
- the Freedom of Information Act 2000 provides a general right of access to information held by public authorities
- regulations under the Local Government Act 2000 make provision for public access to meetings and to information relating to decisions of council executives and their committees
- the Equality Act 2010 requires specified public bodies, when exercising functions to have due regard to eliminating conduct prohibited by the Act and advancing equality of opportunity and fostering good relations between people who share protected characteristics and those who do not
- the Data Protection Act 1998 makes provision for the regulation of the processing of information relating to individuals.

Regulation 3 of the regulations modifies section 101(2) of the Local Government Act 1972 to clarify that health and wellbeing boards can appoint sub-committees to discharge their functions in accordance with section 102 of the 1972 Act.

Provisions that apply to committees also apply to any sub-committees that may be set up under them, since boards may delegate some decision-making powers to sub-committees.

The provisions described above do not apply to less formal sub-structures such as working parties which do not make decisions, but simply report and make recommendations to boards. It is usual, nonetheless, to keep similar records of the activities of working parties to those kept for sub-committees, for future reference.

In Leicestershire there are four sub-boards and two steering groups which sit directly beneath the shadow board:

- Staying Healthy Board
- Integrated Commissioning Board (Adults and Older People)
- Substance Misuse Board
- Leicester, Leicestershire and Rutland Health Protection Group (this is a sub board of the health and wellbeing boards in Leicester, Leicestershire and Rutland)
- Health and Wellbeing Board Steering Group (co-ordinates the day to day operation of the board's business and provides executive support to board meetings)
- JSNA and JHWS Steering Group.

These sub-boards take the lead on delivering specific outcomes, although the Health and Wellbeing Board will be held ultimately responsible for the achievement of all health related outcomes.

Contact: **Rosemary Palmer**, Senior Committee Officer
Rosemary.Palmer@leics.gov.uk

Wandsworth has opted for a tripartite structure: a board including all the members who will be required by statute, with a smaller joint commissioning executive responsible for operational matters and a wider health partnership for engagement around major policy issues, especially JSNAs and JHWSs.

Contact: **Richard Wiles**, Health Policy Team Leader
wiles@wandsworth.gov.uk

The intention in Barnsley is for the Health and Wellbeing Board to identify the totality of spend on health and social care and to use this on a pooled/aligned basis to address the needs of the Barnsley population. Due to the strategic nature of the Board, a series of supporting sub groups will take elements of the work forward, on behalf of the Board, and report back periodically to inform policy direction and resource allocation. This includes a senior strategic development group – effectively the executive group reporting to the main (currently shadow) Board. The role of this executive group is to ensure that implementation and actions are delivered by those responsible and to pull together the different agencies' 'transformation plans' into a whole system plan which supports the Health and Wellbeing Board in delivering its vision and outcomes. In addition, a joint commissioning group is being developed to co-ordinate the use of public funding and resources.

Contact: **Martin Farran**, Executive Director of Adults and Communities
Martinfarran@barnsley.gov.uk

Essex has established an executive board that sits under the shadow Health and Wellbeing Board and provides the capacity to deliver the HWB's strategy. The shadow Health and Wellbeing Board is also currently exploring a network approach to engagement with providers and other stakeholders as well as locality board arrangements aligned to either district council boundaries or clusters of districts in alignment with the CCG boundaries.

Contact: **Clare Hardy**, Senior Manager for Health and Wellbeing
Clare.Hardy@essex.gov.uk, 07747 486348

Warwickshire's shadow Health and Wellbeing Board does not have any formal sub-committees. Instead it has opted for a system of panels and steering groups which it believes are a good way of developing an advisory framework for the board for the following reasons.

The full board meets for two hours six times a year. As its workload has grown, so has the ability to give key areas the attention they require. Only by establishing some form of alternative working arrangements is it possible to cover the work.

Panels can be made up of people with the knowledge and interest to focus on specific topics.

Panels may focus on single issues or on different communities, based around the priorities set by the future JHWSs.

