Public Document Pack

Health Overview and Scrutiny Panel

Wednesday, 15th August, 2012
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Claisse
Councillor Jeffery
Councillor Lewzey (Vice-Chair)
Councillor McEwing
Councillor Parnell
Councillor Pope (Chair)
Councillor Tucker

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PUBLIC INFORMATION

Southampton City Council's Seven Priorities

- More jobs for local people
- More local people who are well educated and skilled
- A better and safer place in which to live and invest
- Better protection for children and young people
- Support for the most vulnerable people and families
- Reducing health inequalities
- Reshaping the Council for the future

Fire Procedure – in the event of a fire or other emergency a continuous alarm will sound and you will be advised by Council officers what action to take.

Access – access is available for the disabled. Please contact the Democratic Support Officer who will help to make any necessary arrangements.

Public Representations

At the discretion of the Chair, members of the public may address the meeting about any report on the agenda for the meeting in which they have a relevant interest.

Smoking policy – the Council operates a no-smoking policy in all civic buildings.

Mobile Telephones – please turn off your mobile telephone whilst in the meeting.

Dates of Meetings: Municipal Year 2012/13

2012	2013
21 June 2012	24 January 2013
15 August	29 March
11 October	
29 November	

CONDUCT OF MEETING

Terms of Reference

The terms of reference of the Audit Committee are contained in Article 8 and Part 3 (Schedule 2) of the Council's Constitution.

Business to be discussed

Only those items listed on the attached agenda may be considered at this meeting.

Rules of Procedure

The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

Quorum

The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

DISCLOSURE OF INTEREST

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Personal Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PERSONAL INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.
(ii) Sponsorship:
Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.
(iv) Any beneficial interest in land which is within the area of Southampton.
(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.
(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.
(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value fo the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

Other Interests

A Member must regard himself or herself as having a, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

AGENDA

Agendas and papers are now available via the City Council's website

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Panel made in accordance with Council Procedure Rule 4.3.

2 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

3 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

4 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

5 STATEMENT FROM THE CHAIR

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 21st June 2012 and to deal with any matters arising, attached.

7 ANNUAL MEETING PROGRAMME 2012-2013

Report of Democratic Support Officer setting out two revised dates for the Health Overview and Scrutiny Panel for the 2012-2013 year, attached.

These dates were set up to reflect the Overview and Scrutiny Management Committee cycle of meetings and they are no longer compatible.

8 EXCLUSION OF THE PRESS AND PUBLIC - CONFIDENTIAL PAPERS INCLUDED IN THE FOLLOWING ITEM

To move that in accordance with the Council's Constitution, specifically the Access to Information Procedure Rules contained within the Constitution, the press and public be excluded from the meeting in respect of any consideration of Item No 9. The report contains information deemed to be exempt from general publication based on Category 3 of paragraph 10.4 of the Council's Access to Information Procedure Rules, as it includes details of a proposed transaction which, if disclosed prior to entering into a Legal contract, could put the Council or other parties at a commercial disadvantage.

9 CONSULTATION ON SHORT BREAK SERVICE

Confidential report of the Director of Integrated Strategic Commissioning, NHS, Southampton setting out the PCT's consultation plans on proposals for a short break service, attached.

10 JOINT HEALTH AND WELLBEING STRATEGY : CONSULTATIVE DRAFT

Report of the Director of Public Health, detailing the draft Health and Wellbeing Strategy for the Panel to consider and respond to the consultation questions set out in the document, attached.

11 LOCAL AUTHORITY HEALTH SCRUTINY - PROPOSALS FOR CONSULTATION

Report of the Senior Manager, Customer and Business Improvement, summarising the Department of Heath's consultation and inviting the Panel to respond to the proposals on changes to the legislation on Health Overview and Scrutiny (HOS), attached.

12 COMMISSIONING LOCAL HEALTHWATCH : LEARNING POINTS FROM LOCAL INVOLVEMENT NETWORKS (LINK)

Report of the Executive Director of Health and Adult Social Care providing details on learning points from Local Involvement Networks (LINk), attached.

Tuesday, 7 August 2012 HEAD OF LEGAL, HR AND DEMOCRATIC SERVICES

SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 21 JUNE 2012

Present: Councillors Parnell, Jeffery, Lewzey, Pope (Chair), Tucker, Claisse and Thomas

Apologies: Councillor McEwing

1. **ELECTION OF VICE-CHAIR**

RESOLVED that Councillor Lewzey be elected Vice-Chair for the Municipal Year 2012/2013.

2. **APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)**

The Panel noted that Councillor Claisse had been appointed as a new Member of the Panel to replace Councillor Baillie and that Councillor Thomas was in attendance as a nominated substitute for Councillor McEwing in accordance with Council Procedure Rule 4.3.

3. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED that the Minutes of the Meeting held on 29 March 2012 be approved and signed as a correct record.

4. **SOUTHAMPTON, HAMPSHIRE, ISLE OF WIGHT AND PORTSMOUTH HEALTH OVERVIEW AND SCRUTINY COMMITTEES: ARRANGEMENTS FOR ASSESSING SUBSTANTIAL CHANGE IN NHS PROVISION**

The Panel considered the report of the Senior Manager, Customer and Business Improvement seeking agreement to the arrangements for assessing substantial change in NHS provision. (Copy of the report circulated with the agenda and appended to the signed minutes)

There was a discussion regarding the arrangements. The Panel wanted to review the framework before agreement was given. It was reported that the framework had been agreed by all the HOSC's across the SHIP area and by the previous Health Overview and Scrutiny Committee.

RESOLVED that the Panel review the arrangements for assessing substantial change in NHS provision in association with LINK and present the new framework to the next Health Overview and Scrutiny meeting for approval.

5. **UPDATE FROM JOINT SEMINAR RE VASCULAR SURGICAL SERVICES**

The Panel considered a report of the Chair of the Health Overview and Scrutiny Panel seeking to facilitate a locally negotiated solution to the future of vascular services. (Copy of the report circulated with the agenda and appended to the signed minutes).

Beverley Meeson, Cardio Vascular Network was present and upon request briefed the Panel on the background vascular services and gave an explanation of vascular services.

A seminar had been held on 11 June, chaired by an independent expert with stakeholders which provided an update on the vascular review and future commissioning arrangements. It was felt that this had been positive and it was hoped that a way forward would be established.

RESOLVED

(i) to maintain the view that a locally negotiated solution to the issue be reached as soon as possible and it would continue to work with the PCT Cluster, HOSCs and Providers to achieve this. However, the Panel did not rule out exploring other options available, including referral to the Secretary of State if progress was not made locally;

(ii) that the Chair write to the PCT Cluster to ask how much money had been spent so far on the review of vascular services from the start of the process up to and including the meeting on 11 June;

(iii) that the Chair also ask the PCT Cluster to provide full details of all the network models that had been proposed to date and the reasons provided by providers as to why they had not been agreed;

(iv) that the Chair also ask the PCT Cluster to provide details of the results of monitoring against the 'Clinical Governance Framework to monitor Portsmouth Hospitals NHS Trusts' arrangements for the provision of Vascular Surgery to date and on an ongoing basis; and

(v) that the Chair write to both Southampton University Hospitals Foundation Trust and Portsmouth Hospitals NHS Trust to seek clarity on the staffing (whole clinical team not just consultants) requirements and finance modelling for each of their proposed models.

6. **HEALTH AND SOCIAL CARE ACT - KEY IMPLICATIONS FOR LOCAL AUTHORITIES**

The Panel considered the report of the Executive Director of Health and Adult Social Care seeking to identify any issues for discussion at a future meeting. (Copy of the report circulated with the agenda and appended to the signed minutes)

The Panel received a presentation from Martin Day, Directorate Strategic Business Manager.

The main points from the presentation included the following:

- The idea that the patient would be at the heart of everything;
- The interests of local people would be represented by local Healthwatch. Healthwatch was the successor to LINK but its role was wider than that of LINK;
- Healthwatch would to be at a local and national level;
- It was anticipated that Heathwatch for Southampton would be established in April 2013;
- Membership of the Health and Wellbeing Board was outlined. There were 11 members on the board. 5 were Councillors and there must be one from each political party. The Councillors were elected at the AGM of the Council in May. There were also 3 Directors on the Board;
- The Joint Health and Wellbeing Strategy was being reviewed. The Panel would be asked to comment on the draft strategy at a future meeting.

The Panel expressed concern regarding the current make up of the Health and Wellbeing Board and Healthwatch.

RESOLVED

(i) that the report be noted; and

(ii) that the Chair of the Health and Wellbeing Board be invited to the next meeting.

7. **SOUTHAMPTON CLINICAL COMMISSIONING GROUP ANNUAL PLAN AND PRIORITIES**

The Panel received and noted the report of the Deputy Director, Southampton Clinical Commissioning Group, giving details of the priorities for the forthcoming year. (Copy of the report circulated with the agenda and appended to the signed minutes)

The Panel received a presentation from Stephanie Ramsey, Deputy Director, Southampton City Clinical Commissioning Group.

