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THANET HEALTH AND WELLBEING BOARD

12 FEBRUARY 2015

A meeting of the Thanet Health and Wellbeing Board will be held at **10.00 am on Thursday, 12 February 2015** in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Membership:

Dr Tony Martin (Chairman); Councillor Johnston (Vice-Chairman), Hazel Carpenter, Dominic Carter, Esme Chilton, Councillor Gibbens, Councillor E Green, Madeline Homer, Mark Lobban and Andrew Scott-Clark

A G E N D A

Item
No

1. **APOLOGIES FOR ABSENCE**

2. **DECLARATION OF INTERESTS**

   To receive any declarations of interest. Members are advised to consider the advice contained within the Declaration of Interest form attached at the back of this agenda. If a Member declares an interest, they should complete that form and hand it to the officer clerking the meeting and then take the prescribed course of action.

3. **MINUTES OF THE PREVIOUS MEETING** (Pages 1 - 6)

   To approve the minutes of the meeting held on 13 November 2014, copy attached.

4. **ALCOHOL STRATEGY**

5. **INTEGRATED CARE ORGANISATION**

6. **BETTER CARE FUND**

7. **DEVELOPMENT OF THE THANET HELATH AND WELLBEING BOARD** (Pages 7 - 66)

8. **AGENDA TOPICS FOR THE NEXT MEETING**

   Declaration of Interests Form

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THANET HEALTH AND WELLBEING BOARD

Minutes of the meeting held on 13 November 2014 at 10.00 am in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Present: Dr Tony Martin (Chairman); Councillors Johnston (Thanet District Council), E Green (Thanet District Council), Hazel Carpenter (Thanet Clinical Commissioning Group), Dominic Carter (Thanet Clinical Commissioning Group), Esme Chilton (Children's Board), Madeline Homer (Thanet District Council), Mark Lobban (Kent County Council) and Andrew Scott-Clark (Kent County Council)

In Attendance: Anne Charman, Karen Maxted and Margaret Mogentale

1. APOLOGIES FOR ABSENCE

Apologies were received from Mr Gibbens.

2. DECLARATION OF INTERESTS

There were declarations received at the meeting.

3. MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting held on 4 September 2014 were agreed.

4. ASPIRATIONS FOR THANET

Andrew Scott-Clark led the discussion on the item with a power-point presentation. He emphasised the need for using more positive data in order to convey a positive message to the public. Mr Scott-Clark requested Board members to agree on the best approach to present statistical data, whether through percentages or the 'thermometer.' He said that life expectancy data showed significant inequalities between Thanet and other areas in the county. There was therefore a need to provide support that was proportionate to the significance of the problem in Thanet.

Aspirations for Children
Mr Scott-Clark said that with regards to the Aspirations for Children, officers were still working on coming up with some of the Key Performance Indicators (KPIs). As regards the Universal Child Programme, not all the mandatory performance indicators were currently being delivered in Thanet and other areas of the county.

Women Not Smoking
Evidence based approach was being used to support an early referral approach for pregnant mothers and first time mothers under 18. The aspiration was to have 95% of women not smoking when pregnant in 4 years' time. CO^2 monitoring has helped identify early on a number of issues/problems not necessarily related to smoking, like a leaking boiler in one of the households. Midwives were engaging expecting mothers and talking to them about smoking up to the point they gave birth.

The Board agreed to aspire to achieve the following target; that 95% of women not smoking when pregnant in 4 years' time.

Women Initiating Breastfeeding
Mr Scott-Clark said that there were challenges regarding the information system. Peer support programmes for midwives to work with individual mothers had been started county wide. He was going to find out the age profile of breastfeeding women in Thanet.

The Board agreed to aspire the following, that 75% of new mothers would be breastfeeding in 5 years' time and maintain at least 50% breastfeeding over six to eight weeks.

Reduce Alcohol Specific Stay in Hospitals
Mr Scott-Clark said that Thanet has the highest admission rates in the county. Madeline Homer said that TDC had previously directly funded pastoral street persons in Thanet. Mr Scott-Clark advised the meeting that work was in progress on some initiatives that would increase children resilience to say no to peer pressure in relation to alcohol use.

The aim to reduce alcohol related stays in hospitals from 58.3% per 100,000 to 40% in 5 years' time. Board members suggested that more discussions be conducted that would look at approaches that the Licensing function of Council could play to the health and wellbeing of the local residents.

Reduce Teenage Pregnancy
Thanet's aspiration was to reduce the rate to below 30% in the next 5 years.

Reduce Prevalence of Adult Smokers/Adults Not Smoking
Members were concerned that currently the advertisements that were being put out by companies selling cigarettes were sending the wrong messages to the public. Mr Scott-Clark said that discussions were on-going about the national policy on e-cigarettes.

The Board agreed to aim for a 20% reduction in smoking in 5 years' time.

NHS Health Checks
Mr Scott-Clark said that letters were sent out to individuals in the 40-74 age groups who were not on the register for health checks of vascular diseases. However the challenge was to get some of those individuals who would have received the letters to actually attend appointments. Thanet statistics were not yet available.

The Board agreed to aim for 100% population invitation for a health check. And that by the end of the current financial year 50% of eligible cohort would have received an NHS Health Check.

Early Deaths From Heart Disease & Stroke
Mr Scott-Clark said that the current mortality rate due to cardio-vascular disease was 95% in Thanet. The aim was to reduce it to 50% in the next 5 years.

Hip Fractures
The meeting was advised most falls occurred in people's own homes and that landlords were being encouraged to ensure that their properties had appropriate facilities to ensure that hazards were kept to a minimum.

Esme suggested that safeguarding children information should be added to that monitoring report. A report will be brought to the next Board meeting.

Thanet aspiration was to reverse the current trend hip fracture rate from 523 for the over 65yrs to below 450 in the next 5 years.

5. ASSURANCE FRAMEWORK

Andrew led discussion on the item. He gave a brief overview of the framework for monitoring of the agreed indicators. He said that county targets will be used to report back at a local level.

The report was noted.

6. KENT TEENAGE PREGNANCY STRATEGY 2015-2020

Andrew advised of the need to conduct extensive consultation with stakeholders through stakeholder engagement events with district representatives, teachers and young people in order to implement the county strategy on preventing teenage pregnancy. In order to successfully implement the strategy, joined up working was required. There should be universal access to services for young people. The services should be friendly. The challenge was how schools could be engaged effectively to break the cycle of teenage pregnancy. Part of the aspiration was to find ways to get young women into employment or back to school. The strategy now required to be translated into an action plan for implementation and monitoring in Thanet.

The report was noted.

7. NHS STATEMENT OF SUPPORT FOR TOBACCO CONTROL

Andrew indicated that the report sought the support of the NHS and the Thanet Board for the initiative that sought to stop tobacco smoking. He said part of the strategy to stop young people from smoking was to work with families. The approach had to be pragmatic; with an initial target being to lead individuals to gradually stop smoking but later on move to permanently abstinence.

Andrew suggested that Thanet District Council appoints a representative to attend the meetings of the Tobacco Anti-Smoking Alliance. He was going to provide the minutes of the last meeting of the Alliance held on 12 November 2014. Thanet CCG, TDC and the board should sign up to the 'Stop Tobacco Smoking' Campaign.

The Board agreed that Andrew Scott-Cark would draft a letter that would be signed by the TDC Leader and Board Chairman signing up to the Campaign.

8. RECOMMENDATIONS OF KCC HEALTH & WELLBEING BOARD AT ITS MEETING ON 16 JULY 14

(a) Engagement with the Kent Fire and Rescue Service, particularly in relation to falls and dementia

Madeline Homer outlined how engagement was taking place with the Kent Fire & Rescue Service (KFRS) through the Margate Task Force. Support of vulnerable persons was a high priority, illustrated by the fact that the Task Force now had its own dedicated Vulnerable Person Officer. Going forward, work would take place with KFRS in relation to health related issues such as dementia, slips, trips and falls. Penny Button, Head of Safer Neighbourhoods (Thanet Council) had spoken to Sean Bone-Knell, KFRS Director of Operations, and would be meeting with the KFRS Strategic Lead to discuss how this could be taken forward and broadened to the rest of Thanet. An update on progress would be brought to the next meeting of the Board.

The report was noted.

(b) **Ensure that the Kent Joint Health and Wellbeing Strategy is reflected in all public engagement activities**

Hazel Carpenter reflected on the meetings of the Board since its inauguration one and a half years ago, and the various debates that had taken place, particularly through the offices of Andrew Scott-Clark, on matters developed within the Kent Health and Wellbeing Strategy. There was undoubtedly synergy between the joint strategy and the work of the Board.

However, what has been done implicitly rather than explicitly was anything around engaging with the public on issues specifically relating to the Strategy; for example, the various Summits which had been organised by the CCG and supported by the Board.

Hazel referred to the need for the Board to develop a strategy on communications and public engagement.

Esme Chilton suggested that consideration should be given to how public engagement takes place online.

The report was noted.

(c) **Demonstrate how the priorities, approaches and outcomes of the Joint Strategy will be implemented at local levels**

It was noted from Andrew Scott-Clark that all of the aspirations agreed by Thanet Board fitted into the Kent Joint Strategy. Clearly, Thanet Board was localising Kent-wide priorities and ensuring delivery.

Hazel concurred that key elements of the joint strategy were in action, and some in development. The Board needed to be sharp, however, on how these were put together through the Thanet Plan.

She added that it was important to reflect, in the near future, on what a good health and wellbeing board for Thanet should look like and what the next developmental step should be to ensure that public engagement and communications were right, and that measures and outcomes were right in reflecting the County Strategy.

Tony Martin stated that he would circulate the results of an online benchmarking exercise that had recently been undertaken by the clerk in relation to Health & Wellbeing Boards in Kent. It was important to assess where that Board was delivering and where it was not delivering and to ensure that it added value.

The report was noted.

9. THE THANET PLAN

Hazel Carpenter led the discussion. She said that all the six work streams were now active. The focus has been on ‘beefing up’ the care support outside the hospital. Madeline Homer suggested that the roles played by Thanet District Council and Kent County Council ought to be made clear in the Thanet Plan. Madeline and Hazel were going to talk about that issue outside the meeting.

Members noted the report.

10. AGENDA TOPICS FOR THE NEXT MEETING, TO BE HELD AT 10.00 AM ON THURSDAY, 12 FEBRUARY 2015

The Chairman confirmed that the next Board meeting would be on Thursday, @ 10.00am on 12 February 2015.

Meeting concluded: 12.15 pm

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Local Government Association

Making an impact through good governance

A practical guide for health and wellbeing boards

Report

Acknowledgements

The Local Government Association (LGA) is grateful to all those board members and others from councils, clinical commissioning groups (CCGs) and local Healthwatch who participated in interviews, provided information for case studies and made suggestions for issues to be covered in this guide. Their contribution has helped to ground the discussions in the guide in the practical realities of running an effective health and wellbeing board.

The guide was written by Fiona Campbell for the LGA.

Many of the longer case studies were written by Nick Triggle.

Contents

Foreword

There can be nothing more important than the health and wellbeing of our residents. That is why I am delighted that one of my first tasks as Chair of the LGA's Community Wellbeing Board is to introduce this guide to the governance of health and wellbeing boards.

One year on from their establishment, health and wellbeing boards are beginning to consolidate the partnerships they have developed. It is now time to take on fully their role as strategic leaders of the health, social care and wellbeing systems of their areas. Recent reports suggest that in some cases, boards are already grasping the challenge, but have more to do. In other cases, boards are still far from being in this position.

This guide is intended to support all boards in making the step change required from wherever on the journey you are starting. How this is done will differ according to local circumstances. Through examples from across the country, the guide offers practical ideas and different models to help health and wellbeing boards become efficient and effective system leaders. Some sections in the guide will be of more direct relevance to board members themselves; others will be of interest to officers providing support. We hope that the guide contains something for everyone involved in these vital partnerships.

Boards are facing a huge challenge working across a range of organisations, some of them only recently established themselves, in an incredibly difficult financial climate with demographic challenges across the age spectrum. But I do think that the prize – improving people's health by giving them the right services of the highest possible quality – is worth the effort we need to put in. If this means making new allies, having difficult conversations, reaching out to the people who use services and doing things differently, then that's what we must do. I hope that this guide will help health and wellbeing boards and the officers who support them to develop processes and styles of governance that make the task easier.

I particularly want to welcome and thank all those members of health and wellbeing boards who are not council members or officers. For CCG chairs, local Healthwatch representatives and others, this is a new and sometimes strange-seeming world. I know that those of my fellow elected members and senior council officers who are members of health and wellbeing boards will do their best to see that all members of boards have parity of esteem, and that they are enabled – by the way that boards run their affairs – to make a significant contribution to their collective leadership role and to our common goals.