Contact: **Paul Williams**, Democratic Services Team Leader
Paulwilliamscl@warwickshire.gov.uk

Options

As board members will be aware, the principles of openness and transparency are not just about conforming to the letter of the law. Many people are put off by complex formal meetings which can rapidly become incomprehensible to observers, with frequent reference to board papers and use of shorthand and jargon. Both councils and the NHS – and now shadow health and wellbeing boards – have developed more inclusive ways of running meetings that actively involve the public. Decisions can still be taken and minuted in a way which conforms to requirements, but is more open and welcoming than formal committee meetings. Formats could include:

- café-style roundtable discussions in which members of the public are invited to participate
- presentations at which observers may ask questions and give their views
- devoting part of a decision-making meeting to listening to the experiences of service users and the public
- providing important board papers in an 'easy read' format to facilitate participation by, for example, people with learning disabilities
- providing a leaflet explaining how meetings will work, who will be present, how members of the public can contribute etc.
- webcasts of board meetings with mini-videos by board members explaining issues they are discussing.

Some PCT boards in recent years have begun each board meeting with an individual

case study to try to ensure that the decisions they take are based on the lived experience of service users. Local authority scrutiny committees frequently offer opportunities to members of the public and service users to talk about their experiences and how services could be improved, a model that could also be helpful to health and wellbeing boards. One option for increasing public involvement is to involve service users, their organisations and the public in working groups or task groups set up for specific purposes, for example, working groups focused on developing the board's public engagement strategy.

One issue that is likely to come under discussion by health and wellbeing boards is how, when they must meet in public, boards can have early and frank discussions on complex and sensitive issues without starting rumours or raising concerns amongst stakeholders before issues and options are understood fully, are ready for consultation or decision. This may be a particular concern for CCG representatives and other board members who have not had experience of serving on committees under similar transparency requirements.

Councils are subject to provisions under the Local Government Act 1972 which provides for access to meetings, reports and documents, subject to specified confidentiality provisions. Councils have extensive experience of operating under transparency requirements while retaining the option of having some discussions in private.

One way of doing this is to alternate meetings held in public at which decisions are taken, with less formal workshops or seminar sessions which take place outside the board, for both brainstorming and board learning and development. This is not to say that public board meetings need to be conducted with rigid formality, as discussed above.

Some shadow boards, particularly those which have a large and inclusive membership, have set up executive sub-groups to progress the formal decisions made by boards at their public meetings. For large boards which meet formally on a bi-monthly basis, some such executive arrangement may be considered essential to the effectiveness of the board.

Equally, boards will want to ensure that the option of holding some informal exploratory or planning workshops in private is not used to exclude stakeholders inappropriately. Indeed, 'task and finish' groups or working parties can be a way of including people with an interest and experience in the topic under review, with reports and recommendations being made to boards for public discussion and decision. Many shadow boards have set up such working parties to bring forward proposals or to help prepare draft JSNAs and JHWSs from 2013. Others have set up working groups to develop a public engagement strategy for the board's approval.

Some shadow boards are using the option of setting up sub-committees to make proposals for future arrangements for joint commissioning.

The shadow Health and Wellbeing Board for East Sussex has been meeting in public and is also webcast. In addition to full board members, attendees are involved in board meetings, to ensure the board can involve the district and borough councils, voluntary and community sector representation in the discussions and debate. The board put in place a formal review for December 2012 to ensure that any learning from the shadow process as well as from others can be built into the statutory board from April 2013.

Contact: **Barbara Deacon**, Policy Officer, Chief Executive's Office
Barbara.Deacon@eastsussex.gov.uk

Wandsworth's shadow Health and Wellbeing Board alternates formal meetings of the board with informal seminars – which operate outside standard governance procedures and without formal decision-making powers. The board envisages the need for this split in meeting type continuing beyond the commencement of the board's statutory status. Members believe that as relatively new bodies, health and wellbeing boards are benefitting from an energy and enthusiasm that will not exist in the long term unless the space for creative thinking is protected.