The main points from the presentation included the following:

- Clinical Commissions Groups (CCGs) were led by GP's. CCGs commission services on behalf of the community in order to deliver the best outcomes for patients within the resources available. They do not provide services;
- NHS Southampton Clinical Commissioning Group was functioning in a shadow format. It was expected to be authorised by January 2013;
- An aim was to ensure that people have fair access and fair provision. Individuals would be able to make choices regarding their health provision;
- Quality was the core element of being a CCG. Everything would be considered when commissioning services and not just price.

RESOLVED that an update be provided to the Panel at a future meeting.

8. **SOUTHERN HEALTH NHS FOUNDATION TRUST ANNUAL PLAN AND PRIORITIES**

The Panel considered the report of the Financial Director, Southern Health NHS Foundation Trust, seeking comments on the current services and vision for future services of Southern Health NHS Foundation Trust. (Copy of the report circulated with the agenda and appended to the signed minutes)

The Panel received a presentation from David Robertson, Director of Finance and Corporate Services, Southern Health and Dr Helen McCormack, Interim Medical Director, Southern Health.

The main points from the presentation included the following:

- There were 3 overlapping aims and goals – to improve patient and user experience, to reduce costs and to improve outcomes for patients and users;
- Southern Health was a NHS Foundation Trust commissioned to provide mental health services, integrated community services, social care and learning disability services and forensic services;

- Mental heath services had transformed over the years. Specialist care and support services were provided to enable people to live in the community and with a better quality of life;
- In the current economic climate there was more incentive to be innovative to ensure that the best services were provided and that resources were used as effectively as possible.

RESOLVED

(i) that the Panel noted the current services provided by Southern Health NHS Foundation Trust;

(ii) that the Trust's vision for future services be noted.

9. **SOLENT NHS TRUST ANNUAL PLAN AND PRIORITIES AND FOUNDATION TRUST CONSULTATION**

The Panel considered the report of the Director of Strategy, Solent NHS Trust, giving details of priorities for the forthcoming year and seeking a response to the consultation. (Copy of the report circulated with the agenda and appended to the signed minutes)

The Panel received a presentation from Dr Ros Tolcher, Chief Executive, Solent NHS Trust.

RESOLVED

(i) that comments from members of the Panel be sent to the Chair of HOSP for incorporation into a formal response to Solent NHS Trust on their consultation;

(ii) that the update from Solent NHS Trust be noted.

10. **UNIVERSITY HOSPITAL SOUTHAMPTON ANNUAL PLAN AND PRIORITIES**

The Panel received the report of the Director of Nursing, University Hospital Southampton giving details of priorities for the forthcoming year. (Copy of the report circulated with the agenda and appended to the signed minutes)

The Panel received a presentation from Judy Gillow, Director of Nursing and Michael Marsh, Medical Director, University Hospital Southampton.

The Panel noted the invitation to attend an additional briefing or a site visit to the hospital. The full 200 page version of the annual plan was offered to the Panel, however a summary plan would be available at the end of June, which could be provided to the Panel.

There was a discussion regarding the Hospitals journey to receive Foundation Trust status and it was reported that it had helped them to focus on the services they provided and how best to run them efficiently and effectively in order to deliver the best outcomes for the community.

The Panel expressed concerns regarding smoking immediately outside of the hospital building. It was acknowledged that this was a difficult issue to address and that campaigns and strategies had been put in place to discourage this, in particular staff had received additional training to deal with smokers in a non confrontational way. Concern was also expressed regarding the cost of car parking at the hospital and the implications for the wider neighbourhood. It was reported that this was a difficult

situation. Should the charges be removed or reduced funding would need to be found from elsewhere to invest in services. Charges were reduced for vulnerable groups. Staff no longer park at the hospital and therefore more spaces were available to patients and their families and visitors. Park and ride facilities were provided by the hospital for staff.

RESOLVED

(i) that the Panel noted the briefing;

(ii) that a summary of the annual plan be requested.

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DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	ANNUAL MEETING PROGRAMME 2012 – 2013
DATE OF DECISION:	15 AUGUST 2012
REPORT OF:	DEMOCRATIC SERVICES MANAGER
STATEMENT OF CONFIDENTIALITY	
None.	

BRIEF SUMMARY

Following the publication of the new Administration's Executive meeting dates, the Chair of Overview and Scrutiny Management Committee requested that its programme of meeting dates be revised to reflect the established practice of meeting on the Thursday before the Executive decision making meetings. This decision has subsequently affected some Health Overview and Scrutiny Panel meeting dates which now coincide with Overview and Scrutiny Management Committee Meetings.

In accordance with Member User Group (December 2005): *That where time permits any changes to the published calendar requested in the day or time of meetings should firstly be submitted to the appropriate committee for approval.* The existing date programme was confirmed by Council on 16th May, 2012. Therefore, this report is brought to Committee for consideration.

RECOMMENDATIONS:

(i) To consider and approve the revised programme of meeting dates set out in the report.

REASONS FOR REPORT RECOMMENDATIONS

1. To ensure that the Health Overview and Scrutiny Panel meeting dates do not fall simultaneously with Overview and Scrutiny Management meetings.

DETAIL (Including consultation carried out)

2. The Committee's current programme of meetings is detailed on the internet and conforms to the established principle that Scrutiny meetings are held on Thursday evenings.

3. These dates were set up to reflect the Overview and Scrutiny Management Committee cycle of meetings and they are no longer compatible.

4. The following table details the current and proposed dates for the remainder of the municipal year:

HEALTH OVERVIEW AND SCRUTINY PANEL PROGRAMME 2012 – 2013	
EXISTING DATE	**PROPOSED DATE**
16th August 2012	**15th August 2012 ****
11th October 2012	**4th October 2012**
29th November 2012	29th November 2012
24th January 2013	**31st January 2013**
21st March 2013	21st March 2013

**** The August meeting has already been changed due to time constraints.**

5. It is proposed that the meetings will start at 6:00pm and that there will be a pre-meeting for Committee Members only starting at 5:30 pm.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

6. Not to adjust the programme of meetings.

RESOURCE IMPLICATIONS

Capital/Revenue

7. None.

Property/Other

8. None.

LEGAL IMPLICATIONS

Statutory Power to undertake the proposals in the report:

9. None.

Other Legal Implications:

10. None.

POLICY FRAMEWORK IMPLICATIONS

11. None.

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SUPPORTING DOCUMENTATION

Non-confidential appendices are in the Members' Rooms and can be accessed on-line

Appendices

1.	None.

Documents In Members' Rooms

1.	None.

Integrated Impact Assessment

Do the implications/subject/recommendations in the report require an Integrated Impact Assessment to be carried out.	Yes/No

Other Background Documents

Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1. None.	

Integrated Impact Assessment and Other Background documents available for inspection at:

WARDS/COMMUNITIES AFFECTED:	None

by virtue of paragraph number 3 of the Council's Access to information Procedure Rules

Document is Confidential

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DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	JOINT HEALTH AND WELLBEING STRATEGY – CONSULTATIVE DRAFT
DATE OF DECISION:	15TH AUGUST 2012
REPORT OF:	DIRECTOR OF PUBLIC HEALTH
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

The Health and Social Care Act 2000 places a duty on Southampton City Council and Southampton City Clinical Commissioning Group to produce a Joint Health and Wellbeing Strategy (JHWS). A draft strategy has been prepared and is now the subject of a period of engagement to enable stakeholders and the public to comment. The scrutiny panel is now invited to contribute to the engagement process and respond to the document.

RECOMMENDATIONS:

(i) That the scrutiny panel considers the draft Health and Wellbeing Strategy and responds to the consultation questions set out in the document.

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the Health Overview and Scrutiny Panel to consider the contents of the draft Joint Health and Wellbeing Strategy and to submit comments in response to the draft document.

DETAIL (Including consultation carried out)

2. The Health and Social Care Act 2012 places a duty on upper tier local authorities and clinical commissioning groups (CCGs) to produce a Joint Health and Wellbeing Strategy. The strategy must address needs identified in the Joint Strategic Needs Assessment, and the CCG and the local authority "must, in exercising any functions, have regard to" both the Joint Strategic Needs Assessment (JSNA) and the JHWS . The Health and Wellbeing Board will subsequently review the commissioning plans developed by the CCG and the local authority to assess whether they address the needs and priorities identified in the JSNA and the JHWS. As the Department of Health has stated, "JSNAs and joint health and wellbeing strategies are not ends in themselves, but a means to improve health and wellbeing outcomes through evidence based strategic commissioning and positive action."

3. The council and Southampton City CCG have worked jointly through the shadow Health and Wellbeing Board to develop a draft strategy document. Using the information in the JSNA, which was reviewed and update in 2011, the strategy identifies 6 priority areas and a series of actions designed to improve the health of people living in Southampton and to reduce health inequalities. A copy of the draft strategy is attached at Appendix 1.

