Health and Wellbeing Board Review: Update, Emerging Issues and Findings and Next Steps.

1. Introduction

At its last meeting the Health and Wellbeing board (HAWB) agreed to a review of its functions, structure and governance.

Following the urgent concerns of the CQC, the Chair and Vice-Chair undertook an extensive process of review through interviewing key stakeholders and inviting written views. The meetings were informal and the views expressed non-attributable.

The following programme of interviews was undertaken:

Date	Stakeholder Group	Invitees
1st February 2018	County Council and CCG Senior Officers	Catherine Mountford Jonathan McWilliam Kate Terroni Lucy Butler Peter Clark
1st February 2018	County Council Cabinet Members. All current members of the HWB	Cllr Lawrie Stratford Cllr Hilary Hibbert-Biles Cllr Steve Harrod
15th February 2018	Chair and Chief Executive, Oxford University Hospital NHS Foundation Trust	Dame Fiona Caldicott Bruno Holthof
15th February 2018	Chair and Chief Executive, Oxford Health NHS Foundation Trust	Martin Howell Stuart Bell
15th February 2018	GP Federation Chairs and Chief Executives	Helen Shute; Ben Riley; Andrew Elphick, John Harrison Mark Bish. David Ridgway
15th February 2018	Chairs of CCG Locality Patient Fora	Helen van Oss Anita Higham Graham Shelton Jeremy Hutchins Tracey Rees Shelagh Garvey
15th February 2018	Chair and Director, Oxfordshire Healthwatch	Prof George Smith Rosalind Pearce
15th February 2018	Chair and Chief Executive, South Central Ambulance Trust	James Underhay (Dep CEO) Lena Samuels (Chair) Will Hancock (CEO)
20th February 2018	Social Care Provider organisations	Chris Ingram (Style Acre) George Tuthill (Oxon Carehomes Assoc) Charles Taylor (Oxon Carehomes Assoc Chair elect) Eddy McDowell (Oxon Assoc Care

		Providers) Trish O'Leary (Vale House); Dan Hayes (Order of St John)
20th February 2018	Chair and Vice Chair of Health Improvement Board	Cllr Anna Badcock Cllr Marie Tidball
21st February 2018	Chief Executive, Oxfordshire Clinical Commissioning Group	Lou Patten
1st March 2018	Medical Directors and Lead Nurses, OUHFT, OHFT, SCAS	Tony Berendt Sam Foster Ros Alstead / Pete McGrane Mark Hancock John Black
1st March 2018	Carers and Patient Advocacy Organisations	Dan Knowles (Mind) Kay Francis (Carers Oxon) Penny Thewlis (Age UK Oxon) Angela Cristofoli (OCVA) Kathy Shaw (OCVA) Bryan Mitchell (My Life My Choice)
1st March 2018	NHS England	David Radbourne Ruth Williams (Director of Nursing) Anne Eden

Written views were invited from all those interviewed, District Councils and the Police and Crime Commissioner. Written views were received from:

1 Councillor Jeanette Baker, West Oxfordshire District Council
2 Councillor Hilary Hibbert-Biles, Oxfordshire County Council
3 Helen Shute, Oxfed
4 Dan Knowles, Oxfordshire Mind
5 Cherwell District Council
6 Oxford City Council

The views of MPs were sought in one to one discussion.

In addition, Healthwatch agreed to seek and represent views from the wider Voluntary sector through their network.

The full recent report of the Care Quality Commission (CQC) appears elsewhere on this meeting's agenda and comments in detail on the current working of the HAWB. A precis of the CQC's views regarding the HAWB is given below:

Summary

- *The Oxfordshire Health and Wellbeing board (HWB) did not have a clear role in influencing and supporting a strategic approach to support the joined-up delivery of services.*
- *There was recognition that the HWB required reconfiguration and a stronger sense of purpose.*

- *The chair and vice chair had a clear view for the development of the HWB and were keen to enact changes that would make it more effective and improve engagement with providers including the VSCE sector.*
- *There was a strong demonstration of commitment in respect of the HWB and it was expected that once this had undergone reconfiguration it would become more effective in its role*