Contact: **Richard Wiles**, Health Policy Team Leader
Rwiles@wandsworth.gov.uk

Key issues to consider

- ✓ Are health and wellbeing board members aware of the duties of transparency and openness placed on boards by the legislation listed above?
- ✓ Has the board considered and developed formats for running its public meetings in a more inclusive way?
- ✓ Has the board considered whether it wants to set up any standing sub-committees and/or working parties which might draw in additional stakeholders to contribute to the work of the board?
- ✓ Has the board developed an approach to exploring sensitive issues before they become public?

Further information

Department of Communities and Local Government, 'Making local councils more transparent and accountable to local people' – summary of and links to legislation and government policy:
http://tinyurl.com/apn2ko5

Office of the Information Commissioner – website has guidance on the Freedom of Information and Data Protection Acts:
http://tinyurl.com/4omgo28

7. Accountability and relationships between health and wellbeing boards, other council structures and partnerships

What the legislation says

Health and wellbeing boards are not committees of a council's cabinet. Therefore, their decisions do not need to go on the cabinet's key decision list or forward plan. However some councils may choose to delegate additional functions to the board. In these cases councils will need to adhere to the requirements of all of the applicable legal frameworks.

As overview and scrutiny can consider functions which are the responsibility of the council's executive as well as those which are not, and as there are additional scrutiny powers in relation to scrutiny of health, the discharge of functions by health and wellbeing boards fall within the remit of scrutiny but the core functions are not subject to call in as they are not executive functions.

Involving the public (people who live or work in the area) in JSNAs and JHWSs is a statutory requirement under the Local Government and Public Involvement in Health Act 2007 and is a form of ongoing accountability for boards.

Options

Health and wellbeing boards will need to think carefully about how best to relate to existing governance arrangements, both within councils and across partnerships. Although organograms with reporting lines do not in themselves build good working relationships, it will be helpful to clarify formal relationships between boards and different local governance structures from the outset.

Although not committees of cabinets, health and wellbeing boards will be making an important contribution to councils' overarching priorities and will be the means by which councils implement their duties to prepare and produce JSNAs and JHWSs. Because of this, boards will need to establish very strong working relationships with leaders, cabinets and elected mayors where relevant. This may take the form of membership of the board, or of regular meetings between the chair of the board and the council leader or elected mayor and/or regular reports to cabinet.

It will be important to develop a means of ensuring that the priorities in the JSNAs and JHWSs are aligned with other council and local NHS strategies and those of other strategic bodies for the area, including those relating to children's services, safeguarding boards, community safety partnerships and local enterprise partnerships and others. Some areas have retained a local strategic partnership which acts as the overarching co-ordinating body.

Other areas have given a co-ordinating role to the shadow health and wellbeing board and intend to give it to statutory health and wellbeing boards. Others have 'dotted line' reporting between various strategic bodies, where one body reports on its activities to another although the former is not formally accountable to the latter.

Relationships with local Healthwatch, the NHS Commissioning Board and CCGs will be facilitated by their representatives on health and wellbeing boards, but boards will also want to develop broader and deeper relationships at both a strategic and operational level.

As mentioned above, boards will need to develop an understanding with CCGs about how they take forward their duty to encourage integrated working – this may need more than a bi-monthly strategic meeting at board level which many shadow boards have instituted. Boards will therefore need to think about an operational as well as a strategic approach to the whole system and, specifically, about their relationship with joint commissioning structures.

There will need to be a three-way relationship between health and wellbeing boards, scrutiny committees (particularly health overview and scrutiny committees) and local Healthwatch. Some areas have begun to develop protocols or memoranda of understanding between the three elements of this relationship to ensure clarity and mutual understanding of roles and responsibilities.

As well as scrutinising the work of boards, scrutiny committees may also be in a position to assist boards to understand their populations better. For example, a health and wellbeing board could ask a health overview and scrutiny committee to investigate through a scrutiny review the low uptake of a particular service in certain geographical areas and make recommendations to the council, the CCG or the board and others as to how uptake might be increased (see the Centre for Public Scrutiny publication referenced below for more options).