4. The 6 priorities set out in the draft strategy are:

1. Early years and childhood – sustaining work to support vulnerable families with young children
2. Adolescence and young adulthood – taking action to reduce the harm to individuals and society caused by misuse of alcohol and drugs
3. Working age adults – working with employers and local education providers to support people into employment and prevent people falling out of employment due to ill health
4. Helping people grow old and stay well
5. Reducing admissions to hospital from preventable causes of both physical and mental ill health
6. Improving housing options and conditions for people in the city to support healthy lifestyles

Each of these priorities are underpinned by evidence set out in the JSNA, and summarised in the tables in the draft strategy document, alongside the actions proposed.

5. Key outcomes sought from the consultation include identifying whether the right priorities and actions have been identified, and if not then which ones should be included. There are clearly a large number of actions identified in the draft strategy, and through the consultation it is hoped to identify those matters of greatest concern to the widest number of individuals and stakeholders. This will then help to prioritise actions and enable the council, the CCG, and National Commissioning Board where appropriate, to focus efforts on addressing key issues and making demonstrable improvements to health outcomes and reducing health inequalities.

6. A key ambition of the strategy is to develop an asset based approach and through this to identify resources that exist in communities across the city which may not be known about but which can deliver health and wellbeing improvements. This work is still at an early stage of development. Through responses to question 4 in each section, stakeholders will be able to identify ways in which they feel able to deliver the actions proposed, and these may lead to innovative and cost-effect ways of working to deliver improvements.

7. The JHWS is not intended to be an exhaustive list of everything that needs to be done across health and social care systems. It aims to follow key aspect of the guidance issued by the Department of Health in respect of JSNAs and JHWSs. As the forward to the draft strategy identifies it should not try to solve everything, but should take a strategic overview on how to address the key issues identified in the JSNA, including tackling the worst inequalities. It also aims to follow the advice by concentrating on an achievable amount. The responses to the consultation will help identify the key issues and actions.

8. The Act places a duty on local authorities to involve the community in undertaking JSNAs and JHWSs. In addition to placing the draft strategy on the PCT and council websites and directly contacting key stakeholders, Southampton LINk is undertaking a specific piece of work to engage the

general public, which will include a public event in September.

9. The draft strategy deliberately attempts to be much more than a document about actions for just the health and social care systems. The JSNA identified that issues such as employment, earnings, housing, access to leisure and a safe environment all have major contributions to make to health and wellbeing, and all these topics are covered in the draft strategy document.

Conclusion

10. The process of developing the draft strategy for Southampton attempts to follow the values identified by the Department of Health that will underpin a successful JHWS. These are:

- setting shared priorities based on evidence of greatest need
- setting out a clear rationale for the locally agreed priorities and also what that means for the other needs identified in JSNAs and how they will be handled with an outcomes focus
- not trying to solve everything, but taking a strategic overview on how to address the key issues identified in JSNAs, including tackling the worst inequalities,
- concentrating on an achievable amount – prioritisation is difficult but important to maximise resources and focus on issues where the greatest outcomes can be achieved
- addressing issues through joint working across local the local system and also describing what individual services will do to tackle priorities

supporting increased choice and control by people who use services with independence, prevention and integration at the heart of such support.

11. Following the conclusion of the consultation process , the strategy will be re-drafted taking account of the comments received and priorities identified, and then submitted to the shadow Health and Wellbeing Board. Following consideration by the board it will then be submitted to the Cabinet and the CCG Board for adoption.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

12. There is no alternative, as the Joint Health and Wellbeing Strategy is a duty under the Health and Social Care Act 2012.

RESOURCE IMPLICATIONS

Capital/Revenue

13. None at this stage. The actions adopted in the final version of the strategy will inform commissioning plans, which themselves will then be determined by the budgets set by both the council and the CCG.

Property/Other

14. None.

LEGAL IMPLICATIONS

Statutory Power to undertake the proposals in the report:

15. Section 193 of the Health and Social Care Act 2012 requires local authorities

and clinical commissioning groups to prepare a JSNA and a JHWS.

Other Legal Implications:

16. None.

POLICY FRAMEWORK IMPLICATIONS

17. None.

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SUPPORTING DOCUMENTATION

Non-confidential appendices are in the Members' Rooms and can be accessed on-line

Appendices

1.	Gaining Healthier Lives in a Healthier City: Southampton Joint Health and Wellbeing Strategy, Consultative Draft, July 2012

Documents In Members' Rooms

1.	None

Integrated Impact Assessment

Do the implications/subject/recommendations in the report require an Integrated Impact Assessment to be carried out.	No

Other Background Documents

Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1. None	

Integrated Impact Assessment and Other Background documents available for inspection at:

WARDS/COMMUNITIES AFFECTED:	

Feedback by 30 September 2012

Gaining Healthier Lives in a Healthier City

Southampton Joint Health and Wellbeing Strategy

Consultative Draft July 2012




NHS
Southampton City Clinical Commissioning Group

SOUTHAMPTON CITY COUNCIL ®

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Southampton's Joint Health and Wellbeing Strategy

Gaining Healthier Lives in a Healthier City

Forward

From the Cabinet Member for Communities, Southampton City Council and the Chair of the Clinical Commissioning Group (CCG).

We are delighted to be able to introduce this draft Health and Wellbeing Strategy for Southampton. The Health and Social Care Act 2012 requires Local Authorities and Clinical Commissioning Groups to jointly produce a strategy. The Department of Health advises that our strategy should not try to solve everything, but should take a strategic overview on how to address the key issues identified in our Joint Strategic Needs Assessment (JSNA) including tackling the worst inequalities. The Department of Health also advises that the strategy should concentrate on an achievable amount. That is why the strategy identifies six priority areas for action. Issues that are not referred to in this document are not unimportant. We have tried to identify the priority areas for this first joint strategy based on those needs where we really believe we can work together to improve the health of our citizens and have a positive impact on health inequalities.

We want it to provide a process through which all organisations, services and local people can help determine the priorities we should be focussing on to improve the health and quality of life of local people. The six key priority areas proposed will support improving health from cradle to older age.

We want your views on whether we have identified the right priorities and actions. Along with other cities, Southampton faces financial challenges and we need to make sure we make robust decisions about where we focus local action. We want local organisations and local citizens to have their say in making these decisions and to become part of the solution to address them.

We have set out our ambitions based on the evidence we have available on local needs in the City and are keen to hear your views and welcome comments to improve the strategy through this consultation process.

Councillor Jacqui Rayment

Dr Steve Townsend

Section One – Background and Local Context

Introduction

The promotion of health and wellbeing across Southampton City requires collective effort across a range of services and activities including those affecting the wider determinants of health (such as housing, education, transport, environment and economic regeneration) clinical and care services, community interventions, the voluntary sector and the business sector. This draft Joint Health and Wellbeing Strategy provides an overarching framework for action across the City for the period 2013 - 2016. This will require collective actions across a range of agencies, including the Local Authority, Clinical Commissioning Group (CCG) and local arm of the NHS Commissioning Board. It proposes the priority areas for action to improve health and wellbeing for local communities based on the needs identified in Southampton's Joint Strategic Needs Assessment (JSNA).

Consultation on this draft strategy will support the Health and Wellbeing Board in fostering commitment, involvement and collective effort to improving the health and wellbeing of those who live and work across the City.

The cornerstone of our decision making – Southampton City's Joint Strategic Needs Assessment (JSNA)

What is the JSNA?

Southampton City's JSNA includes a huge wealth of information, intelligence and analysis from a number of different sources that cover the health and wellbeing of the population.
http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/jsna2011/

This information is shared between local organisations, key stakeholders and is made available to the public. It provides those planning, commissioning and delivering services across the city with a common and consistent evidence base which supports the identification of gaps in services and priority areas for improvement and action.

Specific challenges highlighted in the JSNA include:

- Demographic pressures, especially the growth in the city's birth rate (around 35% in seven years)
- The increasing proportion of older people and accompanying increase in dementia
- Deprivation and children in poverty – the city is ranked the fifth most deprived local authority in the South East and 81st out of the 326 local authorities in England
- The increase in unhealthy lifestyles leading to preventable diseases
- The need to ensure high quality services for specific care groups, including those living with mental ill health, physically disabilities and learning disabilities
- The need to ensure that provider services are joined up and seamless to create robust care pathways for a 'whole person' approach
- The need to support carers to care and the need for volunteering
- Work and worklessness and the impact on mental health
- Recognising the impact on health of wider determinants (housing, transport and economic regeneration)

Nine key overarching themes to improve health and wellbeing in Southampton City were identified through stakeholder and public consultation as part of the JSNA development:

- Economic wellbeing
- Mental health
- Early years and parenting
- Taking responsibility for your health
- Long-term conditions- maximising the quality of life
- More people living longer
- Creating a healthy environment
- Safeguarding children and vulnerable adults
- Protecting people from health threats

Key Priorities

This strategy proposes six priority areas to focus local action and ensure best outcomes from our combined efforts.