Councillor Izzi Seccombe
Warwickshire County Council
Chair LGA Community Wellbeing Board

1. Introduction

> "Health and wellbeing boards provide a forum for the health and social care economy in an area to recalibrate in a way it hasn't done before. At its most effective, the health and wellbeing board could be enabling people to live longer with a better quality of life – there's no better goal."
>
> **Health and wellbeing board chair and council cabinet member**

This guide is a follow-up to the guide by the LGA and Association of Democratic Services Officers published in 2013, as health and wellbeing boards (HWBs) were being set up. Now that boards are fully operational, their emphasis is on being as effective as possible in their statutory and influencing roles.

The carrot before them is the ultimate one of making a difference to the quality of people's lives and even to how long they live. The stick urging them on is that if they don't engage with uncomfortable debates, the consequences may be a lot more uncomfortable. Services may not be fit for purpose and important decisions will be made elsewhere. To be the 'fulcrum of decision-making' that this enormous challenge demands, requires fully functioning and effective partnership bodies that are capable of being leaders, not followers.

The guide discusses how health and wellbeing boards can make an impact through their governance structures and procedures – delivering business within council constitutional requirements, as required by statute – while enabling all board members to participate as equal partners. Governance is understood broadly to include issues of leadership and good functioning.

The guide is intended to be of practical use to members of health and wellbeing boards in all of the membership categories: councils, clinical commissioning groups (CCGs), local Healthwatch and voluntary sector members, representatives of NHS England who sit on health and wellbeing boards, and additional non-statutory members.

In preparing the guide, we spoke to a wide range of health and wellbeing board members from each of the membership categories. We asked them which issues they would like to see covered in the guide and what they and their boards were doing to address these issues. What members most wanted was to find out what other boards are doing to make an impact through the way they govern themselves and conduct their business. The case studies and examples below are all based on these interviews and suggestions from board members.

The guide is not intended to tell boards what to do, but offers information from across the country which may assist in deciding options for effective governance. We hope that the wide range of approaches discussed here both emphasises the flexibility open to boards to respond to their local circumstances, and provides a variety of models for boards to draw on in becoming effective system leaders.

The quotations throughout the guide are from the board members interviewed.

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

2. Being agents of change

To make a real difference for the people they serve, health and wellbeing boards need to be agents of change. This requires making a commitment to taking action in a number of areas based on a broad and strategic vision for the whole locality – "keeping their eyes on the big prize" as one stakeholder put it. Some of these are discussed in the Options section below.

Options

Shared leadership and decision-making

Bristol underwent a Local Government Association Health and Wellbeing Peer Challenge review in September 2013. The process identified many strengths, but also highlighted that the city's health and wellbeing board needed to 'up' its clout and pace.

This has now started happening. A recent paper to the health and wellbeing board said there was a desire for the board to become a "system leader in response to unprecedented financial and demographic challenges". To enable this to take place, the board has changed the way it is run. The elected mayor, George Ferguson, is now cochairing the board – replacing an assistant mayor – along with the chair of the Bristol Clinical Commissioning Group.

Recent changes to the council's constitution mean that the mayor can now take key decisions at health and wellbeing board meetings. It is intended that these will cover health and care related decisions that would previously have be taken at the cabinet, so could include everything from spending to service provision.

Mayor Ferguson believes the changes are a "significant and innovative development" that will allow Bristol to respond more quickly to change.

He says: "I much look forward to working closely with our health partners to address the current and future health and care needs in a city with greatly varying life expectancy, and to influence the wider determinants of health, such as sustainability and the built environment. 'Health of the City' will be the overarching theme during our European Green Capital Year in 2015."

Contact: Kathy Eastwood
Health Strategy Service Manager
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Unless, by local agreement, they have taken on additional responsibilities or a direct commissioning role, many boards are responsible for very few direct decisions. This makes their influencing role all the more important. Potentially, there is no limit to the extent they could influence the local health and care landscape. But unless all members are agreed in shouldering this leadership role, it is unlikely to be effective.

The concept of shared leadership is about transcending individual organisations and their interests, and coming together to make a combined effort on behalf of local people. This may mean on occasion overriding the best interests of one constituent organisation in favour of the best interests of the system as a whole, and therefore of people who use or will use services. It may also mean one or more existing bodies devolving power and/or funds so that the whole system can be more powerful and effective, as in the Brighton and Hove example below.

After a year of existence, **Brighton and Hove's** health and wellbeing board was concerned that it was becoming a 'talking shop' instead of the real catalyst for change that members wanted it to be. A full review of the board was undertaken, resulting in a fundamental change to the governance of health and wellbeing in the city. The new arrangements provide system leadership for health and care across the city and increase integration of services by pooling together resources and decision-making between the council and the CCG.

In addition to its original functions – which were the minimum necessary to satisfy statutory requirements – the health and wellbeing board has been given full delegated powers from the council to discharge all of its public health, adult social care and health and children and young people functions. This includes the power to deal with joint arrangements with health.

The board also has referred functions regarding the 'people' side of housing and, in particular, housing-related support to vulnerable adults and children. The remit of the health and wellbeing board in relation to CCG functions was made more explicit to include helping shape the CCG's commissioning strategy and holding the CCG to account for the impact of its commissioning decisions.

The board's remit explicitly includes providing collective leadership to a whole range of city-wide collaborative working and whole-system issues – including emergency planning, resilience and preparedness, and urgent care.

The health and wellbeing board is chaired by the leader of the council. An officer executive board consists of the directors of children's and adults services and public health and head of housing and two representatives from the CCG. It was also agreed that the committee would move away from the traditional local government committee-style format to a more relaxed and inclusive style in the way it conducts meetings.

The health and wellbeing board is now the most powerful committee of the council and of the local health and social care system.

Contact: Barbara Deacon
barbaraldeacon@hotmail.com

> "The board needs to be the fulcrum of decision-making for health and social care. It needs to be driven in a resilient, determined and dogged way. It needs leadership that makes a difference."
>
> **Former chair of health and wellbeing board**

Having difficult conversations

Board members need to build on the trust they have established with each other and confront difficult issues in which there will be winners and losers. To take a leadership role, they will sometimes need to make uncomfortable compromises.

It will be most helpful in making difficult decisions, to always bear in mind the perspective of patients, service users and the public and to make decisions based on the evidence of which changes could improve quality, access to services and health and wellbeing outcomes for local people – whichever partner or partners is providing them.

Trust between health and wellbeing board members in **Bexley** has been hard fought and hard won.

Part of the process of building trust and consensus on the health and wellbeing board took the form of a visit by the council's leader and chief executive to GPs in all localities. The council chief executive sat on the panel with the CCG in presenting its case for authorisation and also sat on the appointment panel for the CCG chief officer.

These efforts to build alliances and find common cause took place in the context of a history of differences between the council and the NHS in the area on proposed reconfigurations. These included losing the accident and emergency and maternity services at Queen Mary's Hospital in Sidcup. This was strongly opposed by the council, but after mounting a lengthy and attritional campaign, the council decided instead to focus on the future.

This involved putting considerable energy into working through the health and wellbeing board to build community-oriented services on the site. Mental and community health services are now centred at Queen Mary's with plans in train for a major enhancement of services, including renal and cancer care and contributions from the large acute trusts.

The health and wellbeing board has acted as the champion for change and has overseen coordination of planning and implementing of the reconfigured services. The health and wellbeing board's name has been used to develop and clarify a Bexley-wide view on how services can be enhanced for local people.

The health and wellbeing board has also been instrumental in the development of a prime contractor model for children's health, bringing together acute care, public health services and social care for children and young people. This has required a significant amount of trust, as different parts of the NHS, the council and social services have agreed to go through a common tendering process.

Contact: Shanie-Louise Dengate
Policy and Health Integration Officer
shanie.dengate@bexley.gov.uk

System redesign and reconfiguration of services

One director of adult social care described the redesign of services as "the elephant in the room" of health and wellbeing boards. There are many different interests that may be threatened by doing things differently, but this is clearly one area where health and wellbeing boards can make a difference through clarity of vision and collective firmness of purpose.

Changing the way the health and care system delivers is a necessity, not just because of huge financial pressures, but also to improve services and health outcomes. Health and wellbeing boards' development sessions and seminars provide opportunities for 'blue skies thinking' about how the system could be changed for the better and how new service models might work. Boards also need to begin to develop a sense of collective responsibility when things go wrong in one part of the system or another, irrespective of whether this is in their own organisation or others.

> "The board is keen on giving high-level strategic direction. What is missing is a sense of responsibility for outcomes in the system and for the resilience of the system."
>
> **CCG chief executive**

County Durham's health and wellbeing board has made improving services and support for people with dementia a priority. The most recent joint health and wellbeing strategy (JHWS) identified refreshing the local dementia strategy as a key step. A strategy task group was established and carried out a stocktake of services as well as consulting with patients and carers groups. This was supplemented by in-depth interviews the two local Healthwatch organisations coordinated with 130 people.

A new three-year strategy was agreed by the health and wellbeing board setting out a series of measures including extra training for frontline staff, improving diagnosis rates and the roll-out of dementia cafes.

Another key element of the strategy is the piloting of two 'dementia-friendly communities' in Barnard Castle and Chester-le-Street. Board chair Councillor Lucy Hovvels says these communities will focus on "improving inclusion and quality of life for people living with dementia". Central to the push for more dementia-friendly communities will be strong partnership work between health, social care and housing that the health and wellbeing board is keen to champion.

This is just one example of how the HWB is helping redesign services and support. A five-year palliative and end-of-life care plan has also been agreed to provide the best possible care, in the place where people want to receive it.

Contact: Andrea Petty
Strategic Manager, Policy, Planning and Partnerships
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Lincolnshire's health and wellbeing board is playing its part in moving care out of hospitals and into the community through a county-wide programme involving GP, nursing, mental health, hospital, ambulance and social care services and the voluntary sector, known as Lincolnshire Health and Care.

Care design groups composed of clinicians, patients and community representatives were created to help draw up a blueprint that was signed off by the health and wellbeing board. The document sets the ambition to treat fewer people in major hospital settings, including accident and emergency, and instead meet the vast majority of people's health and care needs in the community near to where they live. It recognises the key to achieving this lies in improving access to services in the community.

Four areas are starting to roll out neighbourhood teams. These will include social care, district nursing, GP staff and mental health nurses all working together.

Options are also being drawn up for the root-and-branch redesign of services, which will include changes to urgent and elective care and services for women and children.

Councillor Sue Woolley, chair of Lincolnshire's health and wellbeing board, says: "The best way to address issues such as budget shortfalls, problems with recruitment and making sure services are of high quality, is to put changes in place to the whole system."

Contact: Sophie Dickinson
Programme Manager
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"Health and wellbeing boards are about creating the environment where leadership and change can thrive and integration and health improvement can take place."

Director of adult social care

Integration

Board members have identified integration as one of the biggest issues they have to deal with and believe that this will continue to be a priority for successive governments. Boards need to think now about how integration of commissioning and delivery of services can happen locally and how they want to progress towards greater integration. Otherwise, national policy is likely to move ahead of them and bring about changes that are not tailored to the needs of their own area.

Barnsley's health and wellbeing board expects to oversee a pooled budget of £20 million as part of the Better Care Fund (BCF) for integration. The board believes it has benefited from extending its membership to include representatives from providers – the local acute trust, community health trust and police.

To help push ahead with transformational change, including plans for the BCF, the board has established six programme boards:

- Ageing Well
- Promoting Independence
- Think Family
- Unplanned Care
- Planned Care
- Cancer

These boards have been asked to take forward a range of projects covering the BCF agenda. For example, Ageing Well is reviewing intermediate care and support to the frail elderly, while Promoting Independence is overseeing a reconfiguration of assessment and care management plus the development of personal health budgets. Meanwhile the Unplanned Care group is looking at how to reduce demands on secondary care and, in particular, on accident and emergency admissions.

In time, these programme boards are also expected to play a key role in other aspects of the BCF and wider agenda, including working on areas such as preventing ill health and improving support and diagnosis for people with dementia.

Contact: Scott Matthewman
Health and Wellbeing Development Manager
scottmatthewman@barnsley.gov.uk

Integration is not just, as it is sometimes understood, about improving care pathways within the NHS or within the social care system. It is about working across organisations and functions that have traditionally been kept apart in 'silos', to develop services that provide individuals with the support they need so they can live the lives they wish. Current discussions about specific aspects of integration – while they may make a significant difference to keeping people out of hospital and discharging them as soon as possible – will be a wasted opportunity if they focus only on this objective. Health and wellbeing boards can seize the chance to think strategically about:

- personalisation – giving support and choice to individuals so that they can determine what services they need to remain independent and in control
- integrating public health, prevention, early intervention and treatment
- integrating community, primary and secondary care in a SMARTer (Strategic, Manageable, Achievable, Realistic, Timely) way.
- integrating health and care services with other services under the influence of local authorities, including housing, planning and leisure services
- integrating services for a particular group, such as children, across the whole spectrum of their lives.