In Bath and North East Somerset, there is agreement between the chairs of the shadow Health and Wellbeing Board, Wellbeing Scrutiny and shadow local Healthwatch to develop supportive arrangements that work towards the same goal of reducing health inequality. This means that the work programmes of the Board, Wellbeing Scrutiny and Healthwatch will be shared and loosely aligned to create pathways for influence, whilst maintaining independence and the role of scrutiny.

Contact: **Andrea Wolfenden**, Programme and Strategy Officer, Policy and Partnerships
Andrea.Wolfenden@bathnes.gov.uk

Health and wellbeing boards will be accountable not only to councils, but also to the communities they serve. They will need to consider the most appropriate methods of responding to these various accountabilities. For example, it may be good practice to report the activities of a health and wellbeing board through presenting its minutes to council meetings. Accountability to patients and the public is likely to be carried out through an ongoing engagement strategy, informing the way in which the board works, its priorities and membership. Some boards are setting up sub-committees or working groups to progress their engagement with patients and the public and co-opting additional voluntary sector members to contribute their expertise and network with local communities.

Boards will also want to develop mechanisms for evaluating and reporting to stakeholders on their own performance.

Birmingham Council and PCT have recognised the intrinsic link between improved health and wellbeing and access to suitable employment. For this reason, consideration is being given, in the first formal year, of giving a seat on the Health and Wellbeing Board to the Local Enterprise Partnership (LEP). At present, representatives of the LEP are invited to take part in the Health and Wellbeing Board Operations Group. This is the group that filters agenda items for the shadow Board, but also prioritises issues for consideration in JSNAs. This group has a wide range of interests represented on it to reflect the diverse range of stakeholders that influence health and wellbeing.

Contact: **Darren Wright**, Senior Programme Manager, Health and Wellbeing Board and Community Engagement
Darren.Wright@nhs.net

Cornwall has confined its Health and Wellbeing Board membership to those who will form the core statutory membership. However, the board is developing links to stakeholders and the public through other established partnerships and networks. The board is also developing links to the Local Enterprise Partnership and emerging Local Nature Partnership, recognising the inter-connectedness of the three strategies. The board has begun to develop its brand to distinguish itself from the council and to reflect the partnership nature of the board.

Contact: **Simon Mansell**, Principal Legal Officer, Corporate Governance
Simon.Mansell@cornwall.gov.uk

Barnsley's shadow Health and Wellbeing Board's relationship with One Barnsley, the Local Strategic Partnership, is being explored in detail. The plan is to adapt the current LSP delivery partnerships to report into the Health and Wellbeing Board as appropriate, for example, in the future, there is the potential to include the Community Safety Partnership. Furthermore, there is also the intention to develop an integrated commissioning function and an integrated intelligence function (wider than traditional JSNAs) which will also support the LSP and economic strategy as well as the Health and Wellbeing Board.

Contact: **Martin Farran**, Executive Director of Adults and Communities
Martinfarran@barnsley.gov.uk

Key issues to consider

- ✓ Is there clarity about the health and wellbeing board's formal relationships, including reporting arrangements and joint working, with internal council structures, including cabinets and scrutiny, CCGs, local Healthwatch and other partnership boards whose work has a significant health impact?
- ✓ Has the board considered what existing or new mechanisms can be used to progress its specific duties to encourage integrated working and to prepare JSNAs and JHWSs?
- ✓ Is there an agreed process by which the board will consider and comment on the council's and CCG's commissioning plans?
- ✓ How will the board make itself accountable to its constituent members and to local communities?
- ✓ Has the board considered developing a protocol or memorandum of understanding on roles and responsibilities and relationships with scrutiny and local Healthwatch?
- ✓ Are there performance systems in place to evaluate and report on the board's performance in relation to its objectives?