Priority 1: Early Years and Childhood – sustaining work to support vulnerable families with young children

Priority 2: Adolescence and Young Adulthood – taking action to reduce the harm to individuals and society caused by misuse of alcohol and drugs

Priority 3: Working Age Adults – working with employers and local education providers to support people into employment and prevent people falling out of employment due to ill health

Priority 4: Helping People Grow Old and Stay Well

Priority 5: Reducing admissions to hospital from preventable causes of both physical and mental ill health

Priority 6: Improving housing options and conditions for people in the city to support healthy lifestyles

A whole range of on-going work continues outside of this strategy to address the wider determinants of health, delivered through mainstream services the voluntary sector and communities (e.g. transport, housing, economic development and mainstream health and social care service provision).

Key Principles

Southampton's Joint Health and Wellbeing Strategy is underpinned by six key underlying principles:

A. **Adopts a Life Course approach** (cradle to grave) – action to improve health and wellbeing and tackle inequalities must start before birth and continue throughout childhood and into adult life and later years. For this reason our strategy recognises the importance of giving children the best start in life and strengthening the role of ill health prevention throughout the life-course journey is a high priority.

B. **Needs driven** – it takes account of the current and future health and social care needs of the entire population (based on the JSNA).

C. **Mobilises local assets** – it enables the city's Health and Wellbeing Board and wider stakeholders across the city to look beyond identified *needs* to mobilise local *assets* (including those of the local community itself). Consultation question four at the end of each section will help identify local community-based assets to support delivery.

D. **Addresses inequalities** – within the City by addressing the wider determinants of health including poor housing, worklessness, community safety and economic regeneration.

E. **Maximises collaborative working** – to secure best outcomes from working together across the member organisations of the health and wellbeing board, key stakeholders and local people across the city

F. **Determines focused priorities to maximise outcomes** – the strategy prioritises the issues requiring the greatest attention and as part of the consultation process will work with key stakeholders across the city to identify what success will look like against key priority actions.

Section Two – Key Priorities for Action

Priority 1 – Sustaining work to support vulnerable families with young children

Rationale

Good health and wellbeing outcomes in early years have a major impact on the future health and emotional and economic wellbeing of individuals throughout their life course. The city's early years population continues to grow and there is a need to achieve the best possible outcomes for children under five years.

The majority of children and young people who enjoy good outcomes do so without the support of targeted or specialist support services, but through the care of their parents or other carers as part of family life. For many of those children who are at risk of poor outcomes, targeted and specialist services find that parents and carers are less able to provide children and young people with the support, guidance, challenge and resilience they need to enjoy good outcomes.

Whilst there is a strong correlation between socio-economic status and education and parenting skills, the situations which place challenges upon parents are complex and varied. Closer working between professionals in different services has confirmed the importance of the role that services can play in building the capacity of families to develop and make better use of their own resources to overcome the challenges that make them vulnerable to poor health and well-being outcomes.

Health and wellbeing needs of looked-after children also represent a key priority for this population group. The effectiveness of a variety of programmes, most notably integrated working between health and social care professionals in Sure Start Children's Centres and targeted programmes such as the Family Nurse Partnership, has confirmed the need to help parents and carers to recognise and address the contribution that they make to their children's health and wellbeing.

Local Evidence from the JSNA	What we will do
Child Poverty • 12,575 children live in poverty in the city; 28% compared to 21% in England (in some wards of high deprivation this is around 50%) • 385 children (0-17 years) were in local authority care (March 2011)	• Improve take-up of benefit entitlements • Undertake a Child Poverty Needs Assessment and develop a local action plan/strategy to tackle child poverty • Build parents self esteem, confidence and skills through volunteering and training pathways in Children's Centres • Support with helping parents into employment e.g. though sustained input from Job Centre Plus advisors • Meet the particular needs of looked-after children and young people, including those from black and minority ethnic backgrounds, unaccompanied asylum seekers, and those who have disabilities
Healthy Pregnancy • Increase the number of pregnant women accessing antenatal care before the twelfth completed week of pregnancy • Maintain the offer of choice for place of birth and promote a higher normal delivery rate • To promote best outcomes, enhanced support is needed during pregnancy up until the child reaches school age • Mothers smoking during pregnancy has reduced	• Sustain the delivery of the Healthy Child Programme, ensuring that every mother and child receives the health and development support they need, when they need it and to increase the routine promotion and uptake of the Healthy Start Scheme across the city • Sustain and build on the good practice of integrated working already achieved across the city (e.g. through Sure Start Children's Centres, midwifery service for

Local Evidence from the JSNA	What we will do
from 24% to 20%. Mothers who smoke are at higher risk of having premature and low birth weight infants • Mental ill health during pregnancy and early motherhood, or 'perinatal mental illness', is a serious public health issue. In Southampton postnatal depression rates are 10% with moderate to severe depression affecting 3-5% (104 to 173 women per year)	teenage parents under 18 years and family support workers as part of the heath visiting service) • Continually improve maternity services – implement recommendations from the review undertaken in January 2011 • Sustain and further develop the Family Nurse Partnership to improve outcomes for teenage mothers • Implement the on-going development of the Health Visiting Service including the increase in workforce by 2015
Maternity Services and Breastfeeding • Caesarean section rates in the city are 22.7%, which is an increase of 2.3 percentage points on the previous year (UHS births and bookings data). Caesarean birth rates are significantly lower within the most deprived areas compared to the rest of the city, although the gap is narrowing • Breastfeeding rates are indicating a steady increase and are now at 75.3% with greatest success in areas of higher deprivation	• Action is needed to sustain and increase the rate of normal births (currently around 60%) • Maintain breastfeeding rates so that more women continue to breastfeed at 6-8 weeks and beyond
Child Dental Health • Children's dental health in the city is poor when compared to the England average (42% of children aged 5 years with decayed missing or filled teeth compared to 38% for England) • The number of children requiring dental extractions under a general anaesthetic is unacceptably high at around 500 a year	• Sustain targeted oral health programmes in schools and nurseries across the city
Tackling Childhood Obesity • Almost 24% of children in reception classes are overweight and this increases to almost 32% by year 6 (10 years of age) • 9.5% of children in reception classes are classified as obese and this increases to 19.6% by year 6 • Of those who are obese in reception classes, 64% remain obese in year 6	• Implement the recommendations and actions detailed within the Fit 4 Life (tackling obesity) Strategy for Southampton • Improve support and engagement of women as they become pregnant in terms of good nutrition and activity in order to prevent and reduce levels of obesity in pregnancy • Provide support for children and their families to address levels of weight management, in line with the Fit for Life Weight Management Care Pathways and continue to engage providers through the Healthy Early Years Award scheme • Support schools where there is a greater prevalence of obesity to take a whole school approach to ensure an ethos and environment exists that encourages being active and eating well • Increase the proportion of children that take part in up to 5 hours of good quality PE or physical activity per week both within schools and in the wider community • Take actions to ensuring the physical environment in local areas helps to

Local Evidence from the JSNA	What we will do
	promote walking, cycling and safe local recreation and play
Emotional Health and Wellbeing • 53% of children enjoy good relationships with their family and friends in Southampton compared to 56% national average • The emotional wellbeing of children in care is also lower than the national average (as calculated through the strengths and difficulties questionnaire) • Based on a prevalence rate of 15%, an estimated 6,385 children and young people will experience a mental health problem in the city, according to the CAMHS Needs Assessment (2010)	• Promote positive mental health and wellbeing through activity in schools • Ensure the engagement of children and young people in CAMHS services continues to meet their needs at the earliest possible opportunity (assessment of effectiveness of local CAMHS resulted in them achieving maximum score)
Reducing Teenage Pregnancy and Support for Teenage Parents • Southampton's under 18 conception rate was 49.2 per 1000 females aged 15 to 17 years old (2009) • Southampton's under 16 conception rate remains significantly higher than national and regional comparators, although the gap is narrowing • Outcomes for teenage mothers continue to improve year on year – in 2011/12, 58.7% of young people under 19 years were breastfeeding, 7.2% had a previous live birth and 9.6% had a low birth weight baby.	Implement the Children and Young People's Trust strategy for reducing teenage conceptions (March 2012). Key actions include: • Continued provision of high quality sex and relationships education in all secondary schools (including health and well-being drop-in services in secondary school and FE college settings) • Sustain targeted work with young people at risk of early pregnancy/parenthood (e.g. prevention and inclusion, safeguarding services) • Sustain provision of supported accommodation for teenage parents and young families • Continue provision of the full range of maternity services, including those currently jointly commissioned for dedicated teenage parent case loading (under 18s) • Continue support into employment – Job Centre Plus • Monitor uptake and provision for teenage parents of full learning curriculum for school-aged teenage parents – with dedicated and tailored provision from 14-16, 16-19 years and beyond • Sustain parenting, Early Years and CAMHS focused work to support relationship skills and interventions for vulnerable teenage parents

Consultation Questions

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Priority 2 – Taking action to reduce the harm to individuals and society caused by misuse of alcohol and drugs

Rationale

Alcohol

Excessive alcohol consumption is impacting negatively on the city's population in a number of ways including health, mortality, and crime. Misuse of alcohol costs the NHS £2.7 billion per annum and puts strain on emergency department resources, police services, and other support agencies as well as the abuse and violence suffered by staff in many of these settings.

