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Report of the Director of Adult and Community Services CBMDC and the Director of Collaboration NHS Airedale, Wharfedale and Craven, Bradford City and Bradford Districts CCGs to the meeting of the Health and Wellbeing Board to be held on 18th March 2014.

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Subject: Terms of Reference and membership of Health and Wellbeing Board

Summary statement:

The Terms of Reference and membership of the Health and Wellbeing Board (HWB) were agreed by the Shadow Health and Wellbeing Board (SHWB) in March 2013 in preparation for the HWB taking over its statutory duties from April 2013.

This paper builds on the discussion at the January 23rd HWB meeting summarising the issues raised over the last year. It presents the HWB with options for membership to decide on in order to ratify the Terms of Reference and membership for the coming year.

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Portfolio:

Adult Services and Health

Overview & Scrutiny Area:

Health and Social Care

1. SUMMARY

1.1 The Terms of Reference and membership of the Health and Wellbeing Board (HWB) were agreed by the Shadow Health and Wellbeing Board (SHWB) in March 2013 in preparation for the HWB taking over its statutory duties from April 2013.

1.2 This paper builds on the discussion at the January 23rd HWB meeting summarising the issues raised over the last year. It presents the HWB with options for membership to decide on in order to ratify the Terms of Reference and membership for the coming year.

2. BACKGROUND

2.1 Health and Wellbeing Boards were viewed as an important aspect of the reforms introduced with the Health and Social Care Act 2012. Bradford District introduced the HWB in shadow form in April 2012 which then became fully operational in 2013. The Board brings together partners from the NHS, public health and local government with Healthwatch as the public voice. Here in Bradford the Third Sector has also been represented through Bradford District Assembly.

2.2 The overall purpose of the HWB remains unchanged, bringing together the named partners to jointly plan how best to meet the local health and care needs. Bradford has met its challenges to identify the needs of the population through the Joint Strategic Needs Assessment (JSNA) and set out how these needs will be addressed though the development of the Health and Wellbeing Strategy and the Health Inequalities Action Plan (HIAP).

2.3 A core function of the Board is to promote integration and this has been reinforced by policy developments in this area. The Government will introduce the Better Care Fund in 2015/16 which will establish a pooled fund across Health and Social Care to support whole system transformation and better integrated care and support.

3. OTHER CONSIDERATIONS

3.1 There has been general agreement that the Boards have become operational at a time of great organisational challenge and financial pressures. The need for a local partnership has never been greater. To enable the Board to continue to deliver strong local leadership it is imperative that it has both the right membership and the most appropriate governance arrangements

3.2 The Board wishes to look at alternative ways of working with all stakeholders to harness the great enthusiasm in the district to make the HWB work well for Bradford and its people.

3.3 The current Bradford and Airedale Terms of Reference, March 2013 is included as Appendix 1. There is no recommendation to change the name or the existing stated purpose. It is proposed that the stated purpose remains as follows:

To create a close working partnership between the NHS and City of Bradford Metropolitan District Council and to bring a new local accountability to assessing health and care needs. To be the key partnership forum for determining local priorities and providing oversight on their delivery through enabling and driving the integration of health and social care, and wellbeing in order to create more effective pathways for both service users and those who need to access services. This relationship should significantly reduce health and social inequalities and ensure accountability for local commissioning plans, creating a whole systems approach to improving health and wellbeing and maximising value for money

3.4 There is a suggestion that the principle duties are changed to extend 3.4 to read

'To oversee the production of the Joint Strategic Needs Assessment and the Pharmaceutical Needs Assessment'

3.5 To extend principle duty 3.6 to read

'To provide collective leadership and a local interface for both planning and governance through engagement with the NHS Commissioning Board, Public Health England, Local Partnerships and providers, including the Voluntary, Community and Faith Sector and to undertake all statutory duties'

3.6 To add an additional principle duty to receive reports from the Integration and Change Board.

3.7 The HWB now has an opportunity to look to the future and the challenges ahead and consider if it should make any changes to its membership in order to fulfil its purpose and duties.

3.8 The current Board membership is detailed in Appendix 1 section 4.1. The legal appraisal of the Board in section 7 of the report explains the statutory membership of the Board.

3.9 A number of suggestions have been made to review the membership of the Board as follows:

- To include formal representation from the Bradford Community Safety Partnership (CSP) following a Home Office report that recommends strengthening links between Health and Wellbeing Boards and the CSP Board. Strong links would contribute to delivering sustainable interventions in relation to the harmful impact of groups, gangs and serious youth violence.