Further information

Outputs of the National Learning Network for health and wellbeing boards:
'A guide to governance for health and wellbeing boards': http://tinyurl.com/at7dyon

'Operating principles for JSNAs and JHWSs': http://tinyurl.com/bzhyw7l

'Encouraging integrated working to improve services for adults and older people: a practical guide for health and wellbeing boards': http://tinyurl.com/aotkf8y

'Health and wellbeing boards and criminal justice system agencies: building effective engagement': http://tinyurl.com/d9xhgj3

'Patient and public engagement: a practical guide for health and wellbeing boards': http://tinyurl.com/bdvhcvo

LGA, 'A new development tool for health and wellbeing boards': http://tinyurl.com/a5wjvtd

Centre for Public Scrutiny, 'Local Healthwatch, health and wellbeing boards and health scrutiny – roles, relationships and adding value': http://tinyurl.com/c8u3e6k

8. Health and wellbeing boards in two-tier areas

What the legislation says

The Local Government and Public Involvement in Health Act 2007 imposes a duty on health and wellbeing boards to involve district councils in the development of JSNAs. The legislation does not specify district councils' involvement in developing JHWSs, but it is in keeping with the spirit of the legislation and of a broad and inclusive approach to health improvement and to tackling health inequalities that districts should be included in JHWSs and in the work of boards in general.

Options

The functions of district councils and their relationships with their communities make them central to the health and wellbeing of those communities. Some district councils have public health units and/or staff. All have environmental health teams and are involved in local child and adult safeguarding boards. But even when their services don't have 'health' in their title, district councils have powers and responsibilities which are essential to the effective delivery of health and wellbeing services. As with upper-tier authorities, district councils have their own strategies and networks for engaging with local residents to consult them about priorities and the quality of services.

Health and wellbeing boards in two-tier local government areas will need to find ways of working with district councils and tapping into their engagement with stakeholders, to ensure that the health impact of district councils' functions is maximised to ensure services are integrated between counties, districts and the NHS and are planned around individuals, rather than around administrative units.

There is a wide range of options available to health and wellbeing boards to include district councils in their governance structures:

- some shadow health and wellbeing boards offer places to district councils, usually offering two or three places to be shared by a greater number of district councils, the members being nominated by the district councils in agreement with each other
- some shadow health and wellbeing boards invite district councils to send observers to board meetings and to participate in informal board learning and development sessions
- district council representatives, either councillors, officers or both, can also be offered places on sub-structures of the board, including sub-committees or working parties set up specifically to look at partnership work and integration of services between the local tiers of local government and the NHS

- all health and wellbeing boards will need to devise mechanisms for involving district councils in the development of JSNAs and, where appropriate, JHWSs.

Leicestershire's shadow Health and Wellbeing Board includes two district councillors. There is a designated district council chief executive who:

- co-ordinates the work of the district councils in relation to health issues
- is a member of the health and wellbeing steering group which plans for agendas and the forward workplan of the health and wellbeing board
- actively support the two councillors representing districts on the health and wellbeing board.

Contact: **Rosemary Palmer**, Senior Committee Officer
Rosemary.Palmer@leics.gov.uk

Lincolnshire has two district council leaders who have responsibility for representing seven districts on the shadow Health and Wellbeing Board. Districts have taken it upon themselves to set up arrangements to support the work of the health and wellbeing board with support from the individual public health link allocated to that district.

Contact: **Jennie Chapman**, Partnership Manager
Jennie.Chapman@lincoln.gov.uk

Kent is one of a small number of areas in which shadow Health and Wellbeing Boards have been established at district level and relating to CCG boundaries. The South Kent Coast Health and Wellbeing Board covers the Dover and Shepway district council areas and its title reflects the CCG boundaries that it covers. This and the other CCG/district level health and wellbeing boards will be established as formal sub-committees of the county health and wellbeing board.

Contact: **Caroline Davis**, Strategic Business Adviser
Caroline.Davis@kent.gov.uk

In Warwickshire, three district councillors represent the five districts/boroughs on the shadow Health and Wellbeing Board.

Contact: **Paul Williams,** Democratic Services Team Leader
Paulwilliamscl@warwickshire.gov.uk

Key issues to consider

- ✓ Has the health and wellbeing board considered how district councils will be involved in the board's work, either through membership of the main board, through its sub-structures or through other forms of engagement?
- ✓ Are any district council representatives appointed to the board or its sub-structures clear on their role and how they will feed back and represent the views of all the districts in the area?
- ✓ What mechanisms will be used to involve district councils specifically in the development of JSNAs and, where appropriate, JHWSs?
- ✓ How will the board implement its duty to promote integrated working between commissioners of health and social care services in relation to those aspects of district councils' work that impacts on or complements health and social care services?
- ✓ Has consideration been given to involving district councils in the board's patient and public engagement strategy?
- ✓ What regular communications channels will the board establish with district councils?