- The direct standardised rate of alcohol-attributable deaths amongst males in Southampton was 35.7 per 100,000 in 2009-10
- The direct standardised rate of alcohol attributable deaths among females shows an increasing trend at 26.3 per 100,000 in 2009-10
- The rate of alcohol-specific admissions amongst under 18s is significantly higher in Southampton, at 122.5 per 100,000 population, compared with 64.5 for England as a whole.

Drug Misuse

In common with the rest of the region, drug misuse prevalence is apparently highest among the 25-35 year age group. However, the use of so-called "recreational" drugs is reported to be growing within the under 18 age group and also the 18-25 age range, with an increasing number of individuals presenting at the open access services for assistance with stimulant and "legal high" usage.

Local Evidence from the JSNA	What we will do
• Alcohol specific admissions to the Emergency Department (ED) for under 18s in Southampton are high compared to the national average (122.5 per 100,000 compared to 64.5 for England) • To tackle alcohol harm and prevent damage to health and wellbeing, there is a need to broaden the base of alcohol treatment services by investing more in early intervention services that achieve sustained change in relation to our local drinking culture and behaviour • The government seeks to re-focus drug treatment services on the need to plan for Recovery and Re-integration, thus improving the rate of planned exits from treatment. This increases the need to improve treatment pathways (including abstinence), access to mutual aid groups and support for families and carers of service users • The shared care protocol for drug services needs to be implemented in order to ensure there is improved clinical governance and leadership by senior clinicians • City agencies need to increase collaboration across the health and social care system to foster a culture of joint investment, commissioning and integrated service delivery • Young people in Southampton are demonstrating problematic substance use at age	• Develop better understanding of young people's use of alcohol by undertaking further surveys across the city • Implement awareness/public education campaigns around alcohol and substance misuse e.g. Buzz without Booze campaign • Maintain existing schemes to address underage drinking and associated behaviours (through a programme of test purchasing of alcohol to control underage sales) • Develop wider awareness amongst health and social care practitioners to ensure engagement of patients on alcohol issues and application of risk assessment tools • Develop and expand the current services in Southampton through partnership working approaches that develop "wrap around services" (including housing and access to education, employment and training) and link health, social care, housing, leisure, night-time activities and criminal justice to include tacking alcohol and substance abuse in young offenders • Increase numbers accessing both drug and alcohol services with increasing numbers achieving recovery from alcohol or other drugs

15 and too few young people receive support through young people's substance misuse treatment services • To tackle the impact drug use has on the city there is a need to develop robust prevention around the spread of blood borne viruses (BBV) • In Southampton there are over 11,500 dependent drinkers and approximately 2,000 problematic drug users. These individuals will need to access treatment that offers a focus on recovery and reintegration back into their communities • Treatment needs to incorporate a stepped care approach, through commissioned services, in partnership with primary care and acute hospital settings	• Improve the percentage of people staying in treatment and achieving abstinence • Encourage take up of personalised services for drug and alcohol treatment • Enhanced liaison across services over shared clients and review the dual diagnosis protocol • Improve performance management with a focus on data compliance /monitoring • Review drug treatment services available to young people to ensure a best value, high quality treatment system which is reflective of young people's drug use • Work together with local agencies to help address the detrimental effects of parents' problem drug and alcohol use upon their children • Build abstinence and recovery as the central theme for all clients accessing treatment • Increase the range of interventions for crack cocaine users and stimulant users in effective treatment • Refocus services on recovery and helping people regain control of their lives, including returning to employment and achieving stable accommodation • Develop an appropriate suite of abstinence and harm reduction services for blood borne viruses

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Priority 3 – Working with employers and local education providers to support people into employment and prevent people falling out of employment due to ill health

Rationale

The relationship between employment status, income and health is well documented. National research clearly identifies the link between poverty and health. Health inequalities associated with class, income or deprivation are pervasive and can be found in all aspects of health, from infant death to the risk of mental ill-health. Men aged 25-64 from routine or manual backgrounds are twice as likely to die as those from managerial or professional backgrounds.

An estimated 2,000 households in the city do not have a bank account and around 16,000 households have no home contents insurance. Around 6,500 households are without affordable credit and approximately 1,800 people use loan sharks. Also financial abuse is high and it is estimated that 1.2% of older UK residents have experienced financial abuse by a friend, relative or care worker since reaching the age of 65 years.

The economic recession has had a marked impact on Southampton and its residents. The average house price is nearly eight-times the average annual salary for residents. In November 2011, there were a total of 19,300 claimants of out of work benefits in the city, 11.3% of the working age population. This compares with a rate of 8.6% for the South East region.

In 2010 the average weekly gross earnings for a full-time employee who lives in Southampton were estimated at £452.20. This compares poorly to Portsmouth and Hampshire, where the average earnings are £480.20 and £540.70 respectively.

There are 5,690 people aged 16-64 claiming job seekers allowance in Southampton and 2,503 notified vacancies for April 2012. This is a rate of 2.27 people per job. The priorities identified below aim to maximise the opportunities to help promote health and wellbeing to the working age population across the city by working with local employers, improving economic wellbeing and helping young people into employment.

Local Evidence from the JSNA	What we will do
Helping Young People into Employment • There is a need to sustain the number of 16 year olds progressing into education and training	To maximise the proportion of young people who are on track to achieve good levels of economic wellbeing there is a need to: • Broaden learning opportunities for 14-19 year olds through apprenticeships, diplomas, GCSEs and 'A' Levels so that Southampton outcomes catch up and surpass levels elsewhere • Reduce the number and level of young people not in education, employment and/or training to much lower levels that compare more favourably with similar cities • Understand the housing and accommodation pressures upon young people better so that appropriate provision can be put in place, particularly for the most vulnerable
Improving Economic Wellbeing • The key issues to improving economic wellbeing are: ○ tackling worklessness	To improve the economic wellbeing of the population, especially those most vulnerable, there is a need to: • Ensure that people can stay in or return to

Local Evidence from the JSNA	What we will do
○ improving skills and employability ○ promoting financial inclusion ○ mitigating poverty ○ maximising incomes • It will be important to support key developments in the city that make it more attractive to residents and businesses and ensure these maximise their potential to reduce disadvantage • The partner organisations of the Health and Wellbeing Board have an important part to play in encouraging economic development to reduce the levels of deprivation and its associated health and social care consequences	work as soon as possible e.g. through the appropriate use of the 'Fit Note' • Ensure that those who do stop working because of illness or a health condition access advice and support that enables them to get back to work sooner, claim appropriate benefits or rethink their future job prospects • Extend benefit take up/welfare rights campaigns and other anti-poverty initiatives • Ensure that those who have been off sick for a significant length of time are helped back into training and/or employment in a timely way • Ensure that the range of initiatives to improve economic wellbeing through employment and skills across all sectors of the population are coordinated for maximum benefit/effect
Employment and Mental Health • People with mental health problems often have fewer qualifications, and find it harder to both obtain secure and stay in work. Mental health problems are the most common reason for incapacity benefits claims (replaced by employment and support allowance in 2008 for new claimants) – around 43% of the 2.6 million people on long-term health-related benefits have a mental or behavioural disorder as their primary condition • The highest proportion of incapacity benefit claims are for mental and behavioural disorders. These claimants represent a significant proportion of total out-of-work claimants in Southampton • Sickness absence due to mental health problems costs the UK economy £8.4 billion a year and also results in £15.1 billion in reduced productivity	To ensure that the appropriate mental health services are provided for patients and preventative measures are taken, there is a need to: • Improve access to employment for people with mental health problems • Identify opportunities and services to improve access to work for people with mental health problems • Ensure early access to psychological therapy/services which help people retain and return to employment • Work with other agencies to develop an anti-stigma campaign as part of the national campaign – Time to Change • Work with employers to ensure they have policies and procedures in place to support positive mental health • Adopt a public health approach in the development of strategies which promote mental wellbeing for the whole population including activities which reduce health inequalities and which promote good mental health in the workplace

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Priority 4 - Helping people grow old and stay well

Rationale

Average life expectancy in Southampton is increasing. The fastest growing sector of the population is that aged 65 years and over with a projected increase of 14% between 2010 and 2017, whilst the number of people over 85 years is forecast to grow from 5,200 to 6,000, an increase of over 15%.