Benefits of the review of the HWB cited by the CQC

- *The planned HWB review presented an opportunity for:*
    - *improved coproduction bringing together a full range of providers, and holding them to account for the delivery of the transformation programme, as well as providing clarity in respect of the interface with the wider STP.*
    - *It was anticipated that the restructure of the HWB would provide the vision for integrated systems and structures*
    - *The review should focus on setting a shared vision for the system and the relationship between the HWB, the Oxfordshire Transformation Programme and the STP. This is particularly important if the HWB is to become the locus for the journey towards an Accountable Care System.*
    - *Given its statutory role for system leadership the HWB is the right place to set, agree and lead this vision, linked also to the STP*

Other issues to be addressed:

- *there was recognition amongst system leaders that the most likely route to resolving recruitment and retention issues was through joint working across the system, and through the Oxfordshire Transformation Programme aligned with the STP and the HWB*
- *the HWB did not fully set out the strategic ambition of system integration, including integrated commissioning*
- *It was not evident that identified priorities from the JSNA were aligned with the STP and BCF priorities*

This paper summarises the views expressed to the Chair and Vice Chair; sets out key areas of consensus and areas where views differed; sets out the emerging consensus view for discussion; seeks the views of the HAWB on all of these matters and proposes the next steps.

The document sent to stakeholders to request views is included at Annex 1.

Annex 2 contains a summary of the role and powers of the HAWB as expressed in statute.

2. Report on Views and Issues Expressed by Stakeholders

2.1 Status of the HAWB

There was wide consensus that the HAWB, as set out in statute, should be the premier oversight body for a very wide range of health and wellbeing issues in the County.

2.2 Profile of the HAWB

There was wide consensus that the profile was currently too low and needed to be higher.

Many of those interviewed did not know of the work of the Board.

2.3 Functions of the HAWB

Those who knew of the work of the Board felt that it did cover a wide range of health and wellbeing issues, particularly through its three sub-groups.

The breadth of coverage could be further extended to cover issues such as housing, but respondents understood that the two-tier nature of Local Government presented practical problems in achieving this. There was a general consensus that the HAWB should have more formal links with the Growth Board, but no clear view on how this might be achieved.

The HAWB should be seen to exercise authority over a wide range of health and wellbeing issues.

It was acknowledged that there were areas of overlap function with Partnerships such as the Community Safety Partnerships.

There was wide consensus that a single authoritative HAWB Strategy which was agreed by all would be a major step forward. The HAWB should hold partners to account for delivery of this strategy.

There was a clear view, in agreement with the CQC's view, that the Board should have a more active oversight of issues of 'system flow' involving the NHS and Adult Social Care.

The sub-groups called the Children's Trust and Health Improvement Board were generally seen to be functioning well over a wide range of topics.

The two Joint Management Groups covering adult's issues were felt to be functioning well, but there was a need for the HAWB to cover a wider range of strategic topics around health and social care services for adults as follows:

- The HAWB is one of a range of groups partially overseeing similar topics for adult's services This needs to be streamlined so that there are fewer groups.

- The 'health and social care system' does not have a single place where strategic priorities are clearly set or where overall transformational change is agreed. This should be a overseen by the HAWB and its subgroups.

- There is duplication of membership and scope with groups such as the A and E Delivery Board and the Transformation Board.

- Decision making is confused and insufficiently transparent.

- There is a lack of clarity regarding 'commissioner' and 'provider' bodies and their respective roles. Clearly commissioners and providers need to come together to agree strategic priorities, yet we also need a mechanism to avoid conflict of interest, at least in the short term, while 'whole system working' matures.

- There is no single agreed 'envelope of money' within which decisions can be taken.

- If the 'health and adult social care system' moves towards an Integrated Care System (ICS), the majority view was that this should be overseen by the HAWB. It was acknowledged that there may need to be a number of transitional steps before this can be achieved in full.

- the current existing groups and Boards working on NHS and adult social care issues across the County should be rationalised and simplified.

2.4 Structure and sub-groups of the HAWB

There was wide consensus that sub-groups were necessary given the breadth and complexity of the business.

There was wide consensus that the current division into 3 functional topics (i.e children's issues, health improvement issues and adult health and social care issues) was useful.

The sub-groups also allow for a wider range of welcome participation in the work of the overall Board.

Comments about the functions of individual subgroups have been covered above.

2.5 Membership of the HAWB

There was wide consensus that the core membership should be small (various numbers were suggested, generally around 10-12 as a maximum).

However, many respondents felt that they should have a 'seat' which would exceed this number.

Some respondents felt that a 'seat' would not be helpful as their primary engagement was elsewhere in the 'system', particularly on the sub-groups or via a reference group. This was the consensus view from the Voluntary Sector and of patient group representatives.