- To include the Police and the Crime Commissioner or their nominated representative in their commissioning role

- To include the Chief Executive of Bradford Metropolitan District Council (BMDC) considering their key strategic role and their role as Chair of the Integration and Change Board (ICB)

- To include representation from the major NHS providers, Airedale NHS Foundation Trust (ANHSFT), Bradford Teaching Hospitals Foundation Trust (BTHFT) and Bradford District Care Trust (BDCT)

- To review the representation of the Voluntary and Community Sector (VCS) through the Bradford District Assembly

3.10 At the HWB meeting on 23rd January these proposals were discussed. The HWB expressed a view that they did not want the HWB to become too large and unwieldy. There appeared to be a consensus however in favour of the major NHS providers being represented on the Board and the Chief Executive of CBMDC becoming a member.

3.11 The make up of Health and Wellbeing Boards across the country vary and some have additional members above the required statutory minimum

3.12 In preparing this report the membership of the HWBs from 23 other districts was considered. Around two thirds currently just have statutory members although one or two of these are similar to Bradford and are reviewing their membership. Eight of the districts had included major providers as Board members. When including major providers there may be potential for a conflict of interest although this tends to be addressed by declaring the interest then the providers removing themselves from the debate as appropriate. It was felt by those who had included major providers that the benefit of provider membership outweighed any difficulties. Provider inclusion was viewed as a positive proactive way to support the transformation towards integrated care and the Boards wished to include providers in the development of systems that would ultimately very much affect them.

3.13 The Board may wish to consider the balance of representation between the Local Authority and NHS if the membership is extended.

3.14 Those districts who choose not to include major providers on their HWBs stated that they did not wish the Board to become unwieldy and did not want difficulties in agreeing which major provider to select for membership.

3.15 Two of the Boards had representation from the Chief Superintendent of Police and the Crime Commissioners Office as formal members recognising that they can help the Board to tackle key issues around safety, mental health and alcohol which are priorities for the Board. One further HWB is in the process of expanding their membership to include the Police.

3.16 None of the districts contacted made a comment on Third Sector involvement. The Third Sector contribute a different approach to delivering Health and Wellbeing services with their understanding of the strategic picture and their close

links to people experiencing inequalities.

3.17 The Board may wish to consider whether the Deputy Chair is a representative from NHS to further reflect partnership arrangements. The Kings Fund report published in October 2013 commented on a survey of HWBs with 70 responding. In the case of the Deputy Chair almost 48% were from the CCG, 34% elected members and the remainder drawn from a variety of different backgrounds.

4. OPTIONS

4.1 To make no changes to the Terms of Reference and keep the HWB membership the same

4.2 To extend principle duties 3.4 and 3.6 as detailed in this report

4.3 To consider each proposal and whether membership should be extended and, if not all proposals are accepted, how engagement with those key stakeholders can be maintained

4.4 In light of the discussion at the 23rd January meeting to retain the existing membership of the HWB and extend it to include representation from the three major NHS providers and the CBMDC Chief Executive. Provider representation could be either one representative from each of the three main NHS providers or one place on the Board to represent health care providers within the District.

4.5 To consider the composition of the Board and the position of Deputy Chair with consideration being given to whether the Deputy Chair should come from the NHS membership if it was felt it would better reflect the partnership of the Board

4.6 To review whether every member is a voting member

5. FINANCIAL & RESOURCE APPRAISAL

5.1 There are no financial issues arising from this report.

6. RISK MANAGEMENT AND GOVERNANCE ISSUES

6.1 N/A

7. LEGAL APPRAISAL

7.1 It is for the local authority to establish the HWB. The Health and Social Care Act 2012 prescribes a core statutory membership of at least one elected representative nominated by either the Leader of the council, the Mayor, or in some cases the local authority; a representative from each CCG whose area falls within or coincides with the local authority area (though a single representative can represent 2 or more CCGs if the board agrees); the local authority directors of

adult social services, children's services and public health; a representative appointed by the local Healthwatch organisation. It is for the Leader, Mayor or in some cases the local authority to determine the precise number of elected representatives on the board and the relevant person would be free to decide upon nominating a majority of elected members. The balance of political groups within the council may be taken into account. The NHS Commissioning Board must appoint a representative to join the HWB when JSNAs and the related HWS are being drawn up.

7.2 The HWB can request a representative of the NHS Commissioning Board be appointed when considering matters relating to the exercise of the commissioning board's commissioning functions. If considered appropriate local authorities or HWBs can add members to the Boards in addition to those set out in legislation, including for example representatives from other groups or stakeholders who can bring in relevant expertise or skills or perspectives or who have key statutory responsibilities that can support the work of boards, such as those from the criminal justice agencies or District Councils or local representatives of the voluntary sector or clinicians or providers (whilst seeking to avoid potential conflicts of interests in relation to providers)

7.3 After the board is established it must consult with the whole board before appointing any such non-statutory members.