However, people on lower incomes living in the most deprived areas in the city have shorter lives than those in the more affluent areas, with premature deaths (under age 75) 62.5% higher and increasing. The life expectancy of men is lower by 3.5 years and widening, and for women by 1.4 years and narrowing, against the population living in more affluent areas in the city.

Many older person households are living in poverty, including fuel poverty where a household is spending more than 10% of its income on fuel to maintain a warm home. This is closely related to ill health and increased risk of death.

Caring is a role that many older people take on or require. Maintaining the health and wellbeing of carers is a key challenge for the city. Demands for social care and wider support are increasing as the population ages and ill health and disability increases as a consequence.

The priorities identified include the aim to support older people to:

- stay healthy and actively involved in their communities for as long as possible, thus helping prevent, reduce or delay the need for more specialist care services;
- effectively regain as much independence as possible when this has been lost through accident or illness, and to re-engage within their community;
- access the information and the means to take more control over their health and care arrangements, and have more choice over services when there is a continuing need for such services.

Abuse of older people is a hidden and often ignored problem in society, and many older people are too frightened to report its presence or may be unaware that it is happening. Locally, the reporting of abuse against older people and other vulnerable adults has increased significantly in the last few years. It is likely that this is the result of increased awareness amongst both professionals and the public, but it is not known whether prevalence of abuse is increasing simultaneously. Safeguarding of vulnerable adults and ensuring the quality of the care that they receive is an important priority.

Each year about 460,000 people die in England and around 1,790 residents in Southampton (3 year average). End of life care is about enabling people to live their life to the end with dignity and having their choices respected. Not all people will be able to plan for their death, but for a majority of people planned end of life care has enabled them to experience a peaceful and dignified death.

Local Evidence from the JSNA	What we will do
Poverty and Deprivation in Later Years • The older population living in Southampton faces substantial poverty. There are seven areas in the city where Income Deprivation affecting Older People is in the worst 10% for England. These are mainly clustered in the central areas of the city (with the exception of Weston) • Mosaic data shows that 3,863 households consist of deprived, very elderly single pensioners living in council owned, purpose built accommodation • 46% of homeowners over 85 live in non-decent housing compared to an England average of over 50%	Action is needed to continue delivering programmes and partnership working designed to reduce fuel poverty, specifically focusing on: • Promoting take-up of “Warm Front” grants to those eligible for them and the Warm Home Discounts offered by "the big six" energy companies • Encouraging more households with a person over 70 years to take up the Government’s free loft and cavity wall insulation benefit • Targeting older people who live in rented and owner-occupied accommodation with

Local Evidence from the JSNA	What we will do
• In the winter of 2008/09, an estimated 113 people died in Southampton because of cold weather, with frail, elderly women thought to be at greatest risk • National research indicates a third of all pensioner households entitled to Pension Credit and two-fifths entitled to Council Tax Benefit do not claim it	no central heating • Improving the multi-agency referral process • Establishing effective mechanisms for delivering the Green Deal when it is launched in October 2012 • Providing recognition, respect and support for carers to enable them to maintain their caring role and retain their health and wellbeing, including economic wellbeing • Develop a sustainable and diverse community-based support system that best utilises people's skills to help themselves and each other. For example, encompassing quality information and advice (including financial advice), active community groups, peer networks and opportunities to contribute including volunteering, training and employment options
End of Life Care • In 2010 there were 1,713 deaths registered in Southampton's resident population and of these cancer was responsible for 29.6%, coronary heart disease 13.4% and circulatory diseases 8.8%. Around 59.3% of these deaths occurred in an acute hospital setting, 11.2% in a nursing/care home and 23.6% in the individual's own home • By working collaboratively across the city with GPs, specialist palliative care teams, community teams, care homes, University Hospital Southampton Foundation Trust and social services, progress is being made to identify people who may be approaching the end of their lives to ensure, generally within the last year of life, their care at this crucial time is planned • Locality registers and advance care planning can help support people to express their wishes. For example, people's wishes around resuscitation, preferred place of care/death	To better support people at end of life care action is needed to: • Increase public awareness and discussion around death and dying • Enable more people to express their preferences for care through advance care planning • Assess the population need for end of life care services more robustly • Map current provision, to ensure that the Gold Standard Framework and Liverpool Care Pathway are incorporated and audited in hospitals • Extend palliative care to other diseases besides cancer • Ensure access to physical, psychological, social and spiritual care • Establish an end of life care register accessible to all appropriate service providers (e.g. Out of Hours Service) • Establish a single point of access for the co-ordination of services • Have timely bereavement counselling available
Dignity and Safeguarding • The Government's ambition for promoting greater independence and choice is through social care reform, making personalisation the cornerstone of change where every person is enabled to exercise choice and control over their care and support • The political commitment as a result of this is the 'personal budget': a transparent allocation of social care resources to eligible individuals which are managed either by the council, by another organisation or paid as a direct payment or a mixture of both	In order to support the increasing numbers of people living longer in Southampton, action is needed to ensure as many people as possible are able to live as independent and active lives as possible in their own homes. Specific action is needed to: • Target resources so that personal budgets are available to all eligible social care clients by March 2014 • Enhance service user involvement in planning Action is needed to support people live more

Local Evidence from the JSNA	What we will do
• The agenda has safeguarding implications combined with the management of potential risk. A core part of a personalised system is an effective and established way of enabling people to make supported decisions built on appropriate safeguarding arrangements • Safeguarding policies have resulted in experience and learning that must be built into the transformation process in public services. At the heart of this transformation is the need to recognise that, for the most part, organisations and professionals do not need to make decisions for people – it is time they had real, informed choices. But with that may come greater risk of harm and abuse (No Secrets Review, 2008) • To provide confidence that the city's most vulnerable adults are safe from abuse, or other harm there is a need to address safeguarding issues from an equalities perspective. The issues involved in not reporting harm need to be looked at in culturally sensitive ways • It will also be necessary to address the recommendation of the Law Commission Review of Social Care (2011) for lowering the threshold for safeguarding action. Should these be implemented locally, the demands placed on the health and social care system will increase	independently through: • An emphasis on re-ablement services • Cost-effective telehealth and telecare • Training and recruiting 500 additional care workers by 2015 • Increased support for carers • Timely discharge from hospital to appropriate accommodation of choice • Timely access to equipment to support moves from hospitals and acute settings to home care seven days a week • Develop the prevention agenda • Ensure that vulnerable adults in hospital/care homes have their nutritional needs met Further action on safeguarding should include: • Education for all care staff (including those in primary care teams) • Learning from and acting on recommendations from any Serious Case Review • Develop quality assurance processes which ensure services are safe, of good quality and which people can have confidence in accessing

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Priority 5 – Reducing admissions to hospital from preventable causes of both mental and physical ill health

Rationale

The numbers of people with long term conditions requiring health and social care solutions is increasing and set to grow, now representing 30% of the population but utilising 70% of NHS and Social Care resources. For example one third of people over 65 years will die with dementia and 25% of hospital beds are occupied by someone with dementia as part of the diagnosis.

National and local evidence identifies the need to shift services towards proactive identification and management of individuals "at risk" to reduce the number of unscheduled admissions for acute care or residential /nursing care usage by increasing the independence of individuals and carers. This care transcends organisational boundaries of social care, primary and community care and hospital care. Increasing numbers of people have more than one long term condition yet face an increasingly fragmented specialised response.

As the proportion of older people in the population increases, the management of long term conditions will make a growing contribution to the overall burden of disease. As people become more burdened with disease, there is often a requirement for more social care support. Treatment of these conditions is costly both to the NHS and to society, however the condition and their complications are often preventable.

Long term conditions are one of the major health challenges in the UK. For example diabetes is the fastest growing chronic condition in the UK, with one new case diagnosed every 3 minutes, and yet for the majority of patients this is entirely preventable or can be delayed. Cancer can also be seen as a long term but curable condition. Indeed nationally there are over 1.6 million people who have survived cancer and we want them to remain cancer free.

There are also opportunities for providing better support for people with physical, sensory and learning disabilities to enable them to live more independently. Over time the ageing profile of the city is likely to increase the number of people living with disabilities, as people tend to pick up disabilities through injury or degenerative conditions as they get older.

Finally it is important to try and ensure that people who are admitted to hospital for whatever reason are not exposed to further health risks e.g. from healthcare acquired infections.