Further information

LGA District Councils' Network Public Health Survey (November 2012) (includes information on inclusion of district councils in health and wellbeing boards): http://tinyurl.com/abdrxzs

Appendix – Questions and answers on detailed and technical issues

Question: Who establishes a health and wellbeing board?

The Health and Social Care Act 2012 puts a statutory requirement on upper-tier and unitary local authorities in England, the council of the Isles of Scilly and the Common Council of the City of London to establish a health and wellbeing board, and provides that these boards be treated as if they were a committee appointed under section 102 of the Local Government Act 1972.

Question: Who appoints the members of the health and wellbeing board?

Currently regulations provide that the function of making appointments under section 102 of Local Government 1972 Act is not to be the responsibility of the executive. So appointments to the health and wellbeing board are the function of the council rather than the executive in executive arrangements.

The Health and Social Care Act 2012 sets out membership of the health and wellbeing board on the face of the Act and it is thus clear that the boards are different to other section 102 committees in certain respects. In particular the Health and Social Care Act 2012:

- Sets a core membership for each health and wellbeing board. This includes the Directors of Public Health, Adult Social Services and Children's Services, a representative of each relevant Clinical Commissioning Group (CCG) and a representative of local Healthwatch for the area, in addition to at least one elected representative, ie a councillor and, in councils with executive arrangements, the Mayor or Leader in addition to or instead of a councillor.
- Requires that the CCG and local Healthwatch must appoint a person to represent them.
- Requires that the councillor membership is nominated by the Leader or Mayor where councils operate executive arrangements, and by a council in other cases.
- Enables the council to include other members as it thinks appropriate but the council must consult the health and wellbeing board if doing so any time after the board is established. In some local areas, for example, there are plans to include representatives of criminal justice, foundation trusts or VCS providers on health and wellbeing boards.

- Enables the health and wellbeing board to appoint additional members as it thinks appropriate.

Question: Who can vote on a health and wellbeing board? Who agrees voting and other procedures for the health and wellbeing board?

Secondary legislation will disapply current restrictions that limit voting on section 102 committees to councillors, in relation to health and wellbeing boards.

The effect of this will be to create a default position where all members of a health and wellbeing board can vote unless the local authority otherwise directs. Thus the secondary legislation also allows local flexibility for a local authority to direct, for example, that officer members of a health and wellbeing board, or members in addition to those in the statutory core membership, do not hold voting rights. The local authority would need to consult the health and wellbeing board before making the direction.

Question: What are the functions of the health and wellbeing boards?

Health and wellbeing boards have three types of functions.

1. Preparation of Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs)
The Local Government and Public Involvement in Health Act 2007 provides that these are functions, both of local authorities and their partner clinical commissioning groups.

Local government legislation makes provision about the exercise of local authority functions. The default position under section 9D(2) of the Local Government Act 2000 is that subject to any provisions made by that Act or subsequent enactments, any function of the local authority which is not specified in regulations under subsection (3) of section 9D is to be the responsibility of an executive of the authority under executive arrangements. In the case of JSNAs and JHWSs, another enactment, section 196(1) of the Health and Social Care Act 2012, directly provides that these functions are to be exercised by the health and wellbeing board. In our view therefore, these are not the responsibility of the executive in executive arrangements.

As undertaking these processes and preparing their outputs is a function of the health and wellbeing board, there is no statutory requirement for the local authority or CCG to separately sign them off. However, many local areas will want to get sign off from the local authority and CCG as part of the process of building ownership of the JSNA and JHWS process – and to help ensure the priorities will be translated into action through commissioning plans.

2. Functions as to promoting integrated working
These functions are conferred directly on health and wellbeing boards under section 195 of the Health and Social Care Act 2012.