The majority felt the Chief Executives of the larger statutory organisations should sit on the HAWB so as to facilitate decision making, although the valuable role of Chairs and Non-Executive Directors was also acknowledged.

There was overall support for the current 'chairing' arrangements.

The balance of view was that major 'service providers' should be members as this was the clear direction of the NHS, while others felt this was a conflict of interest. Major service providers were felt to include Oxford University Hospitals NHS Foundation Trust and Oxford Health NHS Foundation Trust. South Central Ambulance Service NHS Foundation Trust would have a greater impact through representation in the subgroups, as would the Federations.

As stated above, the consensus voluntary and community sector view expressed was that input would be better focussed through subgroups or through a reference group.

The statutory mandatory composition of the Board was felt to be restrictive and tended to put too much emphasis on County Council membership.

MPs were felt by all to be important stakeholders who needed to be constructively engaged. There was no clear consensus on how they might be systematically engaged.

Various solutions were proposed to resolve these issues e.g.:

- Members might be of two groups, voting members and advisory members (as per the CCG Board).

- there might be wider representation on subgroups

- standing reference groups of various kinds could be set up or periodic 'big tent' events could be held

- inviting people with subject-specific expertise to give views on specific topics

- regular and focussed written updates from specific sectors and groups

- more creative ways might be sought of involving the mandatory statutory officers which would still meet statutory requirements.

2.6 Decision-making powers of the HAWB

There was wide consensus that the HAWB should be decision-making, but differing views as to the scope and nature of the decision-making.

It was noted that the HAWB is already decision-making over a range of issues: a Joint Health and wellbeing Strategy, the JSNA, the Better Care Fund agreement etc. This was supported.

Almost all of the debate around decision making centred on the 'NHS and Adult Social Care' subgroup. The consensus was that clear and binding decisions were needed in this area.

Decision making in the Children's and Health Improvement subgroup attracted little comment or was felt to be satisfactory.

Some Statutory Bodies were willing to devolve further decisions and some were not. As devolving decisions to the HAWB is discretionary this cannot be a matter of compulsion and has implications for the future functioning of the Board.

Some favoured HAWB decision-making over a fairly detailed strategy and holding bodies to account for delivery of that strategy as set out in performance indicators, financial targets and outcome measures.

Regarding the future 'adult's subgroup(s)', some favoured a process of 'sign off' in individual organisations before coming to the adult's subgroup or HAWB for decision making.

Regarding the future 'adult's subgroup(s)', the majority felt that decision-making of some kind was essential, with these decisions receiving final approval from the HAWB. There was concern that a decision-making process involving, in sequence, NHS Boards, the 'adult's subgroup' and then the HAWB was far too slow and cumbersome to be effective.

2.7 Relationship of the HAWB to other Partnerships, Groups and Boards

This is covered above. There majority view was that this was a complex topic.

There was consensus that 'system transformation' of health and social care should be part of the HAWB mechanism and should be overseen within the revised 'adult's subgroup(s)', and that if properly assimilated would obviate the need for a parallel Transformation Board.

However, the wider representation and ensuing debate at the Transformation Board was valued and should be retained.

Relationships with the Community Safety Partnership and Growth Board were satisfactory but should be more active as stated above so that these 3 partnerships together could cover a very wide range of interlocking issues across the County.

2.8 Designing a Health and Wellbeing Board that meets current national direction of health care organisations and emerging governance models

The national policy governing NHS and Adult Social Care Services direction favours the creation of Integrated Care Systems. The consensus was that that the potential for an ICS in Oxfordshire should be built into the design of a revised Adult's Sub-group or sub-groups

2.9 Style of the HAWB meetings

The consensus view was that the meetings 'feel too much like County Council Committee meetings rather than meetings of equal partners'. Meetings should feel inclusive. A move away from County Hall as the permanent venue would assist.

2.10 Frequency of the HAWB

The current schedule of 4 monthly meetings was felt to be too infrequent. Various proposals were made from quarterly to monthly, the majority favoured quarterly meetings provided that the sub-groups were active and able to make decisions.

These meetings might be supplemented by special 'deep dive' sessions and/or Board development sessions.