Each of these issues will be priorities at different times and each may sometimes attract the attention of the board to the exclusion of others. But even when thinking about one kind of integration it will be to the advantage of the system if board members have in the back of their minds how the rest of the system impacts on the current focus of their attention.

The growing desire for integration between health and social care services has prompted **Essex** to re-think the way its health and wellbeing board is operating.

The integration agenda has "deepened and accelerated" in recent months. This has increased the workload of the health and wellbeing board and has implications for governance arrangements. At the May 2014 meeting the board agreed to increase membership from 21 to 25 to give providers representation. There are now two members to represent the five acute hospital trusts and another two to represent mental health and non-acute providers. The hope is that this will support system leadership, and enable the integration agenda to "progress at pace".

The board will (subject to approval by the Essex County Council cabinet and CCG boards) consider annually the county-wide pooled budget arrangements between Essex County Council and the CCGs, including the 'envelope' of resources.

The board also endorsed the recommendation that each CCG invites a council member, nominated by the leader, to attend and speak at their board meetings. CCGs boards are currently considering this proposal.

A secretariat has been established to carry out agenda planning, while a programme board drives delivery of the integration programme and supports the health and wellbeing board in meeting its statutory responsibilities. Both are staffed by senior officers from the council and CCGs.

Contact: Charlotte Downes
Senior Commissioning Support Officer
charlotte.downes@essex.gov.uk

Leicestershire's health and wellbeing board established an 'Integration Executive' to oversee day-to-day delivery of its integration programme including the BCF plan.

The Integration Executive is led by the clinical chair of a CCG and has senior representation from all partners including the NHS community, acute and ambulance trusts.

The group has adopted existing programmes of joint working in areas such as learning disabilities, continuing care and community equipment but has also started to deliver new important areas of work through the BCF plan.

As a result in 2014/15 Leicestershire is piloting 'local area coordination' (LAC). By taking the learning from other councils, such as Derby and Thurrock, it is developing the best model for Leicestershire's communities. LAC will provide low level support by helping to identify and signpost vulnerable people to the support and opportunities available on their doorstep, helping them get the best from what is on offer, and avoiding inappropriate use of statutory services.

LAC coordinators will be a local resource for community capacity building and a key member of the locality team responsible for integrating services with other agencies – in particular helping GP practices, councils, local community health and services and the voluntary and community sector work more effectively in each locality.

The Integration Executive is also leading:

- A major review of domiciliary care services to a) develop the market in support of more effective hospital discharge and b) improve reablement and independence in the home.
- The innovative Lightbulb Project – part of the new local Housing Offer to Health, developed by the health and wellbeing board in 2013 in collaboration with all district councils. From 2015/16, the Lightbulb Project will bring together a range of currently disparate services into one consolidated new offer across agencies and localities to provide citizens with a one stop shop for affordable warmth support, handy-person services, occupational therapy, assistive technologies, aids and equipment and links to informal housing advice and support.

Contact: Rosemary Palmer
Principal Committee Officer
rosemary.palmer@leics.gov.uk

"It's important for local Healthwatch not to go into victim mode, but to be part of collective responsibility and part of being the system leader – it's not only there to challenge, although challenging is part of its role."

Local Healthwatch manager

Budget issues

> "We have to stop thinking about 'our budget' and think more about the public pound – it doesn't matter who spends it as long as it's for the public good"
>
> **CCG chair**

Budget issues have been difficult for health and wellbeing boards to grasp. Stakeholders have said that this is partly because some members are not thinking in terms of the whole system. It is important for boards to encourage a sense of collective responsibility for the system so that public money can flow at the right time, to the right place, to do the right thing, for people using services – whichever organisation is contributing financially.

Seven-day working arrangements are an example of this – they should enable people to leave hospital earlier needing less intensive packages of care. This potentially means a saving to the whole system as well as better outcomes for patients and service users.

Thinking holistically about the 'public pound' rather than individual budgets is not easy, given that each member organisation has ultimate accountability for its own budget, but the legislation not only permits but positively encourages the use of pooled budgets for which there are accepted legal processes of accountability. The extent to which local leaders are willing to contribute resources to the health and wellbeing 'pot' through such arrangements is a measure of the board's achievement in establishing trust and a sense of collective responsibility.

The Better Care Fund has given added urgency to the development of whole-system thinking about budgets. If local areas choose to allocate significant joint funding, health and wellbeing boards could become responsible for signing off very large budgets. How this is done needs to be agreed by all board members and their organisations.

> "The Better Care Fund has been a tremendous reality check – it's where things get real. It needs a move from good intentions and visions to action – how to spend the money."
>
> **Health and wellbeing board chair**

Key issues to consider

- ✓ How does the health and wellbeing board demonstrate system leadership by collective responsibility for local outcomes?
- ✓ Does the health and wellbeing board benchmark itself against comparator boards, such as boards in areas which have a similar profile to its own? Have board members established any ongoing relationships to exchange advice and experiences with their counterparts on comparable boards elsewhere in the country? Does the chair of the board participate in a mentoring process?
- ✓ Does the board create the space to have challenging discussions about difficult issues? Are such discussions linked to actions, which are followed up?
- ✓ How is your health and wellbeing board taking a lead in initiating discussions about system redesign? Is it involving all relevant potential contributors in the sector in identifying synergies between services, reducing transactional costs, simplifying points of access and pathways of care, access to emergency services, seven-day working, to name only a few potential areas?
- ✓ Is your board thinking broadly about horizontal and vertical integration of services across the whole of the public sectior?
- ✓ To what extent do section 75 pooled budget arrangements and BCF plans build on the evidence of future need in your joint strategic needs assessment (JSNA), the priorities for improving health outcomes in the joint health and wellbeing strategy (JHWS) and clinical commissiong group and council commissioning plans?

3. Delivering core business

The policy background and statutory underpinnings of health and wellbeing boards are outlined in some detail in the previous guide (see references). Below is a brief summary of key points.

The principles on which boards are based include:

- shared leadership
- parity between board members
- shared ownership of the board and accountability to communities
- openness and transparency
- inclusiveness.

Health and wellbeing boards were set up to take a strategic view across the whole of a local health and care economy. The core statutory functions of board include:

- production of 'joint strategic needs assessments' and 'joint health and wellbeing strategies', involving district councils where appropriate
- a duty to encourage integrated working between health and social care – this has been further strengthened by the introduction of funding for integrated care through the Better Care Fund which boards are required to oversee
- a power to encourage close working between health-related services (such as housing) and health and social care services
- new duties since the legislation was enacted include producing a pharmaceutical needs assessment, signing-off the area's proposals for joint funding under the Better Care Fund and becoming part of the Unity of Planning which signs up to five-year strategic plans for the local health economy
- duties arising from recent legislation including:
    - the Care Act 2014, which emphasises a preventive approach to health and gives councils new duties to consider physical, mental and emotional wellbeing, gives new rights to carers, requires the setting up of adults safeguarding boards in each area and provides for a failure regime for NHS healthcare providers and Ofsted-style ratings for hospitals and care homes
    - the requirements of the Children and Families Act 2014 – including an integrated 'education, health and care (EHC) plan' for each child or young person who would previously have received a statement of special educational needs, or who has a disability; and councils, CCGs and NHS England to make joint commissioning arrangements about education, health and care for these children and young people – collectively known as 'EHC provision' and must have regard to the JSNA and JHWS.

Boards are committees of the council and must, therefore, operate according to the relevant requirements, which include:

- meeting in public
- publishing an agenda five days in advance of meetings
- conforming to the regulations concerning access to information
- all members conforming to the council's code of conduct (for example in relation to declarations about potential conflicts of interest).

Health and wellbeing boards differ from traditional council committees in having council officers and other non-councillors as full members.

Statutory (required) members of boards are:

- at least one council elected member
- at least one representative from each CCG in the area (the same person can represent more than one CCG)
- directors of adult social services, children's services and public health
- a representative from local Healthwatch
- a representative of NHS England when required.

The intention is that members of boards should have parity with each other, but voting arrangements are made by individual boards.

Culture and style

> "At first, very few board members 'got it' that the board is about collective membership. Each thought their job was to hold the others to account. Each thought the others had a remit to 'interfere' in their business."
>
> **Council head of health and wellbeing**

Good governance is not just about procedural correctness. It is also about developing an organisational approach and style that enables a maximum contribution from board members and other relevant parties. This is particularly so in the case of a board made up of representatives from very different organisations with different cultures. The role of the chair is very important in setting the style, but officers supporting the board can also make a difference.

While it is true that health and wellbeing boards are council committees, it is also true that they are intended to be very different from the traditional type of council committee – in particular, they are intended as a forum for collective decision-making by all their constituent members. Most boards, led by their chair, seem to have taken this message on board and have made a conscious effort to develop a relaxed and participatory style, while conforming to statutory requirements for council committees. Some have remained very traditional in style, leaving some CCGs and local Healthwatch representatives nonplussed.

> "I have constantly to guard against our health and wellbeing board defaulting to being just an arm of the county council."
>
> **Councillor and chair of health and wellbeing board**

> "I observed at a board meeting in another area where the chair who is a council elected member was flanked by the council leader on one side and the council chief executive on the other. All the presentations were from council officers."
>
> **Councillor and chair of health and wellbeing board**

Options

> "Our board works well because we've spent a long time in development."
>
> **Chief executive of CCG and future chair of health and wellbeing board**

Demonstrating as much parity as possible between board members is "not just a matter of being nice to CCGs", as one director of public health put it. The board and its activities need to be seen as trustworthy by all its members. Otherwise, when it comes to issues like pooling budgets in a pot which is overseen by the board, members will be understandably reluctant. Boards also need to develop sufficient trust to have difficult conversations, for example, where board members think that commissioning plans of member organisations are not sufficiently aligned with the JHWS.

There is plenty of flexibility for the board to develop a different model to the traditional council committee in how it presents itself and how it engages with the public. Parity between board members needs commitment at the highest level. Many boards have a vice chair who is the chair of the CCG board or another senior CCG member.

> "At the first board meeting I attended, I sat down and put my briefcase on the table to take out my papers. I was asked by a council Democratic Services officer to remove my briefcase and 'sit over there' – away from the table in a row reserved for officers. This made it difficult to support my CCG chair at the meeting."
>
> **CCG chief officer**

This could be seen as tokenistic unless the vice chair has a specific role or roles on the board. Some boards have a co-chairing arrangement with the CCG based on the principle that they are equal members of the health and wellbeing board. It is not enough for CCG members just to have a role in chairing. It is important that they should be involved in the board's business structures as well. (See the next section).

Brighton and Hove has reconfigured its board so that the council and CCG have the same number of members. The board wanted not to be identified with the council alone, so has developed its own logo, style and seating arrangements for meetings.

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There are specific issues about the role of council officers on the board. In some areas, both council elected members and council officers are uncomfortable about the idea of officers having voting rights, for example in case of awkward splits along party lines.

Some boards are happy with council officers having voting rights, taking the pragmatic view that voting will hardly ever be necessary. Others, such as Brighton and Hove, have, with the agreement of all board members, removed the right of officers to vote, because of concerns about potential awkward splits along party-political lines.

Either of the above solutions is acceptable – the important point is that boards should have discussed and made a decision about voting rights of members, in advance of any voting having to take place, rather than allowing the situation to be decided by default.

Some local Healthwatch representatives do not feel that they have 'parity of esteem'. Boards need to find a way to enable local Healthwatch representatives to play a full part in the board's work and also to enable local Healthwatch to play its special role of representing the voice of patients, service users and the public. Some boards have appointed their local Healthwatch representative as the vice chair. As in the case of CCG vice chairs, this could be seen as tokenistic unless local Healthwatch is enabled to play an active part in steering the board.

A small number of local Healthwatch representatives have expressed a reluctance to exercise voting powers on boards on the grounds that they may want to dissent at some point from board decisions, based on views they have collected from the public. However, local Healthwatch members, while remaining accountable to communities, are full members of the board with all that that entails. A number of local Healthwatch representatives have strongly expressed the view that Healthwatch needs to participate in the collective responsibility of the board.

Understanding each other's culture and developing mutual trust and respect need to be worked at, as many stakeholders have pointed out. Most boards have held at least one or two development sessions, and there is clear agreement among stakeholders that such sessions need to be ongoing, to give board members an opportunity to carry on with mutual learning, understand and develop the role of the board, and explore ways to maximise their own contribution.

> "If Healthwatch representatives decide not to vote, they are throwing away an opportunity to influence and an opportunity for people to lobby."
>
> **Manager of county-wide local Healthwatch organisations**

This is important not least because board membership may change, particularly following council elections and new members need an opportunity to understand the board's work and their own role in an informal and relaxed setting.

> "We need to take time out to learn to work together."
>
> **Director of local Healthwatch**

Leeds health and wellbeing board set up a series of joint visits by board members (a member from the CCG and a member from the council) looking at a particular service and reporting back to the board. This helped to cement relationships quickly between board members and has provided a 'reality check' for the board about what really matters – the quality of services and their outcomes.