Local Evidence from the JSNA	What we will do
Prevention of Hospital Admissions from Conditions Amendable to Health Care • An estimated 22% of adults smoke in the city • An estimated 22% of adults are obese • An estimated 20.5% of adults participate in the recommended levels of physical activity per week, this is higher than the England average and influenced by our large numbers of young people • Over 11,000 people are diagnosed with diabetes, however 14,000 people (a crude rate of 6.4%) are estimated to be living with this disease • GP figures show 4,573 people have a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) 1.7%, although modelling suggests 8,723 or 3.55%	• Continue to invest in the prevention of long term conditions. Sustain prevention programmes around smoking, obesity and physical activity and cardiovascular disease. Support the NHS Health Checks programme • Support development of integrated community teams and personalised care approach to support individuals with long term conditions to pharmacists to make appropriate self-management/care plans

Local Evidence from the JSNA	What we will do
Long Term Conditions • There is a need to ensure that long term care needs are identified as early as possible and that appropriate care provision is in place to meet these needs. Everyone with a long term condition should be provided with their own personalised care plan • Individual care plans can enable different agencies to anticipate/ co-ordinate people's needs more effectively and invest in more Medication Use Reviews to increase the benefits of good prescribing by GPs and community pharmacies, for people with long term conditions and complex medications • Services should be designed so that they take account of the increase in most long term conditions as people get older. Better co-ordination or integration of different health and social care groups for the planning and delivery of care • Better data sharing is required across health and social care IT systems to improve efficiency and outcomes (with appropriate data security) via Hampshire Health Record and the Common Assessment Framework (CAF) project	To better support people with long term conditions and proactively manage diseases action is needed to: • Detect earlier those at risk and improve control to minimize effects of disease and reduce complications • Provide an annual health check for carers who look after a relative at home to help promote their health and wellbeing • Ensure effective case management of long term conditions to reduce the need for hospital admission and improve overall health • Provide more person-centred care closer to home by expanding high quality integrated provision • Ensure better continuity of carers for social care, helping to increase people's confidence in their care and reducing stress • More effective medicines management • Increase use of telehealth and telecare
Learning Disabilities • Local healthcare organisations should collect data and information necessary to allow people with learning disabilities to be identified by the health service and track pathways of care • Family members and other carers should be involved as a matter of course as partners in the provision of treatment and care. Providers should ensure that reasonable adjustments are made to enable and support carers to do this effectively • An understanding of the reasons for inequalities in health and social care outcomes for people with learning disabilities is also needed. Improved primary care awareness and training through primary care learning disability registers would enable more accurate understanding and better planning of resources to meet these needs	To better support people with learning disabilities, action is needed to: • Identify people with learning disabilities to ensure their needs are identified and addressed • Ensure comprehensive implementation across GP practices of annual physical health checks • Ensure that information systems are capable of identifying and recording people with learning disabilities • Develop specialist services to sustain and support people in their local community, avoiding unnecessary admission or re-admission to hospital or out of area placements • Put plans in place that meet the needs of people with learning disabilities who are aging (older adult services) • Raise awareness of the risk of premature avoidable death of people with learning disabilities, and to promote sustainable good practice in local assessment, management and evaluation of services
Cancer • Need to improve public information and health promotion about lifestyle choices/risk factors, including smoking, diet, alcohol consumption, exercise and exposure to ultra violet radiation • Need to improve the uptake of cancer screening	To prevent cancer and improve health outcomes of those living with cancer action is needed to: • Improve the uptake/participation in prevention programmes around lifestyle risk factors • Continue to offer the HPV vaccine to Year 8 girls and link this information to the cervical screening programme

Local Evidence from the JSNA	What we will do
	• Increase the number of women participating in breast and cervical screening programmes in the city • Increase the number of men and women aged 60 to 74 participating in the bowel screening programme from 60% to over 70% by 2013/14 • Improve understanding of the barriers to cancer screening programmes and why some people choose not to be screened • Ensure that all people with a suspected cancer have their first outpatient appointment at a hospital within two weeks of seeing their GP • Improve access to radiotherapy treatment
Healthcare Acquired Infection • Continuing emphasis needs to be placed on the health economy wide efforts to tackle healthcare acquired infections which remain a significant public, professional and political concern	• Ensure all providers in primary, community and secondary care implement high standards of infection control to minimise risk
Sensory Impairment • Eye health is a public health priority and the importance of regular sight tests should be promoted. It is important to ensure that eye disease is detected early in all communities, especially minority ethnic groups • Improvements are needed to ensure that diabetic patients are better enabled to access screening • There is equally a need to ensure early diagnosis and early intervention with hearing aids and specialist support including: ○ Appropriate number of teachers of deaf children to meet their education and communication development needs ○ Access to a comprehensive range of services to prevent hearing loss	To improve visual health and reduce health inequalities and social exclusion, there is a need to: • Increase awareness of eye health amongst children, their families and carers • Improve the diabetic retinal screening programme to consistently meet national standards • Provide access to the best treatment options on the NHS • Enhance the inclusion, participation and independence of people with sight loss To improve hearing and reduce deafness and social exclusion action is needed to: • Sustain investment in the newborn hearing screening programme care pathways so that children and families receive prompt treatment and support from health and education teachers of the deaf • Improve the quality, effectiveness and efficiency of services to mitigate deafness • Increase choice for patients and ensure a better experience of care through greater responsiveness to people's needs

Consultation Questions

1. Do you agree with the 'What we will do' actions in this section? If not, why not?
2. Which four actions do you consider the highest priority?
3. Are there any other actions or recommendations that should be included in this section? If yes what are they and why? Are there any you think that are not strategic priorities?
4. Can you identify ways in which your organisation, sector or community might help to take forward the recommendations/actions in this section?
5. Do you have any other comments?

Priority 6 – Improving housing options and conditions for people in the city to support healthy lifestyles

Rationale

In March 2010 a report jointly produced by the Association of Retained Council Housing (ARCH) and the Association for Public Service Excellence (APSE) reinforced the message that housing is a fundamental human need. It identified that the availability, existence and condition of homes has a direct impact on health and wellbeing, educational attainment, employment opportunities, and safety. Housing is therefore essential to create safe, sustainable cohesive and thriving places where people want to live and enjoy life.

24% of all homes in the city are privately rented (over twice the national average) of which over 7,000 are Homes in Multiple Occupation (HMO). 38% (over 28,000) of privately owned and rented homes do not meet the Decent Homes Standard, of which 8,500 are occupied by vulnerable people. The total cost of dealing with unsafe private housing is estimated at £111m. Older properties (pre-1919) and privately rented homes are generally in the worst condition. To enable people to live independent lives and remain in their family homes there is a need for around 3,900 adaptations for disabled people at an estimated cost of £21m.

As a result of comparatively lower household incomes and associated higher levels of deprivation and poverty, 23% of all homes in the city are in the social housing sector of which over 17,000 are in the ownership and management of the City Council. Over 98% of Council properties currently meet the Decent Homes standard. The Council has a significant number of homes in deprived areas - five Local Super Output Area's (LSOA's) in the top 10% most deprived in the country. The Council also has over 3,300 properties specifically designated for older people, but demand continues to exceed supply available as a result of our ageing population.

The Council has over 14,000 households on its housing waiting list and whilst the Council lets about 1,600 properties a year they receive on average 400 new applications each month. The average wait for a one-bed property is seven years and the average wait for a three-bed house is six to seven years. Therefore the City has about 2,000 overcrowded households within social housing. Overcrowding has detrimental affects on health and wellbeing. In 2011/12 over 1,500 homeless households were assessed with the majority being supported to maintain their accommodation. However 250 single homeless people are seen each month by the Street Homeless Prevention Team (SHPT) and on average 10 to 12 rough sleepers are found on outreach each week and a much higher number "sofa surf" (sleep at friend's homes). Homelessness drastically shortens life expectancy and increases people's vulnerability.

Nationally rising fuel prices are forcing more families into fuel poverty which detrimentally affects infant weight gain, hospital admission rates, mental ill health and increased mortality especially in vulnerable people.

Local Evidence from the JSNA	What we will do
Housing • Fuel Poverty – over 7,000 Council tenants currently heat their homes through a landlord heating system which uses electricity and is not controlled by the tenant • Benefit dependency – over 60% of Council tenants are in receipt of some housing benefit to help meet their housing costs – 24.2% of the working age population in Weston claim out of work benefit (38% in Weston Shore) compared to a city average of 13.2%	• Deliver housing investment schemes that tackle the hardest to heat properties in the city to improve insulation and heating options for residents • Give as many tenants as possible control over their own heating • Monitor stock condition data and ensure investment is targeted at the homes with the greatest need in particular those properties that are cold or damp • Provide information, advice and guidance to tenants who currently rely on housing

Local Evidence from the JSNA	What we will do
	benefit to help mitigate the impacts on their household income as a result of the introduction of Universal Credit • Develop skills and employment initiatives that support tenants to develop pathways out of dependency and into employment

Homelessness and Prevention
• The average life expectancy of a homeless man in the UK is 47 years and woman just 43 years
  ○ Where the needs of homeless people are known around 30% have drug problems, 48% alcohol problems and 30% mental health problems
  ○ The homeless healthcare team has between 400 to 500 people on its GP list at any one time
  ○ Over 1500 households were assessed in 2011/12 with the majority being supported to resolve their housing needs
  ○ 250 people are seen each month by the SHPT and on average 10 people sleep rough each week
	• Provide a holistic homelessness prevention service that supports people to make independent choices about their housing future
	• Work with the housing providers across the city to maximise options for housing for those people in highest need
	• Work with the voluntary and supported housing sectors and the Homeless Healthcare team to ensure that provision in the city can meet the needs of the most challenging people to safeguard both their housing and health needs