7.4 The Health and Social Care Act 2012 does not make reference to the post of Deputy Chair. The normal constitutional rules regarding committees apply.

8. OTHER IMPLICATIONS

8.1 EQUALITY & DIVERSITY

Health and Wellbeing Boards have a responsibility to improve the health of their population and to reduce health inequalities. They are responsible for assessing the needs of the population through production of a Joint Strategic Needs Assessment (JSNA) and for setting out how those needs will be addressed in a Joint Health and Wellbeing Strategy (JHWS). In Bradford this is further enhance though the development of and implementation of a Health Inequalities Action Plan.

It is important that the Terms of Reference provides for a Board best equipped to undertake this duty for the district.

8.2 COMMUNITY SAFETY IMPLICATIONS

N/A.

8.3 HUMAN RIGHTS ACT

N/A

8.4 TRADE UNION

N/A

8.5 WARD IMPLICATIONS

There are no ward implications as all wards are covered by the three CCGs and by BMDC.

9. NOT FOR PUBLICATION DOCUMENTS

None.

10. RECOMMENDATIONS

That the HWB reconsiders the membership and the governance arrangements laid out in the Terms of Reference and decides on which options detailed in paragraph four the Board wishes to adopt.

11. APPENDICES

Appendix 1: Bradford and Airedale Health and Wellbeing Board Terms of Reference, March 2013

12. BACKGROUND DOCUMENTS

The Kings Fund: Health and Wellbeing Boards one year on.
Humphries, Richard and Galea, Amy
October 2013

Appendix 1:

Bradford and Airedale Health and Wellbeing Board
Terms of Reference
March 2013

1. Name
With effect from 1st April 2013 the name of the Partnership will be "Bradford and Airedale Health and Wellbeing Board", referred to as The Board

2. Principle Purpose
To create a close working partnership between the NHS and City of Bradford Metropolitan District Council and to bring a new local accountability to assessing health and care needs. To be the key partnership forum for determining local priorities and providing oversight on their delivery through enabling and driving the integration of health and social care, and wellbeing in order to create more effective pathways for both service users and those who need to access services. This relationship should significantly reduce health and social inequalities and ensure accountability for local commissioning plans, creating a whole systems approach to improving health and wellbeing and maximising value for money.

3. Principle Duties

3.1 To provide local democratic accountability for the use of public resources to improve health and wellbeing and reduce health and social inequalities

3.2 To promote integration in the commissioning and provision of health and social care services across the District

3.3 To engage with Commissioners in the development and overseeing of local commissioning plans and priorities

3.4 To oversee the production of the Joint Strategic Needs Assessment

3.5 To oversee the production of the Joint Health and Wellbeing Strategy

3.6 To provide collective leadership and a local interface for both planning and governance through engagement with the NHS Commissioning Board, Public Health England, Local Partnerships and providers, including the Voluntary, Community and Faith Sector.

4. Membership
4.1. The Board shall consist of:

a) The Leader of the Council
b) The Elected Member portfolio holder for Children and Young People's Services
c) The Elected Member portfolio holder for Adult Services and Health
d) One opposition Elected Member
e) The Accountable Officer from each of the local Clinical Commissioning Groups across the District and a clinician from the CCG if the Accountable Officer is not a clinician

f) The NHS Area Team Director
g) The Director of Public Health
h) The Strategic Director of Adult and Community Services.
i) The Strategic Director of Childrens Services.
j) One member from Bradford HealthWatch
k) One member from the Voluntary, Community and Faith Sector, elected through Bradford Assembly.

4.2 The Board will be able to co opt further members, as required**,** from provider organisations.

4.3 Named alternates can be provided for the members of the Health and Wellbeing Board except the representatives of the Clinical Commissioning Groups who are able to ask any clinician on the CCGs to alternate for them.

5. Meetings of the Board

5.1 The Board will have a chair who is the leader of Bradford Council

5.2 Provision will be made for a Deputy Chair who will be an Elected Member

5.3 Meetings will be held in public

5.4 Meetings will take place bi-monthly

5.5 Each Member of The Board will have a vote though agreement on matters considered by The Board will generally be by consensus. Further persons co-opted by The Board will be non-voting unless the terms of reference are amended by Council.

6. Quorum

6.1 One third of Board members will form a quorum, with at least two Elected Member representatives from the Council, one Council Officer, and one representative from Clinical Commissioning Groups.