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While it is important for boards to be transparent about their work and to discuss and make their decisions in public, they also need the time and privacy to explore options freely at an early stage before reaching conclusions about which workable alternatives may achieve the best outcomes. Many boards timetable at least one development session or seminar between formal board meetings.

These are not usually public meetings, although they may sometimes include invitees such as CCG board members who are not members of the health and wellbeing board, representatives of patients and service users and voluntary and community sector organisations. Some boards have recruited a consultant to support the development of relationships among board members and also to discuss how the board functions.

> "Seminars are a good opportunity to be honest and frank and to think strategically about what kind of service we want."
>
> **Chief executive of CCG and prospective chair of health and wellbeing board**

Liverpool's health and wellbeing board is chaired by the mayor who also chairs a 'health summit' twice a year, inviting all providers and commissioners to develop a coherent vision for the area and to share opinions.

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Brighton and Hove has six development sessions a year with the stated aim of enabling a 'non-combative, non party-political' way of working and provide system leadership in tackling problems. The board also has a wider assembly with stakeholders twice a year.

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Key issues to consider

- ✓ Has the board discussed how it can present itself in a way that shows parity of esteem between all categories of board members?
- ✓ Is it assumed that board meetings will always take place at council locations and will always be serviced by council officers? Can you explore different options such as rotating the venue for meetings?
- ✓ Does the style of board meetings encourage equal participation by all members?
- ✓ Does the board have a programme of development sessions or seminars to enable board members (and others) to develop their relationships and their strategic thinking in an informal setting? Have you considered engaging an external facilitator to support the board's reflections at these sessions?
- ✓ Are board development sessions designed to recognise the different backgrounds of board members and the skills they need to make an effective contribution?
- ✓ Is there agreement about which members of the board have voting rights?

Being clear about the role of the board

The overarching objective of health and wellbeing boards is to set the strategic direction for commissioning of health and social care for their area. The building blocks for the strategic direction are the JSNA and the JHWS. But producing and revising these documents is only the beginning of the work.

Often, it will mean significant redesign of services to meet demographic and financial pressures, while improving quality and ensuring that resources are invested in the most effective services to improve health outcomes.

> "Boards need to keep to their own priorities and resist being a dumping ground for everyone's issues."
>
> **Director of adult social care**

Maintaining a dialogue between board members and their organisations, often about difficult decisions that must be made, is a vital part of being a 'system leader'. This means doing a lot more than holding four or five formal committee-style meetings each year.

At a practical level, consultation with stakeholders has made it clear that boards need to have clear priorities and develop and monitor their own work programmes based on those priorities. It is also evident that boards need to give some thought to the structures that sit below the board and to how the priorities and work programme of the board are progressed between meetings. Governance arrangements need to be fit for the purpose of furthering the work of the board as an effective forum for all system leaders to align priorities and bring about improved services and outcomes.

There is an ongoing debate between those boards that feel they have a performance management role in relation to their constituent member organisations and those that feel their role is different. Whatever they decide about this issue, each board should be clear about its view and plan its activities accordingly.

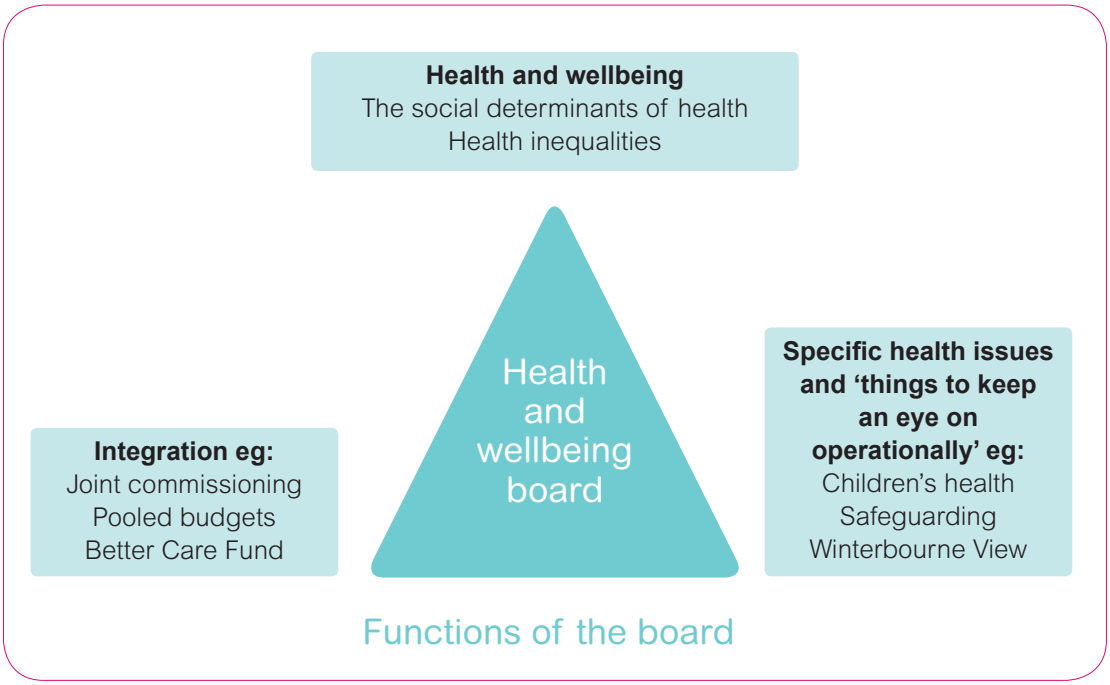
Options

It is important that there is an explicit agreement about the extent to which the board is a decision-making body. For example:

- is it a coming together of commissioners who discuss issues and then take their separate decisions informed by the JHWS? Or
- is it a body that takes decisions itself?

Some boards have taken the view that their exclusive role is to set the strategic direction and – by a system of influencing, monitoring and working with member organisations and other partners – to ensure that their respective plans are aligned with that strategic direction. Others have decided to take a much more hands-on role in commissioning, with all the joint commissioning structures sitting under the board and reporting directly to it.

One CCG chief operating officer described the health and wellbeing board as broadly having a trio of functions:



Different boards may choose to concentrate at different times on one or more points of the triangle. One of the challenges that boards have is managing the competing demands that each of the three points make for space on their agendas. The chair quoted below wants to ensure that the top point of the triangle is never lost to view.

> "Our challenge is to develop beyond the statutory role to the wider remit, for example to address health inequalities, but without losing our focus. My role as chair is to keep these wider issues on the agenda and ensure that there are regular meetings between board meetings with all the relevant players."
>
> **Chair of health and wellbeing board and deputy council leader**

Key issues to consider

- ✓ Has your board reached explicit agreement about its role? Is there a description of its agreed role in the public domain?
- ✓ Is your board clear about what its powers are to take decisions? For example, has the council delegated any decision-making powers to the board? Are there any pooled budgets whose allocation is delegated to the board? What precisely is the decision-making role of the board in relation to joint commissioning?
- ✓ Are there well-defined agreements about how decisions taken by the council and the CCG(s) will be aligned to decisions taken by the health and wellbeing board?
- ✓ Is there a risk-sharing agreement between organisations represented on the board and other relevant partners?

Size and membership of board

> "We took a conscious decision to have very senior people on the health and wellbeing board when it was in shadow form. We decided to continue this on the board proper because the price of not playing in the game was greater than the price of playing. Having the leader as chair of the health and wellbeing board gave a very strong message."
>
> **Council chief executive**

Across the country, health and wellbeing boards vary widely in their size and composition. There is no right or wrong number of members beyond the statutory requirement. This will be determined by how the statutory members see the role of the board. Some want a tightly focused board concentrating on overseeing commissioning of core areas. Others want to make progress on the wider prevention and wellbeing areas and to be more inclusive in style, which may mean bringing additional members on board.

Many boards have decided that while they want the core membership to be small and lean, they also need to have ongoing relationships with other organisations and have built sub-structures and reporting lines that reflect these relationships. This is one way of trying to ensure that outcomes of the health and wellbeing board are replicated in outcomes of other key partnerships.

> "It's been very useful to have the police on the health and wellbeing board – it's one of the best moves we've made. Before, the police were using section 136 of the Mental Health Act [to take people to a 'place of safety']. Now, because of their attendance and discussions at board meetings, we've commissioned a psychiatric liaison person to work with the police."
>
> **CCG chair**

In relation to CCG membership, several stakeholders have made the point that it is useful, perhaps even essential, to have a senior management officer as well as a clinical lead from the CCG present at board meetings.

One factor which is likely to influence the size and composition of boards is whether they are in two-tier local government areas, where relationships with district councils are particularly important (see the section on relationships below). The number of CCGs in an area may also influence the size of a board, although a number of CCGs may choose to be represented by the same representative.

Some boards have chosen to invite certain providers of health services to become members of the board. This is discussed further in Section 4 below on relationships.

Options

When considering the number and role of non-statutory board members, it is important to be clear about what the board's priorities are, which organisations it needs to have relationships with to take forward those priorities and what are the appropriate relationships.

For example, if the board's priorities are tackling alcohol abuse, mental health, domestic violence and health issues relating to the night-time economy, it will clearly want to engage the police. If one of its priorities is tackling obesity among school-age children, it will want to find ways of engaging schools. It may choose to do this through board membership, through the board's sub-structures (see section on this below) or through ad hoc arrangements when particular issues are on the agenda.

Liverpool's board includes advisory members from the police, the university and the fire service and others to enable the board to take a wide approach to wellbeing issues, as well as health and social care services.

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In **Kent**, there are seven CCGs and 12 district councils. The health and wellbeing board operates a devolved structure with seven smaller boards, which are sub-committees of the main board, based around CCG boundaries. All the CCGs are represented on the main board and there are three representatives of the district councils on the main board.

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Plymouth wished from the start to extend membership of its health and wellbeing board to providers and other key partners in the city. Full membership – including voting rights – has been given to representatives from Plymouth Community Housing (the largest social housing provider), Plymouth Community Healthcare, Devon and Cornwall Police, Plymouth Hospitals NHS Trust and the University of Plymouth.

Plymouth City Council performance and research officer Ross Jago says the "huge emphasis" on integration convinced the health and wellbeing board to take this approach.

"I think it has helped show the public that decisions are being made transparently and fairly, while at the same time it has allowed good relationships to develop between all the organisations."

To help foster those relationships, the board has been arranging regular workshops to allow members to meet in more informal settings outside of the four-yearly full board meetings. The impact of this approach is perhaps most obvious in the move to integrate the delivery of adult social care and community health services and create a joint commissioning body for health and care. The new approach will begin in spring 2015 after recently being signed off by the council.

While each programme has been overseen by a dedicated working group, the health and wellbeing board has played a crucial role in the overall process. It set the ambition last summer for the changes to happen and it has also provided the platform in terms of guidance and the confidence that good relationships between the key players brings to allow the integration to take place.

Contact: Ross Jago
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Key issues to consider

- ✓ Has the board made a policy decision about its size and membership beyond the statutory requirements? Are there opportunities to review membership as the business of the board develops?
- ✓ If it has decided to be small and lean, how will it build relationships with key partners – for example, are its sub-structures fit for purpose? How will it engage with patients and the public? (See further sections below.)
- ✓ If it has decided to be broad and inclusive in its membership, how will it ensure that, with a large number of people round the table, each member can contribute and the board can get through its business efficiently?

Agenda setting, prioritisation and work planning

> "We have a very strategic JHWS focused on a small range of priorities including obesity, dementia and diabetes. We need to keep focused on changing the system and not get bogged down in day-to-day bureaucracy."
>
> **Council chief executive**

As they move beyond the preparatory and setting-up stages, boards need to find ways of defining their priorities and developing processes to take them forward. There is a general perception that they may be seen as ineffectual 'talking shops' unless they are able to show where they have made a difference.

Some stakeholders have pointed out that talking can be a good thing in establishing mutual understanding and shared objectives. The formal meetings of the board do indeed provide opportunities for members to report back from their organisations and to seek a steer from the board about how to achieve strategic objectives, but this sort of exchange of information cannot be the only activity of an effective board.

> "A danger we've identified is that it could be a rubber-stamping board. There are so many things that come into the council and the CCG where people say this should go to the health and wellbeing board. So we are developing the board's own work programme and being fairly strict about what gets on the agenda."
>
> **Director of public health**

The consensus among stakeholders is that boards need to be ruthless about prioritisation and rigorous about keeping to a small number of priorities at any one time. As several stakeholders said, the board should do what only the board can do. This requires the discipline of careful agenda management along agreed lines so that only priority issues come to full board meetings.

Boards should also have the means to monitor and manage their own performance in relation to the JHWS (and to their Better Care Fund plan during the relevant period).