3. Summary of the key emerging findings to date:

1. The HAWB should be one of 3 senior decision-making partnerships in the County alongside the Growth Board and the Community Safety Partnership.
2. It should continue to take a broad overview of health and wellbeing issues.
3. It should agree an overarching health and wellbeing strategy and hold organisations to account in delivering it.
4. The Board's membership should be reviewed to ensure that its membership will deliver its agreed function; this should include representatives from OUHFT and OHFT.
5. The HAWB or its 'adults' subgroup(s)' should be decision making where possible over NHS and Adult Social Care issues.
6. The overall structure of topics areas covered by the current sub-groups (eg adult health and social care, children and health improvement) should be retained.
7. The areas in most urgent need of review are: membership and decision making of the HAWB itself and the work of the adults' subgroup(s) and its decision making.
8. The adult's subgroup(s) should have oversight of service transformation and should subsume the current service transformation role of the Transformation Board. However, the wider debate which takes place in the Transformation Board with patient representative and voluntary and community organisations is valued and needs to be retained in some form

9. Voluntary organisations and patient representative groups have a key role to play, but may wish to input via sub-groups or via reference groups or through contribution to debate on specific issues.
10. Regular communication with MPs should be built into the work of the Board.

4. Next Steps

Following discussion at the HAWB the Chair and Vice-Chair propose to continue discussions with relevant parties and to bring a final proposal to a specially constituted HAWB on the 10th May 2018 to ensure that pace of change is maintained.

5. Recommendation

The HAWB is asked to note and discuss the emerging findings and approve the proposed next steps.

Cllr Ian Hudspeth, Leader OCC and Chair Oxon HAWB

Dr Kiren Collison, Chair of OCCG and Vice Chair Oxon HAWB

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Annex 1

Review of Oxfordshire's Health and Wellbeing Board:

Gathering Stakeholder Views

This briefing note sets out proposals for engaging with stakeholders to gather initial views which will be used to inform the review of Oxfordshire's Health and Wellbeing Board (HAWB) as agreed by the Board on 9/11/2017. A summary of the statutory role and duties of Health and Wellbeing Boards are appended for your reference.

The Board felt that it was timely to review the Board's role and governance arrangements for the following reasons:

1. The NHS's priority as stated in the 'Five Year Forward View' and subsequent documents is to move to Accountable Care Systems (ACS) and a number of these have been established. The Health and Wellbeing Board agreed to explore its role in the development of an ACS as part of this review.

2. The NHS has also moved to an emphasis on 'whole system working' as opposed to a clear-cut distinction between commissioners and providers. The previous governance model was based on this distinction and thus the Board's membership was based on service commissioners rather than on service providers. This therefore currently precludes the involvement of NHS trusts who are clearly integral to 'whole system working' and the involvement of the Voluntary Sector for example.

3. The Oxfordshire Transformation Board continues to work on practical issues of service transformation in the County and, although there is a strong synergy and an overlapping membership between it and the Health and Wellbeing Board, the Governance links between the two would benefit from clearer definition.

4. Over the years the Health and Wellbeing Board has received requests to expand its membership and the way it engages with a wide range of organisations. These have come from many sectors, including patient groups and advocacy groups, the voluntary and community sector, cultural and arts organisations, the police and the military. Our initial thinking was to avoid a Board which would be too large to be effective and so we decided to be guided by the statutory membership. It is now timely to review the membership of the Board again.

5. Since the Board met, we have also received verbal feedback from the Care Quality Commission regarding one aspect of the Board's work – that it should more actively oversee 'system flow' i.e. movement of people through primary care to hospital and through to discharge. This is likely to become a formal recommendation of the CQC and will be taken into account in the review.

It is therefore proposed that the Chair and Vice-chair of the Health and Wellbeing Board begin an engagement exercise early in the New Year by gathering the views of key stakeholders which will inform discussion at the next HAWB. This will take the shape of individual meetings and group events during early 2018, the detail of which will be advised in due course.

The following questions will guide the review:

1. What should the functions of the HAWB be?
2. What should its role be in any emerging proposals to form an Accountable Care System?
3. How should the Board balance its role in coordinating a wide range of wellbeing issues with the specific needs to oversee 'system flow'?
4. How should it carry out these functions?
5. The HAWB is currently advisory rather than decision-making, is this sufficient?
6. What governance arrangements are needed to make this effective?
7. What powers should organisations delegate to the Board to make it effective?
8. What should its relationship be with bodies with a similar remit e.g. the Bucks Oxon Berks STP Executive and the Oxfordshire Transformation Board.
9. How should the public/ patient voice be engaged?
10. Should the current HAWB sub-groups be changed?
11. How should statutory organisations be represented and with what authority?
12. How should a potentially wide range of other organisations and stakeholders (e.g. the voluntary sector) be engaged?
13. What barriers might get in the way and how can they be removed?