3. The discharge of other local authority functions
Section 196(2) of the Health and Social Care Act 2012 provides that a local authority may arrange for the health and wellbeing board to exercise any functions exercisable by the authority.

Question: What functions other than the statutory functions can be delegated to health and wellbeing boards?

The legislation does not indicate which other functions a council might delegate to a health and wellbeing board under section 196(2) of the Health and Social Care Act 2012. The most likely functions for delegation are those relating to commissioning of social care and aspects of public health services, especially joint commissioning of services with the NHS or functions relating to wider determinants of health, such as housing, that affect the health and wellbeing of the population. The council would have to act reasonably in exercising the power to delegate.

Question: The Act says that the leader/elected mayor should 'nominate' councillor members to health and wellbeing boards. Does this mean, the council as a whole does not have a say?

The Health and Social Care Act 2012 has given the role of nomination to the Mayor/Leader and the role of appointing to the council. So those respective roles must be respected. While the function of making appointments under section 102 of the 1972 Act is not the function of the executive, the 2012 Act sets out membership of the health and wellbeing board on the face of the Act and it is thus clear that the boards are different to other section 102 committees.

In particular the 2012 Act:

- Sets a core membership for each health and wellbeing board. This consists of the Directors of Public Health, Adult Social Services and Children's Services, a representative of each relevant Clinical Commissioning Group (CCG) and a representative of local Healthwatch for the area, in addition to at least one elected representative which is a councillor and/or the Mayor/Leader (in executive arrangements).
- Requires that the CCG and local Healthwatch must appoint a person to represent them.
- Requires that the councillor membership is nominated by the Leader or Mayor where councils operate executive arrangements, and by a local authority in other cases.
- Enables the local authority to include other members as it thinks appropriate (for example in some local areas there are plans to include representatives of criminal justice, foundation trusts or VCS providers on health and wellbeing boards) but requires the local authority to consult the boards if doing so any time after a board is established.
- Enables the health and wellbeing board itself to appoint additional members as it thinks appropriate.

Question: Can members of health and wellbeing boards send substitutes to board meetings?

The approach to substitution is for local determination. Under the local government legislation, the appointment of section 102 committees is not the responsibility of the executive. In the case of health and wellbeing boards, councillor members are nominated by the leader or mayor (in executive arrangements) and by the local authority in other cases. There is provision for local Healthwatch and CCGs to appoint persons to represent them on the boards. Additional members can be appointed to the board. The regulations are silent on the issue of substitution.

Where substitution does take place, this will need to be done in a way that does not result in unlawful delegation of the boards' functions ie functions being discharged by anyone other than the (properly constituted) boards themselves. Further, the practice of frequently sending substitutes to meetings is generally disliked by governing bodies in general, as it disrupts the continuity of dialogue and debate and may even result in contradictory decisions at different times. This is particularly true when a new committee, such as a health and wellbeing board is being set up and a process of 'institution building' is under way, with members trying to get to know and understand each other's perspectives.

However, councils and boards will also want to take an approach to substitution that recognises the seniority of board members and the pressures on their time, and, in some cases, pressures that may arise from living with long-term health conditions or caring for others. For other committees, councils usually have a scheme of substitution under which named substitutes are agreed in advance.

Question: Are health and wellbeing boards subject to scrutiny?

Generally, yes. In committee systems local authorities must ensure that overview and scrutiny committees have power to review and scrutinise decisions made or other action taken in connection with the discharge of any functions of the local authority. In executive arrangements local authorities must ensure that overview and scrutiny committees can review and scrutinise decisions or action in connection with discharge of functions whether or not they are the responsibility of the executive. Local authorities will have additional powers in relation to scrutiny of health. We expect that local authorities' scrutiny arrangements will be considering both the work of health and wellbeing boards, and the contribution of partners on the boards (CCGs and local authorities) to delivering JSNAs and JHWSs.

Local Government Association
Local Government House
Smith Square
London SW1P 3HZ

Telephone 020 7664 3000
Fax 020 7664 3030
Email info@local.gov.uk
www.local.gov.uk

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