> "We need to have agenda items where something will happen as a result of the meeting."
>
> **Chair of health and wellbeing board**

Systematic work planning is important to enable the full participation of board members. For example, CCGs may wish to timetable their own meetings so as to feed into board agenda items in a timely way. A small number of local Healthwatch organisations arrange pre-meetings with voluntary sector representatives to go through health and wellbeing board agendas, reach a view and bring forward evidence of the views and experiences of patients, service users and the public.

Brighton and Hove has an executive board which filters and organises agenda items, with representation from the CCG and the council, plus local Healthwatch and the chair of the children's safeguarding board. Representatives of provider organisations attend the board as appropriate.

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Luton's health and wellbeing board is supported by a project (officer) group meeting monthly to oversee the board's agenda, whose members are the directors of adult social care, public health, and children's services and the CCG's accountable officer.

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Options

Because health and wellbeing boards are made up of representatives from a number of organisations it is important for them to have a forward plan so that members know when important decisions will need to be made and can consult with their organisations and speak with their authority at board meetings.

This also enables the public to know when the board will be discussing and making decisions on issues of particular concern to individuals and groups. The forward plan could take the form of a decision-making grid, like those used for council cabinets. It is important to be flexible in using and reviewing a forward plan – for example, it may be necessary to change meeting dates or agendas to respond to urgent items that need a decision.

Boards need to have processes not only to ensure that the whole system is working to progress the priorities in the JHWS but also that the board itself is playing its part. An action plan derived from the JHWS which sets out the agreed role of different constituent organisations, including the board itself, will be instrumental in keeping on track.

A number of boards have started using additional business processes such as dashboards and traffic light systems to give an overview of progress and highlight problem areas which require concerted action by board members. Snapshots of performance may be broken down into individual organisations such as providers, or into themes, for example mental health, depending on how boards see their role and priorities.

Whatever their exact role in relation to the performance of constituent organisations, effective boards will develop means to take a system-wide view of, and monitor progress on, key priorities that depend on cross-sectoral collaboration, such as implementation of seven-day working.

Many boards have an officer board or executive group, with members from the council, the CCG and others, which discusses the agenda and filters out items that are not a priority so that only priority issues come to full board meetings. This is in addition to the traditional council 'chair's briefing' which is also helpful in ensuring that the chair guides the board meeting to produce practical outcomes. (Chairs' briefings should include vice chairs where they are representatives of another member organisation, such as a CCG or local Healthwatch.)

> "I am a member of the officer group that agrees the agenda for the health and wellbeing board meeting. This way of including local Healthwatch as an equal partner on the board says a lot about how board members value local Healthwatch in the whole health and social care system."
>
> **Local Healthwatch chief executive and health and wellbeing board representative**

Wandsworth's local Healthwatch has a pre-meeting with voluntary organisations to go through the agenda in advance of a board meeting, thrash out the issues and pool evidence of what patients, service users and the public want.

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A number of boards have identified 'stress indicators' across the system (areas where there are significant pressures on resources and quality of services, such as a sudden increase in accident and emergency admissions or pressures on child and adolescent mental health services) and use board meetings to monitor these. Some have a policy of 'escalation and exception' reporting, under which issues will be reported to the health and wellbeing board where there are problems or a danger that something will go wrong.

Key issues to consider

- ✓ How does the board plan its work and agree its agendas? Who is involved in work planning and agenda setting? Is there representation from across the board's membership in this activity? Do all members have an opportunity to contribute to the agenda?
- ✓ Is there a filtering process to ensure that formal board meetings consider only the most important issues that relate to the JHWS priorities and that only the most essential items 'for information' only are tabled?
- ✓ Is the chair always clear before commencing a board meeting which agenda items need a decision by the board to generate further action on priority issues?
- ✓ Who is responsible for ensuring that progress is made on substantive decisions of the board between meetings? What method is used for tracking board decisions?
- ✓ How are board members and the public kept informed of key agenda items and timetables for forthcoming decisions by the board? (An agenda published five days in advance may not give enough time for member organisations to take a view on individual items.)
- ✓ How will the board know it is making a difference? That is, how does it set its own objectives or outcomes and monitor progress towards them? How well aligned to the health and wellbeing boards outcomes are those of the council and the CCG?

Sub-structures and super-structures – the meetings between the meetings

What happens between meetings through the structures that sit above and below health and wellbeing boards are vital to their success. There is only so much business that can be done in bi-monthly or tri-monthly meetings. The real work of taking forward action plans and of 'joining the dots' between local and regional partnerships needs to take place between formal board meetings.

In some areas, health and wellbeing boards have been established to sit under and report to existing local strategic partnerships (LSPs). In other areas, health and wellbeing boards have taken the place of LSPs. In some areas, all the health and social care joint commissioning structures have been recreated as sub-structures of the health and wellbeing board. In others, joint commissioning has carried on as a stand-alone activity, providing reports but not receiving delegated powers through the health and wellbeing board.

In all cases, whatever the formal structures, because of boards' statutory duty to promote integration and their new responsibilities for related funding through the Better Care Fund, there has to be close liaison with joint commissioning for the area.

Effective arrangements to take forward the board's business between formal meetings can help meet the challenge of getting a board of the right size. When it has been agreed that a board will be small and tightly focused, sub-structures can provide a means of bringing in wider expertise and involving relevant partners, for example other public sector bodies such as the police, the probation service, fire and rescue service and schools, the wider voluntary sector and local employers. Where a board is broad and inclusive with a large membership, smaller working parties and task groups can focus on specific priorities.

Some boards have not yet thought it necessary to have formal sub-group structures sitting under the board, but carry out the board's work through a series of 'task and finish' groups or workstreams. In some areas, each such group is sponsored by a board member who monitors and supports the work and reports back to the board, bringing an element of accountability.

While most stakeholders emphasise the importance of ensuring that the work of the board is carried on between formal meetings, some have mentioned that they are wary of setting up parallel delivery structures that may replicate the work of the board's member organisations.

> "The formal meetings are the tip of the iceberg. The board needs hands-on organisational leaders. It's a high-risk partnership like children's safeguarding. When something goes wrong, it will be board members who have to talk to the news reporters. Board members need to understand this."
>
> **Former chair of health and wellbeing board**

They point out that it is part of the board's role to seek the commitment of its member organisations to delivering the priorities of the JHWS.

Options

> "There's an enormous amount that happens outside formal board meetings but which wouldn't happen without them."
>
> **Chair of health and wellbeing board**

Appropriate, well-designed sub-structures which are fit for purpose, whether they have a formal constitutional identity or not, can make all the difference to whether a health and wellbeing board makes its mark. There are a number of options open to boards, each of which has been adopted by boards across the country to suit the local situation. These include:

- business structures as described in the section above, such as an executive board or officer group to plan the agenda and ensure the board's priorities are implemented between meetings
- formal sub-committees of the board set up under its constitution and subject to its standing orders – these will be necessary where the board wishes to delegate some of its decision-making powers, for example, if the board itself has powers delegated by the council or under a pooled budget arrangement which it wishes to delegate to a joint commissioning sub-committee
- ongoing working parties or workstreams which are designed to work long term on aspects of the board's functions – for example, on health and wellbeing of particular groups such as children or people with learning disabilities; on particular themes, such as obesity or health and housing; or to engage in dialogue with sectors whose involvement is vital to the board's objectives, such as patients, service users and the public and providers of services (see sections below)
- task and finish groups set up to take forward and complete part of the board's action plan for the year.

Luton's health and wellbeing board has three delivery boards, based on the three priority outcomes of its joint health and wellbeing strategy:

- Children and Young People's Trust Board
- Health Inequalities Delivery Board
- Healthier and More Independent Adults Delivery Board.

The delivery boards have been established to help with the implementation of the health and wellbeing board's work and are chaired by the directors with responsibility for children's services, public health and adult services.

"It's important to be clear about the programmes of the different sub-boards. Otherwise, there's a danger of talking about the same things in different places. Each of our delivery boards is working on an agreed annual programme and reports regularly to the health and wellbeing board." Gerry Taylor, Director of Public Health

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Bath and Northeast Somerset has a separate public services board. The health and wellbeing board feeds the public services board with challenges to ensure health and wellbeing impacts are considered in its wider agenda. It also seeks help where it needs assistance from other agencies to achieve its objectives.

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Liverpool's board has a sub-structure – which includes the joint commissioning group (officers from the CCG and the council), an integrated provision group, the local safeguarding children board and safeguarding board for adults – all of which report directly to the health and wellbeing board. Service users are engaged through a number of forums. An important part of this engagement is through a number of 'Making it Happen' groups on different health areas such as mental health. These groups are chaired by councillors and service users.

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Key issues to consider

- ✓ Are the board and its individual members clear about the superstructures above the board, the sub-structures sitting underneath it and the structures that are not part of the board with which it needs to have a relationship?
- ✓ Is there a clear understanding among board members and other bodies about reporting lines – which bodies/groups report to the board; to which, if any, the board reports; and what the force of reporting lines is? (For example, which bodies are subordinate constitutionally to the board? Which have simply agreed to exchange information?)
- ✓ Does your board have appropriate constitutional sub-structures to carry out any functions it wishes to delegate?
- ✓ Is the board clear about its relationship to joint commissioning structures and about who has the ultimate responsibility for signing off joint commissioning decisions?
- ✓ Does the board have appropriate arrangements to oversee or take forward its priorities between formal meetings, including arrangements to develop and maintain relationships with key partners? (See next section.)
- ✓ Is there a need to review the partnership structures in your area to ensure that they are streamlined and fully understood by all participants?

Support for the board

Health and wellbeing boards have support from councils' democratic services officers for the formal side of their work, such as arranging meetings, publishing agendas and writing minutes. However, boards also need support for:

- population-level monitoring and intelligence to underpin the JHWS and other joint strategieand ongoing commissioning activity
- policy development for the joint health and wellbeing strategy and the strands of work arising from it
- board development activities to support members of the board in developing their strategic leadership skills and in working together
- developing, monitoring, performance managing and evaluating outcomes from board work programmes.

> "There need to be people working for the whole board, not just democratic services. They should all put something into a pot and employ people."
>
> **CCG chief executive**

Options

Many boards do not yet have direct officer support, dedicated exclusively to the policy work of the board and the support outlined above. They often have to rely on the director of public health or the director of adult social care to bring their resources to support the board. Sometimes this is appropriate, as in the case of the contribution of public health to population-level intelligence.

However, if boards are to develop to become central strategic leaders within their areas, they will need more direct, dedicated support. Joint appointments funded by board member organisations will not only provide the resources required to harness the board's energy, but will also send a message from board members of commitment and willingness to collaborate. Some stakeholders have suggested that NHS England's 'local area teams' (LAT) might contribute additional resources, either of staff or funding, to support health and wellbeing boards.

Liverpool has an officer working jointly between the council and the CCG to support the board.

A full-time dedicated health and wellbeing board advisor is the lead officer for **Lincolnshire's** board, supported by a dedicated board secretary.

Hounslow Council has recruited a member of staff to act as lead officer for the board, supported by two further members of staff to provide engagement with members between meetings.

Key issues to consider

- ✓ Does your board have appropriate support for its policy work in addition to administrative support from democratic services?
- ✓ Can board members contribute funding to a pooled budget for jointly appointed staff support?
- ✓ Is there scope to second officers with relevant expertise from partner agencies?

4. Relationships and accountabilities

Health and wellbeing boards sit at the centre of a complex matrix of local and national relationships and accountability. They need to invest time and energy in getting their relationships with key players to work well and in ensuring clarity about accountability. Communicating regularly with all members and taking time to invest in working relationships with other partners is a necessary condition for appropriate and effective business.

Options

Relations between board and sub-group members

One of the key issues which became apparent for **Wandsworth's** health and wellbeing board was the need to provide a space for the 17 board members to meet, away from the full public glare of the formal health and wellbeing board meetings.

During the shadow period prior to April 2013, a series of informal seminars were held and worked well. Building on that concept, action learning sets will be formed to provide an informal forum for the members to meet three times a year.

Richard Wiles, Wandsworth Council's Health Policy Team Leader, says: "Health and wellbeing boards are only as good as their relationships, and you can't develop that in four meetings a year."

Wandsworth has also recognised the need to involve others. To incorporate the views of partners from the voluntary and community sectors, as well as local providers, a 'health and wellbeing being partnership board' has been established.

This meets after the health and wellbeing board and usually attracts between 30 to 40 people. The focus is to discuss, engage and prioritise decisions taken by the health and wellbeing board. For example, a new JSNA has just been developed and the partnership board is helping to establish a consensus on priority areas for action.

Wandsworth has had to be careful not to duplicate the work of local Healthwatch, which meets the week before the health and wellbeing board meeting. Healthwatch meetings are focused on discussing topics on the health and wellbeing board agenda, and then feeding into the decision-making process.