The arrangements of other HAWBs elsewhere will also be analysed as part of the review.

Stakeholders to be contacted as part of this engagement exercise will include:

- Organisations currently represented on the Health and Wellbeing Board (Oxfordshire County Council, Oxfordshire Clinical Commissioning Group, NHS England, Healthwatch, District and City Council representatives)
- NHS Foundation Trusts
- NHS GP Federations
- Other providers of health and social care services
- Voluntary Sector Organisations
- Representatives of Patients' and Service Users' Groups

Next steps

We are planning to invite stakeholders to a series of informal discussions with us during February. Written views will also be welcome.

This will assist us in shaping the Terms of Reference for the review which will be presented to the Health and Wellbeing Board on 22nd March 2018

Annex 2 . Health and Wellbeing Boards: Roles, Powers and Responsibilities

A. Purpose, powers and responsibilities - summary

The Health and Social Care Act 2012 established HWBs as statutory committees of all upper-tier local authorities to act as a forum for key leaders from the local health and care system to jointly work to:

- improve the health and wellbeing of the people in their area,
- reduce health inequalities, and
- promote the integration of services.

Local Government Association summarised the functions as follows:

The Health and Social Care Act 2012 gives health and wellbeing boards specific functions. These are a statutory minimum and further functions can be given to the boards in line with local circumstances. The statutory functions are:

- To prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), which is a duty of local authorities and Clinical Commissioning Groups (CCGs).

- A duty to encourage integrated working between health and social care commissioners, including providing advice, assistance or other support to encourage arrangements under section 75 of the National Health Service Act 2006 (ie lead commissioning, pooled budgets and / or integrated provision) in connection with the provision of health and social care services.

- A power to encourage close working between commissioners of health-related services and the board itself.

- A power to encourage close working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services

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

B. The sections of the Health and Social Care Act 2012 gave the following detail regarding the establishment and membership of Health and Wellbeing Boards

S194 Establishment of Health and Wellbeing Boards

(1) A local authority must establish a Health and Wellbeing Board for its area.

(2) The Health and Wellbeing Board is to consist of—

(a) subject to subsection (4), at least one councillor of the local authority, nominated in accordance with subsection (3),
(b) the director of adult social services for the local authority,
(c) the director of children's services for the local authority,
(d) the director of public health for the local authority,
(e) a representative of the Local Healthwatch organisation for the area of the local authority,
(f) a representative of each relevant clinical commissioning group, and
(g) such other persons, or representatives of such other persons, as the local authority thinks appropriate.

(3) A nomination for the purposes of subsection (2)(a) must be made—

(a) in the case of a local authority operating executive arrangements, by the elected mayor or the executive leader of the local authority;
(b) in any other case, by the local authority.

(4) In the case of a local authority operating executive arrangements, the elected mayor or the executive leader of the local authority may, instead of or in addition to making a nomination under subsection (2)(a), be a member of the Board.

(5) The Local Healthwatch organisation for the area of the local authority must appoint one person to represent it on the Health and Wellbeing Board.

(6) A relevant clinical commissioning group must appoint a person to represent it on the Health and Wellbeing Board.

(7) A person may, with the agreement of the Health and Wellbeing Board, represent more than one clinical commissioning group on the Board.

(8) The Health and Wellbeing Board may appoint such additional persons to be members of the Board as it thinks appropriate.

(9) At any time after a Health and Wellbeing Board is established, a local authority must, before appointing another person to be a member of the Board under subsection (2)(g), consult the Health and Wellbeing Board.

(10) A relevant clinical commissioning group must co-operate with the Health and Wellbeing Board in the exercise of the functions of the Board.

(11) A Health and Wellbeing Board is a committee of the local authority which established it and, for the purposes of any enactment, is to be treated as if it were a committee appointed by that authority under section 102 of the Local Government Act 1972.

(12) But regulations may provide that any enactment relating to a committee appointed under section 102 of that Act of 1972—

(a) does not apply in relation to a Health and Wellbeing Board, or

(b) applies in relation to it with such modifications as may be prescribed in the regulations.

C. Health and Social Care Act 2012 – <u>duty to encourage integrated working</u>

S195 Duty to encourage integrated working

(1) A Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.

(2) A Health and Wellbeing Board must, in particular, provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services.