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> "People who attend health and wellbeing board meetings should be empowered to make collective decisions with the rest of the board without having to constantly refer things back. If they are getting deputies and different people coming, something is wrong."
>
> **Council cabinet member and chair of health and wellbeing board**

Councils and CCGs

Leeds health and wellbeing board found that it was encountering difficulties in getting 'sign-off' on joint reports commissioned by the board, for example on safeguarding and quality improvement issues. Structures existed within the council for signing off similar reports, but no equivalent process existed in the council and CCGs.

The agreed solution now is that – where there are joint reports that have implications for more than one member organisation of the board, which nearly all do – a key director or accountable officer from each organisation will be responsible for signing off the report before it comes to the board. The more complex reports are also signed off by the commissioning executive that sits under the board. This means that when the board comes to agree a report, all the partners are ready and willing to implement their contribution.

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A key relationship is that of members of the board as representatives of their organisations and decision-makers on their behalf. Members need to be sufficiently senior to be clear about the extent they are empowered to take collective decisions with the board. This will not always be easy, as board members are individually accountable to a range of organisations with their own reporting and decision-making structures.

> "We have tried to align the collective interest of the partnership with the direct accountability of the constituent organisations."
>
> **Council chief executive**

However, recognition of the board's collective responsibility, and clarity about how and when it takes decisions, should be explicitly agreed. A forward plan and decision-making grid of the kind discussed in previous chapters should help constituent organisations align their own timetables for discussion and decision-making with those of the health and wellbeing board. The formal decisions of the board need to be connected with formal decisions within CCGs and councils.

> "We should come with a mandate from our governing bodies and prior agreement to making commitments at board meetings."
>
> **CCG health and wellbeing board representative**

One way for the board to take forward its business is for different members to take responsibility for leading on specific parts of the work programme, either by chairing a workstream or task and finish group, or by acting as a liaison person with those working on a board priority issue. In such cases, there will need to be mechanisms for reporting back to the full board through the responsible member and for the whole board to take a collective decision when appropriate. Informal interactions outside board meetings also help to move along the business of the board.

Bath and North East Somerset health and wellbeing board has a lead for different priorities in the JHWS (for example creating healthy and sustainable communities) and the board collectively challenges that lead member on issues of quality and effectiveness.

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Local Healthwatch

Planning the business of the board should also help local Healthwatch to carry out its role of bringing the patient, service-user and public voice to the table. Advance knowledge of key issues to be discussed will enable local Healthwatch to consult and gather evidence of views and experiences, with the help of the wider voluntary and community sector, so that they can speak with credibility and authority at board meetings.

There has been some concern expressed by various local Healthwatch bodies about participating in the collective responsibility of the board, while also challenging and holding the board to account on behalf of service users and the public. This is indeed a complex role. But local Healthwatch members are intended to be full members of the board, just as CCG members are full members while still remaining accountable to the CCG board (and sometimes to more than one board where there are a number of CCGs in an area).

There may be occasions on which local Healthwatch is unable to say that there is a clear consensus among service users or the public about a particular issue. In that case, the role of the health and wellbeing board is to try to understand and accommodate the differing views in its proposals.

Where one view prevails on the board, the local Healthwatch representative may feel obliged to abstain if there is a vote, or to vote against the majority. This is a position which other board members should understand. However, there is a strong feeling among stakeholders that formal voting on boards will be very rare, so that local Healthwatch members are unlikely to be faced with this sort of dilemma very often.

NHS England

> "Primary care is the point at which the public touch health services for the first time and where most people receive their healthcare. The health and wellbeing board needs to have an overview of this, assisted by the NHS England local area team representative in their role as commissioner of primary care."
>
> **CCG chief officer and vice chair of health and wellbeing board**

The relationship of the representative on health and wellbeing boards of the NHS England LAT is somewhat different from that of other board members, since that representative is, in statute, only required to be present when relevant commissioning issues are being discussed.

However, as the quotation above indicates, NHS England's commissioning role is central to people's experience of the NHS. Stakeholders have made it clear that they consider it important to have LAT representatives round the table and fully engaged. A consistent presence of a suitably senior LAT representative is essential for developing mutual understanding of roles. Some LATs have changed their representation on boards so that a chief officer attends meetings, as this was felt necessary to cement relationships, at least in the early stages of boards' development.

Leeds health and wellbeing board has received contributions at meetings from its LAT member on specialist commissioning and primary care commissioning (the two areas where NHS England has responsibility for direct commissioning).

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Children's services

Although the director of children's services is a member of the health and wellbeing board, the board also needs to engage with any children's trust arrangements and with the safeguarding children board for the area, to ensure alignment of strategic priorities and communication about safeguarding issues.

It will also be important to engage with other services, such as schools which have a key role in children's health and wellbeing. New duties under the Children and Families Act 2014 require integrated 'education, health and care (EHC) plans' for children and young people with special needs and disabilities.

> "We need to continually refresh the board's perceptions and understanding about children's health."
>
> **Director of children's services**

They also require joint commissioning arrangements for these children and young people. The provisions must have regard to the JSNA and JHWS. This means that the health and wellbeing board will need to ensure that the provisions have responded to these requirements and that they are part of joint commissioning arrangements.

Non-statutory members

Properly planned meetings and decision-making arrangements will also assist other board members, such as representatives of district councils, to gather views to inform their contributions to board discussions and to feed back to the bodies and people they represent.

In the case of local Healthwatch, where a district council board member is representing more than one district council, the views they express will have greater authority and credibility if they have a system for reporting back to the other district councils and gathering their views on issues before the board.

The same applies to other members, such as voluntary sector representatives acting on behalf of a number of organisations.

Providers of services

As one of the key roles of health and wellbeing boards is to promote integrated care, their relationship with providers is critical to developing sustainable whole-system approaches. Providers' contributions to the JSNA and JHWS are also important, as providers may have a particular knowledge and understanding of population needs, service demands and gaps.

One stakeholder likened the board to the architects in a building project, with the commissioners as the engineers and the providers as the builders. "Only the builders can say whether a project is buildable in practice," he said. "They can help make plans meaningful." The experience of this board is that providers can genuinely understand the issues that commissioners are raising about the need for service redesign and help find creative solutions.

Many boards have chosen not to offer board membership to providers, on the grounds that this might involve conflicts of interest, inhibit wide-ranging discussion about reconfiguration of services, re-commissioning and de-commissioning and might contribute to making boards too unwieldy. A number of other boards believe that the contribution of large acute and community NHS providers on boards is so valuable that they are willing to deal with the issues listed above.

Where providers are members of boards, they usually include at least one large acute healthcare provider, mental health, community health and, in some cases, social care. In some areas, providers are invited to attend board meetings, although they are not members. (As formal board meetings are held in public, providers are entitled to attend, whether or not they are invited.)

Many boards have voluntary and community sector representatives as additional board members. Some of these may be providers, but are usually present on boards in their patient, service-user and public representative role. Most stakeholders acknowledge that deciding which providers to involve as board members is a difficult issue which is likely to persist with the expected proliferation of provider organisations.

All stakeholders emphasise that where, as in most cases, providers are not members of health and wellbeing boards, they need some mechanism for engaging consistently and regularly with providers – not least to promote integration and, specifically, to plan effective use of the Better Care Fund. Most stakeholders have already made such an arrangement, with a number of board members meeting with relevant providers, sometimes in smaller groups related to specific commissioning areas, such as children's services.

Bath and North East Somerset has sought to get local providers involved in the work of the health and wellbeing board through new arrangements, which sit alongside the board. A strategic advisory group, which includes representatives from the main health and social care providers in the area, is chaired by the health and wellbeing board chair. It gives providers the opportunity to influence decision-making. Issues, such as the implications of the Better Care Fund and how to tackle loneliness and isolation, have been discussed.

A transformational leadership group has also recently been set up which is managed and chaired by the local clinical commissioning group. This group has been designed to allow providers to have input into the delivery of the CCG's plans. Meetings run immediately after the strategic advisory group to avoid duplication and make the most of providers' time.

In addition, the local Healthwatch organisation also manages a health and wellbeing network, which is open to all local providers as well as other groups, such as community organisations and stakeholders. The network meets shortly before the health and wellbeing board and acts as a forum for key board priorities to be discussed, with recommendations then fed back to the board.

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The **Liverpool** health and wellbeing board has developed and adopted a partnership agreement between Liverpool City Council and Liverpool Community Health NHS Trust.

The integrated provision group established to govern the programme of integration under the partnership agreement meets regularly to develop plans and prepare for implementation. It is cochaired by the chair of Liverpool Community Health and the assistant mayor/cabinet member for adult social care and health.

As part of its remit to manage a joint programme of work to deliver integrated services, it monitors the Section 75 partnership agreement between the council and Liverpool Community Health. A joint programme delivery group meets monthly and reports to the integrated provision group, which in turn sits directly under and reports regularly to the health and wellbeing board.

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Sheffield health and wellbeing board encourages providers to become involved in the work of the board through extensive and regular communication, including by:

- attending meetings and events, for example, on mental health and tackling health inequalities – find out more about engagement events at www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/events/engagementevent.html
- representing service users' views – many providers attend engagement events with service users and they also work with local Healthwatch to feed in views, for example, Healthwatch Sheffield has a Virtual Advisory Network for voluntary and community sector providers, whose website is at www.healthwatchsheffield.co.uk/news/virtual-advisory-network-van
- signing up for the monthly board e-newsletter – when the board was first formed, one thing providers wanted was information provided regularly and transparently so they could choose how to get involved. The newsletter describes what the board is doing and informs about meetings, consultations and events, and can be accessed at us6.campaign-archive1.com/home/?u=4c519d652065c050d46e2444e&id=d680dbeecd
- joining a provider reference group, for example for adult social care providers, home support providers, providers of support for children and young people. Information for health and wellbeing providers can be found at www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/providers.html

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Engagment of providers has been supported and encouraged by **Wakefield's** health and wellbeing board. The board in shadow form initially set up a major providers' forum, which met twice a year to discuss and develop themed issues to be brought to the board.

Wanting to be more inclusive and to enable providers to sign up to the board's general 'direction of travel' and specifically to the JHWS, providers have now been invited to become members of the board (since April 2013). They include the chief executives of Mid-Yorkshire Hospitals NHS Trust and South West Yorkshire Partnership NHS Foundation Trust (community, mental health and learning disability services), the chief superintendent of West Yorkshire Police and the chief executive of Age UK Wakefield District, who represents local voluntary and community sector organisations.

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In **Leeds**, providers were not originally members of the health and wellbeing board, as it was viewed as largely having a commissioning role. There was also concern that if the board expanded its membership, it might become a 'talking shop' rather than having a strategic focus.

Local service providers supported this view and were satisfied that they had good relationships with commissioners through the well established Transformation Board, on which the chief executives of commissioning organisations sat with the chief executives of major NHS providers for the city.

However, at the same time all the public sector bodies in Leeds had been working together to develop the concept of 'the Leeds Pound' – ie the idea that the money available for public services should not be thought of as belonging to separate organisations, but collectively to the people of Leeds.

This has recently led to the public sector chief executives for the area, both commissioners and providers, signing a joint letter committing to the idea of working together as though they were one large organisation. It was decided that it would be difficult for the health and wellbeing board to take this idea forward without actively involving all organisations that contribute to the 'single organisation' – namely the large NHS providers for the area. Therefore, the board invited the three largest providers to become members, which they accepted.

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Relations with key stakeholders

Scrutiny

Stakeholders have indicated that there is still some confusion about the respective roles of health and wellbeing boards and councils' health scrutiny arrangements. Health scrutiny committees or panels, bodies which are independent of council cabinets and executives, are an important mechanism for holding the health and wellbeing board to account. They are also an important source of information, through the inquiries that they conduct, about the quality of services and issues of concern to patients, service users and the public. Local Healthwatch organisations have statutory powers to refer issues to health scrutiny. Therefore, there is a three-way relationship between health and wellbeing boards, scrutiny and local Healthwatch. A number of areas have clarified how these bodies will work together and separately through a written protocol or memorandum of understanding.

Health and wellbeing boards are subject to scrutiny by their council's health scrutiny function. Health scrutiny has specific powers to ask for information and require attendance at meetings. These are laid down in regulations and guidance (see further information section below). Health scrutiny committees and their equivalents have special powers in relation to proposed substantial reconfigurations of services which they (or the council) can refer to the Secretary of State for Health under certain circumstances. It is particularly important, therefore, that health scrutiny bodies are engaged in discussions and consulted about proposals for change at an early stage, and given an opportunity to understand the reasons for the proposals, how they might improve access or quality of services, and how patients, service users and the public are engaged and consulted on the proposals.

The three-way relationship between health and wellbeing boards, scrutiny and local Healthwatch potentially gives rise to a number of conflicts of interest. For example, a councillor might be a member of a health and wellbeing board and also a member of the council's health scrutiny committee or of a joint health scrutiny committee. A local Healthwatch might refer a proposed service reconfiguration to a health scrutiny committee. In this case there could be a conflict of interest for the local Healthwatch representative on a health and wellbeing board that could be involved at some level in the commissioning of the proposed reconfiguration. Any conflicts of interest of this kind can be dealt with through the council's usual arrangements for committees.

Warwickshire's health and wellbeing board has sought to clarify the roles of four key bodies: the board, Healthwatch Warwickshire (HWW), the Children and Young People Overview and Scrutiny Committee (CYPOSC) and the Adult Social Care and Health Overview and Scrutiny Committee (ASCHOSC).

A memorandum of understanding was signed by the chairs of the four groups to establish a 'clear working relationship'. It committed the bodies to share information, respect each others' independence and cross-refer concerns. It also spelt out in detail certain requirements for each body.

For example, HWW has promised to produce regular reports and advice to the ASCHOSC. Meanwhile, the health and wellbeing board has committed to consulting both scrutiny committees on the development of the joint strategic needs assessment and health and wellbeing strategy. The ASCHOSC has also pledged to scrutinise the work of HWW via six-monthly reports and both committees have agreed to commission HWW to carry out reviews when appropriate.

Public Health England has noted that the memorandum was the "beginning of a pioneering approach to joint working" in the region. There are already signs this has begun to happen. The four bodies held a workshop on the Francis Inquiry to establish how they will proceed together in implementing the recommendations and continue to use this approach for other areas of work that have implications across some or all of the bodies.

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Other partnerships and public sector bodies

As discussed in previous sections, some boards have found it very helpful to include representatives of other partnerships, such as the adults safeguarding board (now a statutory requirement for each area under the Care Act 2014), crime and disorder partnership, the police and crime commissioner or public sector bodies such as the police and probation service.

Most boards have not extended full membership this far. This means that they need to consider which partnerships and other organisations they should engage with on a regular basis in order to play their role as system leader and to further common objectives.

Some boards develop these relationships through their membership of overarching bodies such as LSPs. In other areas, the LSP has been disbanded and in some the health and wellbeing board plays this overarching role.

In some areas, the chief executives and/or chairs of local public sector bodies meet together regularly to exchange information and ideas. The health and wellbeing board could be represented in such a forum.

Working across boundaries

District councils

In two-tier local government areas, the work of district councils is vital to the strategic objectives of health and wellbeing boards. Clarity is therefore needed on relationships with district councils and their representatives on health and wellbeing boards. In some two-tier areas, there are fewer places for district council representatives on health and wellbeing boards than there are district councils. Some district councils have mechanisms for meeting together to discuss and develop their views on the work of health and wellbeing boards and to brief their representatives. Others currently rely on the individual efforts of their representatives to feed back to the district councils they represent.

Boards will want to be satisfied that district council representatives are able to speak for all the district councils in the area when participating in collective decision-making at board meetings. It may be that there is not a single district council view of an issue – the district council representatives on the health and wellbeing board should be expected to reflect the range of district council views to the board. They should also be expected to make arrangements, with appropriate administrative support, to feed back on the board's deliberations and decisions to all the district councils they represent. Assuring themselves that there is good communication with all district councils will be a worthwhile investment of time and energy for boards, particularly when controversial service reconfigurations are under consideration.

Multiple CCGs

Similarly, ensuring that there are good links between CCGs where they share the same health and wellbeing board will be important for effective engagement with member organisations. All of the CCGs must be engaged, but they may share representation on the board. Boards will want to satisfy themselves that the views of all member CCGs are represented at board meetings and that they are participating in the board's collective decision-making and committed to implementing its decisions. This means that a single representative of multiple CCGs needs to make a special effort to communicate with those CCGs boards. Health and wellbeing boards may also wish to find additional ways to build personal relationships with the boards of CCGs which share a representative on a health and wellbeing board (for example, by asking CCGs' chairs to informal board sessions).

Key issues to consider

- ✓ Are all board members clear about the extent they can commit their organisations to implementing decisions of the health and wellbeing board? Are any additional arrangements necessary to ensure appropriate 'sign-off' of board decisions by member organisations?
- ✓ Is there agreement about the role and contribution of NHS England's LAT representative on your board?
- ✓ Does your board have appropriate arrangements for regular engagement with providers? Does this include non-acute health and social care providers such as third sector, social care providers, community and mental health trust providers?

- ✓ Does the health and wellbeing board link effectively with the local children's trust, safeguarding children board, adults safeguarding board and CCGs to ensure cohesive governance and leadership across the children's agenda?

- ✓ Does the board have an agreed method of engaging with schools?

- ✓ Is there a protocol or memorandum of understanding between the health and wellbeing board and the council's health scrutiny arrangements about the respective roles of each and how they relate to each other?

- ✓ Do you need to improve engagement with key stakeholders who are not directly represented on the board, including other partnerships, other parts of the public sector, local employers, district councils in two-tier areas and locality/neighbourhood structures? Do policy documents of these bodies refer to the health benefits of their activities and the needs identified in the JSNA?

- ✓ In two-tier local government areas, is the board satisfied that district council representatives who represent more than one district on the board, are appropriately supported to gather the views of all district councils, authorised to participate in the board's decisions on their behalf, and enabled to feed back to district councils on the board's activities? Is there evidence in district councils' policy documents of health objectives arising from the JSNA?

- ✓ On boards where a number of CCGs share a representative on the board, is the board satisfied that there are mechanisms for all CCGs' views to be represented at board meetings and for CCGs to be kept informed of the board's activities?

5. Communications and engagement

Health and wellbeing boards have a duty to engage the public in their work under the Local Government and Public Involvement in Health Act (2007). There is considerable debate about the precise role that health and wellbeing boards should play in engaging patients, service users and the public.

Boards have a statutory role to meet in public, but as discussed above, much of the work of developing and taking forward their strategies is carried out between formal board meetings. This means that boards need to think both about the provision they want to make for public engagement at formal board meetings, and about how they communicate and engage with the public on:

- collecting information and evidence for the JSNA
- developing the JHWS
- the sub-structures and workstreams reporting to the board
- improving services and integrating care for specific groups
- communicating the progress of the health and wellbeing board and how its achievements reflect the priorities of the JHWS
- discussing the future design of health, social care and wellbeing services and the implications for current service provision.

All stakeholders recognise that the board has a role in connecting with the public through the processes listed above. Some boards give more emphasis to direct relationships with patients and service users. Others take the view that, although they meet in public, most people are less interested in the administrative details of board meetings, than in having a chance to influence services. They see the task of the board is to ensure that there is engagement throughout the system, proper consultation when needed and that the public knows where to go if they have a concern about the quality of services or reconfiguration issues.

> "However communications and engagement are organised, it will be important for local Healthwatch to be involved from the beginning so that they can see the detail behind the strategy and identify areas where engagement is needed, for example with different communities."
>
> **Director of local Healthwatch**

Local Healthwatch representatives have an important role to play in ensuring that the health and wellbeing board is clear about its communication and engagement strategy. They point out that they should not be seen as the repository and source of all engagement and consultation in the system. All member organisations should be fully involved and indeed have statutory duties to involve and consult. Nor do local Healthwatch organisations have a monopoly of channels to communicate with local communities, as they themselves recognise.

The most dynamic and effective engagement strategies will bring in a wide range of voluntary and community organisations to reach out to communities. Nonetheless, communications and engagement issues provide an opportunity for local Healthwatch representatives to take the initiative on the health and wellbeing board, for example in setting up a sub-group of the board to develop a communications and engagement strategy.

One of **Luton's** JHWS priorities is to reduce the variability of general practice in Luton. As its contribution to this work, the local Healthwatch organisation was interested in understanding patients' experience of primary care.

Healthwatch Luton undertook a review of GP practices. It surveyed 962 patients and carried out unannounced inspections on 39 practices from September to December 2013. The report was presented to the health and wellbeing board in January 2014 with the Chair, Councillor Hazel Simmons who is Luton Borough Council's Leader, praising it for helping to highlight "where we need to focus efforts".

The findings have also been fed back to the local CCG and NHS England area office and services are now being reviewed. The health and wellbeing board's 'Healthier and More Independent Adults' delivery board is also looking at what needs to be done in response to the report, as part of the delivery board's contribution to this priority area of the health and wellbeing strategy.

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Options

However they choose to engage with the public, boards need to have a clear idea of what their communication and engagement policy is going to be.

Some boards have concentrated on developing a direct public-facing role, carried out through innovative practices at board meetings and through involving patient, service-user and carer representatives in the sub-structures, workstreams, and task and finish groups that report to the board.

Others have concentrated on developing an overarching strategy to tie together all the strands of public engagement going on within member organisations, and to ensure that there is evidence of learning from the experiences and views of patients and service users.

Boards may also want to increase public awareness and the board's profile to build public confidence and the credibility of the board's activities. To do this, they will need to communicate regularly with the public about what they are doing and the difference they have made to local commissioning, local services and health outcomes.

Engagement at board meetings

> "The board meetings need to be flexible enough to accommodate the public on local issues."
>
> **Director of public health**

Liverpool health and wellbeing board has had 40 members of the public or more present at board meetings. A question time is included at each meeting, with responses minuted. Questions have led to a discussion with board members about a local issue of current concern, such as alcohol and smoking.

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A number of boards have arrangements to enable members of the public to talk to board members and/or ask questions. Some boards have an informal 'meet the board' session before the formal part of board meetings begins, where members of the public can ask questions and raise issues. Others have a more formal arrangement by which questions must be submitted in advance and/or must relate to items on the agenda.

Some boards webcast their meetings as part of their commitment to transparency. Some do not make special arrangements other than meeting in public, preferring to carry out public engagement exercises with board members through regular 'health summits' or conferences (twice or four times a year) at which the public has a greater opportunity to participate than they would at a formal board meeting.

Developing an engagement strategy

At however high a level, health and wellbeing boards need to take a strategic view of communication and engagement with the public throughout the system. The board has a responsibility to ensure that effective public engagement is embedded within the day-to-day business of the board and is taking place through the commissioning and delivery of services. This means developing an engagement strategy.

It is not appropriate to leave this to the board's local Healthwatch representative, although they will, of course, play a leading role in the development of the strategy. The board as a whole needs to develop a consistent and rigorous mechanism by which it can continue to assess what form of engagement should take place in relation to its various strategies and its work programme. Board members need to view the public as an equal partner, working with them to shape plans from the very beginning.

This should help to ensure that services are more person-centred than designed around buildings and organisations.

Improving public engagement has been made a key priority by **Bedford's** health and wellbeing board. This can be seen through the changes that are being made to the JSNA process. The next update to the JSNA will involve the incorporation of what is being called 'voice data' in each section. This includes evidence from patient and stakeholder groups about needs on everything from mental health services to cancer care.

To achieve this, the clinical commissioning group and the local voluntary and community sector network will act as 'matchmakers' putting JSNA report authors in touch with key bodies, such as GP patient participation groups, so they can gather first-hand evidence of what the issues are.

Councillor Colleen Atkins, executive member for adults' services and community wellbeing at Bedford Borough Council, says: "It is important to have the JSNA feeding into the board's plans and by having the voices of the people incorporated we hope to provide the members with a much stronger evidence base to make decisions."

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In particular, it will be important for the board to ensure that the public is involved in discussions about service redesign, joint commissioning and integration of services. Clearly, simply making provision for questions at board meetings on these issues would be tokenistic in the extreme.

Boards will wish to assure themselves that engagement via their member organisations is happening at an early enough stage and in a way that enables the views and experiences of patients and service users to have an impact. They will also wish to consider if and how engagement should take place via their own sub-committees, workstreams and task and finish groups. For example, some boards have standing advisory groups of service users, such as people with learning disabilities and carers, who can be engaged with on specific issues.

London Borough of Richmond health and wellbeing board has endorsed the set of guiding principles for engagement and consultation developed by the wider Richmond Partnership. The principles include:

- coordination to reduce duplication and improve efficiency and effectiveness
- reviewing information and knowledge that already exists to ensure consultation and engagement is relevant and necessary
- a commitment to clear, concise and transparent communication
- a commitment to confidentiality while sharing anonymised data
- a commitment to being inclusive and accessible
- timely, well planned and appropriate engagement
- acting on findings to improve services and quality of life
- reporting back to the public on engagement exercises and their outcomes.

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As part of the consultation for the **Plymouth** Joint Health and Wellbeing Strategy, Plymouth Health and Wellbeing Board employed the "Plymouth Plan Sofa".

Moving around the city the sofa gives citizens the opportunity to get involved in conversations about the future of Plymouth. Local people are encouraged to discuss local health and wellbeing issues face-to-face with several of the city's health and wellbeing board members. Alongside a survey, this approach directly informed the JHWS.

These are part of a series of sessions popping up all over the city, gathering ideas to help inform the 'Plymouth Plan', which will be a single strategic plan for the city that brings together all the city's long-term strategic plans into one place and delivers a full review of the current local development framework core strategy.