(3) A Health and Wellbeing Board may encourage persons who arrange for the provision of any health-related services in its area to work closely with the Health and Wellbeing Board.

(4) A Health and Wellbeing Board may encourage persons who arrange for the provision of any health or social care services in its area and persons who arrange for the provision of any health-related services in its area to work closely together.

(5) Any reference in this section to the area of a Health and Wellbeing Board is a reference to the area of the local authority that established it.

(6) In this section—

- "the health service" has the same meaning as in the National Health Service Act 2006;
- "health services" means services that are provided as part of the health service in England;
- "health-related services" means services that may have an effect on the health of individuals but are not health services or social care services;
- "social care services" means services that are provided in pursuance of the social services functions of local authorities (within the meaning of the Local Authority Social Services Act 1970).

D. Health and Social Care Act 2012 – <u>other functions of Health and Wellbeing Boards</u>

S196 Other functions of Health and Wellbeing Boards

(1) The functions of a local authority and its partner clinical commissioning groups under sections 116 and 116A of the Local Government and Public Involvement in

Health Act 2007 ("the 2007 Act") are to be exercised by the Health and Wellbeing Board established by the local authority.

(2) A local authority may arrange for a Health and Wellbeing Board established by it to exercise any functions that are exercisable by the authority.

(3) A Health and Wellbeing Board may give the local authority that established it its opinion on whether the authority is discharging its duty under section 116B of the 2007 Act.

(4) The power conferred by subsection (2) does not apply to the functions of the authority by virtue of section 244 of the National Health Service Act 2006.

E. Health and Social Care Act 2012 – <u>participation of NHS Commissioning Board</u>

S197 Participation of NHS Commissioning Board

(1) Subsection (2) applies where a Health and Wellbeing Board is (by virtue of section 196(1)) preparing—

(a) an assessment of relevant needs under section 116 of the Local Government and Public Involvement in Health Act 2007, or

(b) a strategy under section 116A of that Act.

(2) The National Health Service Commissioning Board must appoint a representative to join the Health and Wellbeing Board for the purpose of participating in its preparation of the assessment or (as the case may be) the strategy.

(3) Subsection (4) applies where a Health and Wellbeing Board is considering a matter that relates to the exercise or proposed exercise of the commissioning functions of the National Health Service Commissioning Board in relation to the area of the authority that established the Health and Wellbeing Board.

(4) If the Health and Wellbeing Board so requests, the National Health Service Commissioning Board must appoint a representative to join the Health and Wellbeing Board for the purpose of participating in its consideration of the matter.

(5) The person appointed under subsection (2) or (4) may, with the agreement of the Health and Wellbeing Board, be a person who is not a member or employee of the National Health Service Commissioning Board.

(6) In this section—

- "commissioning functions", in relation to the National Health Service Commissioning Board, means the functions of the Board in arranging for the provision of services as part of the health service in England;
- "the health service" has the same meaning as in the National Health Service Act 2006

F. Health and Social Care Act 2012 – <u>discharge of functions of Health and Wellbeing Boards</u>

S198 Discharge of functions of Health and Wellbeing Boards

Two or more Health and Wellbeing Boards may make arrangements for—

(a) any of their functions to be exercisable jointly;

(b) any of their functions to be exercisable by a joint sub-committee of the Boards;

(c) a joint sub-committee of the Boards to advise them on any matter related to the exercise of their functions.

G. Health and Social Care Act 2012 – supply of information to Health and Wellbeing Boards

S199 Supply of information to Health and Wellbeing Boards

(1) A Health and Wellbeing Board may, for the purpose of enabling or assisting it to perform its functions, request any of the following persons to supply it with such information as may be specified in the request—

(a) the local authority that established the Health and Wellbeing Board;

(b) any person who is represented on the Health and Wellbeing Board by virtue of section 194(2)(e) to (g) or (8);

(c) any person who is a member of a Health and Wellbeing Board by virtue of section 194(2)(g) or (8) but is not acting as a representative.

(2) A person who is requested to supply information under subsection (1) must comply with the request.

(3) Information supplied to a Health and Wellbeing Board under this section may be used by the Board only for the purpose of enabling or assisting it to perform its functions.

(4) Information requested under subsection (1) must be information that relates to—

(a) a function of the person to whom the request is made, or

(b) a person in respect of whom a function is exercisable by that person

References:

House of Commons Library – Health and Wellbeing Boards
Local Government Association
Health and Social Care Act 2012