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Key issues to consider

- ✓ Has your board agreed a set of public engagement principles to underpin a communications and engagement strategy and inform the way it works?
- ✓ What arrangements has your board made for public involvement at board meetings (either formal or informal)?
- ✓ Does the health and wellbeing board have a vision for where it wants the system to be in two and in five years from now? What will this look like from a service-user perspective? What are the milestones along the way to achieving this vision and how will the board monitor progress?
- ✓ How does the board reflect public engagement in its governance arrangements?
- ✓ How is public engagement embedded in the development and review of the JSNA and JHWS, prioritisation of outcomes and decision-making?
- ✓ How does the board assure itself that patients, service users and the public are engaged with the commissioning, design, redesign and delivery of services and that their views and experiences have influenced decision-making and the shape of services?
- ✓ Is local Healthwatch sufficiently resourced to gather and reflect the views and experiences of patients?
- ✓ Is the board giving due weight to qualitative evidence, such as the personal stories of board members and the user, patient, carer and community voice?

6. What next?

> "Whoever wins, we need to ensure we have time built into our board meetings next year to discuss policy changes that will inevitably arise after the general election."
>
> **Chief executive of CCG and prospective chair of health and wellbeing board**

What issues will health and wellbeing boards be facing in the short and medium term that require a governance response? The list below was suggested by stakeholders.

- Identifying stresses in the system and developing indicators to monitor them. (Some boards are already doing this, but it will be an ongoing imperative).
- An increase in the diversity of providers and more 'churn' of providers will require different types of relationship and close monitoring of the health and care economy in a locality.
- Shifting resources to prevention and early intervention is still a strong imperative, but has been very difficult to achieve, given the pressures in the acute and treatment sectors.
- Some health and wellbeing boards have only just begun to think about the wellbeing agenda and the wider determinants of health; other boards have been wholly concentrated on existing service issues.
- The transfer of responsibility for health of children aged 0 to 5 in 2015/16 will provide both a challenge and an opportunity for public health and for boards.
- Service redesign and transformation – significant changes are coming down the line. The health and wellbeing board will need to take a lead in seeking the views and explaining issues, the advantages and disadvantages of different models to communities, attempting to develop a consensus and, sometimes, having difficult conversations about proposed changes.
- Further pressures for integration may mean a change in the nature of the health and care systems and boards' relations with them.

To take a leadership role boards need to think and talk about some of these issues before they become urgent. Board development sessions and 'summits' with the public will provide forums to introduce and thrash out ideas.

In its report for the LGA on health and wellbeing boards one year after establishment, Shared Intelligence suggests boards should develop a 'road map' to set out how the system can move from where it is now to where it needs or wants to be two to five years down the road. (See section on further information below). A road map of this type could encourage all services to consider their role and contribution, and would offer an evaluative framework for boards to monitor progress towards their vision.

Key issues to consider

- ✓ Does the way the board operates give it flexibility to respond rapidly to changing local and national circumstances, including future pressures in the system and to 'keep ahead of the curve', rather than simply reacting to events? If not, what can be done to ensure the board is both proactive and responsive?

- ✓ Does the health and wellbeing board have a vision for where it wants the system to be in two and in five years from now? What will this look like from a service-user perspective? What are the milestones along the way to achieving this vision and how will the board monitor progress?

7. Further information

A full range of **support for the health and wellbeing system**, see the LGA website: www.local.gov.uk/health-and-wellbeing-boards

NHS Confederation **resources for health and wellbeing boards**: http://www.nhsconfed.org/resources/2014/08/resources-for-health-and-wellbeing-boards

A full summary by the LGA of the legislation which set up Health and Wellbeing Boards, **Get in on the Act: The Health and Social Care Act 2012**: www.local.gov.uk/c/document_library/get_file?uuid=e0e0321b-49f1-4ec2-9e73-5ba379e0787b&groupId=10180

Our 2013 guide gives a more detailed outline of statutory duties and constitutional issues for health and wellbeing boards: LGA and ADSO, 2013, **Health and wellbeing boards: a practical guide to governance and constitutional issues**: www.local.gov.uk/web/guest/publications/-/journal_content/56/10180/3896494/PUBLICATION

Shared Intelligence (2014), **Great Expectations: A Review of the LGA's Health and Wellbeing System Improvement Programme** is available at: www.local.gov.uk/documents/10180/11493/Great+expectations+-+A+review+of+the+Health+and+Wellbeing+System+Improvement+Programme/d8c4b00e-c3fc-4598-9e87-e5a719df2274

Department of Health (2014), **Local Authority Health Scrutiny: Guidance to support Local Authorities and their partners to deliver effective health scrutiny**: www.gov.uk/government/uploads/system/uploads/attachment_data/file/324965/Local_authority_health_scrutiny.pdf

Centre for Public Scrutiny (2012), **Local Healthwatch, health and wellbeing boards and health scrutiny**: cfps.org.uk/domains/cfps.org.uk/local/media/downloads/L12_693_CFPS_Healthwatch_and_Scrutiny_final_for_web.pdf

The King's Fund produces a number of **resources for health and wellbeing boards**, including a directory and monthly bulletin: www.kingsfund.org.uk/projects/health-and-wellbeing-boards

NHS England, LGA et al. (2014), **Integrated Care Value Case Toolkit** – a resource for health and wellbeing boards and others to understand the evidence and impact of different integrated care models: www.local.gov.uk/health/-/journal_content/56/10180/4060433/ARTICLE

More on the Care Act 2014 and **the care and support reform programme**: www.local.gov.uk/care-support-reform

NHS England guidance for NHS commissioners on the planning and development of proposals for major service changes and reconfigurations: www.england.nhs.uk/wp-content/uploads/2013/12/plan-del-serv-chge1.pdf

LGA, **Get in on the Act: Children and Families Act 2014**:
www.local.gov.uk/documents/10180/11431/Get+in+on+the+Act+-+Children+and+Families+Act+2014/4443e520-80c9-4013-a785-cad56b578d23

A range of **guidance and resources** to support Better Care Fund Planning:
www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

8. Appendix

Stakeholders interviewed for the guide

Solomon Agutu, Head of Democratic Services and Scrutiny, Croydon Council

Steve Bedser, Former HWB chair and LGA peer

Councillor Dale Birch, Chair of Bracknell Forest HWB

Dr Andy Brooks, CCG Chair, Member of Surrey HWB

Andrew Christie, Director of Children's Services, Tri-boroughs London and Chair ADCS Health Care and Additional Needs Committee

Addicus Cort, Principal Policy and Projects Manager, Children's Services Team, London Councils

Elizabeth Culbert, Deputy Head of Law, Brighton and Hove City Council

Cheryl Davenport, Director of Health Care and Integration, Leicester City Council

Jo Farrar, Chief Executive of Bath and North East Somerset Council

Claire Fish, Director of Families and Wellbeing, Wirral Council

Julie Fitzgerald, Director of Healthwatch, East Sussex

Abraham Ghebre-Ghiorghis, Head of Law, Brighton and Hove City Council

Anne Goldsmith, Director of Children's Services, Wigan Council

Councillor Roger Gough, Cabinet Member, Kent County Council and Chair of Kent HWB

Frances Hasler, Director of Healthwatch, Camden

Andrew Ireland, Corporate Director Social Care, Health and Wellbeing, Kent County Council

Dr Graham Jackson, Vice-chair of Buckinghamshire HWB and Clinical Lead of Aylesbury Vale CCG

Samir Kalakeche, Director of Adult Social Services, Liverpool City Council

Sandie Keene, Director of Adult Social Services, Leeds City Council

Anthony May, Corporate Director of Children's Services, Families and Cultural Services and Deputy Chief Executive of Nottinghamshire County Council

Dr Joe McGilligan, Co-Chair of Surrey HWB and Chair of East Surrey CCG

Dr Jim McManus, Director of Public Health, Hertfordshire

Steve Morton, Head of Health and Wellbeing, Croydon Council

Councillor Jonathan Owen, Chair of East Riding HWB and LGA Peer Member

Hannah Shah, East of England HWB Coordinator, EELGA

Kate Shethwood, Policy Officer, Association of Directors of Children's' Services

Jane Stewart, HWB support and Overview and Scrutiny Team Leader, East Riding Council

Phil Swann, Managing Director, Shared Intelligence

Caroline Tapster, Health and Wellbeing Improvement Programme Director, LGA

Dr Gerry Taylor, Director of Public Health, Luton Council

John Tench, Healthwatch Adviser, LGA

Will Tuckley, Chief Executive of Bexley Council

Mark Tyson, Group Manager of Policy and Partnerships, Barking and Dagenham Council

Jan Underhill, Executive Head of Community Wellbeing and Partnerships, Sutton Council

Martyn Webster, Director of Healthwatch, Dorset

Dr Cathy Winfield, Chief Officer of Berkshire West CCG

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please contact us on 020 7664 3000.
We consider requests on an individual basis.

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THANET DISTRICT COUNCIL DECLARATION OF INTEREST FORM

Do I have a Disclosable Pecuniary Interest and if so what action should I take?

Your Disclosable Pecuniary Interests (DPI) are those interests that are, or should be, listed on your Register of Interest Form.

If you are at a meeting and the subject relating to one of your DPIs is to be discussed, in so far as you are aware of the DPI, you **must** declare the existence **and** explain the nature of the DPI during the declarations of interest agenda item, at the commencement of the item under discussion, or when the interest has become apparent

Once you have declared that you have a DPI (unless you have been granted a dispensation by the Standards Committee or the Monitoring Officer, for which you will have applied to the Monitoring Officer prior to the meeting) you **must:-**

1. Not speak or vote on the matter;
2. Withdraw from the meeting room during the consideration of the matter;
3. Not seek to improperly influence the decision on the matter.

Do I have a significant interest and if so what action should I take?

A significant interest is an interest (other than a DPI or an interest in an Authority Function) which:

1. Affects the financial position of yourself and/or an associated person; or
   Relates to the determination of your application for any approval, consent, licence, permission or registration made by, or on your behalf of, you and/or an associated person;
2. And which, in either case, a member of the public with knowledge of the relevant facts would reasonably regard as being so significant that it is likely to prejudice your judgment of the public interest.

An associated person is defined as:

- A family member or any other person with whom you have a close association, including your spouse, civil partner, or somebody with whom you are living as a husband or wife, or as if you are civil partners; or
- Any person or body who employs or has appointed such persons, any firm in which they are a partner, or any company of which they are directors; or
- Any person or body in whom such persons have a beneficial interest in a class of securities exceeding the nominal value of £25,000;
- Any body of which you are in a position of general control or management and to which you are appointed or nominated by the Authority; or
- any body in respect of which you are in a position of general control or management and which:
  - exercises functions of a public nature; or
  - is directed to charitable purposes; or
  - has as its principal purpose or one of its principal purposes the influence of public opinion or policy (including any political party or trade union)

An Authority Function is defined as: -

- Housing - where you are a tenant of the Council provided that those functions do not relate particularly to your tenancy or lease; or
- Any allowance, payment or indemnity given to members of the Council;
- Any ceremonial honour given to members of the Council
- Setting the Council Tax or a precept under the Local Government Finance Act 1992

If you are at a meeting and you think that you have a significant interest then you **must** declare the existence **and** nature of the significant interest at the commencement of the

matter, or when the interest has become apparent, or the declarations of interest agenda item.

Once you have declared that you have a significant interest (unless you have been granted a dispensation by the Standards Committee or the Monitoring Officer, for which you will have applied to the Monitoring Officer prior to the meeting) you **must:-**

1. Not speak or vote (unless the public have speaking rights, or you are present to make representations, answer questions or to give evidence relating to the business being discussed in which case you can speak only)
2. Withdraw from the meeting during consideration of the matter or immediately after speaking.
3. Not seek to improperly influence the decision.

Gifts, Benefits and Hospitality

Councillors must declare at meetings any gift, benefit or hospitality with an estimated value (or cumulative value if a series of gifts etc.) of £100 or more. You **must,** at the commencement of the meeting or when the interest becomes apparent, disclose the existence and nature of the gift, benefit or hospitality, the identity of the donor and how the business under consideration relates to that person or body. However you can stay in the meeting unless it constitutes a significant interest, in which case it should be declared as outlined above.

What if I am unsure?

If you are in any doubt, Members are strongly advised to seek advice from the Monitoring Officer or the Democratic Services and Scrutiny Manager well in advance of the meeting.

DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS, SIGNIFICANT INTERESTS AND GIFTS, BENEFITS AND HOSPITALITY

MEETING……...

DATE…… **AGENDA ITEM** ……

DISCRETIONARY PECUNIARY INTEREST □

SIGNIFICANT INTEREST □

GIFTS, BENEFITS AND HOSPITALITY □

THE NATURE OF THE INTEREST, GIFT, BENEFITS OR HOSPITALITY:

……

……

……

NAME (PRINT): ……

SIGNATURE: ……

Please detach and hand this form to the Democratic Services Officer when you are asked to declare any interests.