Addressing poor housing conditions in the private sector • 38% (over 28,000) of privately owned and rented homes do not meet the Decent Homes Standard • Approximately 7,000 houses in the city are classified as HMO's. Less than 500 are currently licensed and many contain breaches of the Housing Health & Safety Rating System (HHSRS) • 46% of homeowners over 85 live in non-decent housing	• Affordable thermal improvements to deliver more efficient heating and better insulation are being made available to the private housing sector now and the 'Green Deal' will commence this autumn • Consult on the introduction of an Additional Licensing scheme for all HMO's in the city to help ensure the conditions in the private rented sector are improved and poor or inadequate housing is eradicated • Provide a Handyman service to older residents in the City to support small scale improvements to private homes and help alleviate risks
Housing in Older Age • In 2011 1,287 people in Southampton (0.5%) were on the dementia register and between 2010 and 2017 those over the age of 65 in the city is predicted to increase by 14% • One third of people over 65 will die with dementia and 25% of hospital beds are occupied by someone with dementia as part of the diagnosis • In 2009/10 249 people were admitted to hospital for a broken hip	• Provide a wide range of housing and support options for older people including supported housing, floating support and assisted technologies to help people stay independent for longer • Refurbish and remodel a supported housing scheme within the city to help meet the housing and care needs of residents with dementia without the need to resort to residential care • Develop local hubs of support and care in the city with high quality, well trained staff including promotion of dementia friendly communities with activities and interactions for people with dementia in the wider community • Promote health and active older age through a programme of activities provided by dedicated Activity

Local Evidence from the JSNA	What we will do
	Coordinators which helps promote movement, healthy eating and health information • Continue to run programmes and initiatives to support falls awareness and design out areas of trips, slips and falls within our older person communities • Provide opportunities for older people to engage in volunteering and intergenerational activities to support active engagement and well being

Consultation Questions

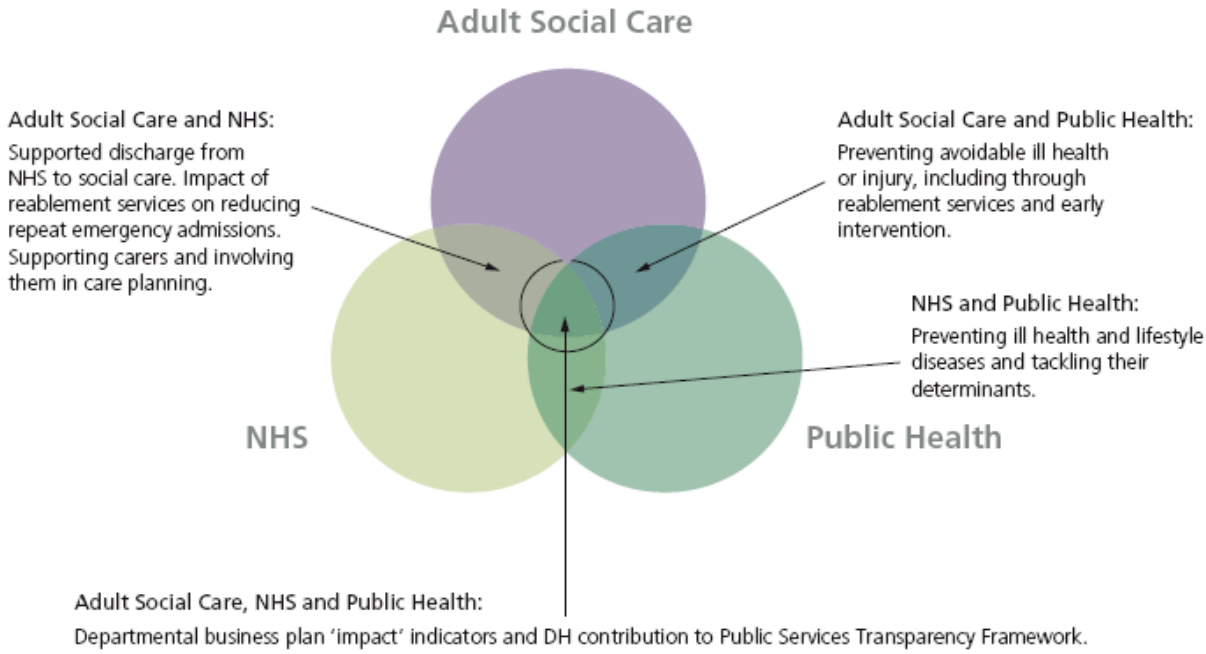
1. Do you agree with the 'What we will do' actions in this section? If not, why not?
2. Which four actions do you consider the highest priority?
3. Are there any other actions or recommendations that should be included in this section? If yes, what are they and why? Are there any you think that are not strategic priorities?
4. Can you identify ways in which your organisation, sector or community might help to take forward the recommendations/actions in this section?
5. Do you have any other comments?

Section Three – How will we measure success?

It is proposed that during the consultation process views will be sought on the actions proposed for the six priorities outlined above. It is also intended that as we talk to groups and organisations views will be sought as part of the consultation process about the most appropriate outcome measures which would enable us collectively to measure success.

Local outcome measures will draw from the national frameworks (NHS, Adult Social Care and Public Health and the Children's Outcomes Framework anticipated later in 2012) and additional local measures will be developed for those actions which fall outside the scope of the national outcomes frameworks.

Figure 1. Overlapping National Frameworks



Section Four – Developing Annual Action Plans and developing Health and Wellbeing

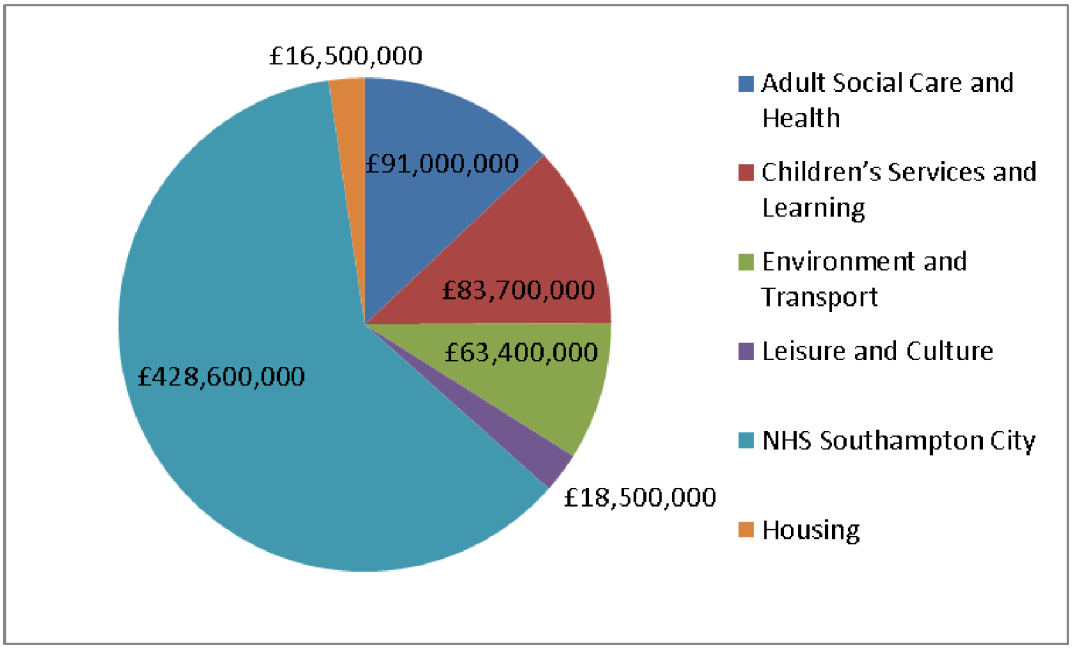
It is proposed that for each year of the strategy annual action plans will be developed. These will include measurable, focussed actions for each of the six priority areas. The national outcome framework will be drawn on to define local priorities, baseline measurements and proposed outcome targets, and other measures will be developed as required.

The partner agencies of the Health and Wellbeing Board will be jointly accountable for the delivery of this strategy and the development and implementation of the annual delivery plans. These delivery plans will comprise short, medium and long term objectives and ascribe specific leads for implementation and accountability.

It is proposed that joint strategic solutions will be brokered and agreed by health and wellbeing partners with agreement on annual investment to support strategy and delivery through the Board.

The total resource available for all service areas in the city is summarised below in Figure 2. :

Figure 2. Indicative budget for health and wellbeing from which all agencies are working towards savings targets



Section Five – Next Steps/Consultation

Section 193 (5) of the Health and Social Care 2012 requires that local Healthwatch and the people living and working in the area must be involved in the preparation of the joint health and wellbeing strategy. Until local Healthwatch is established in April 2013 work can be undertaken with the Local Involvement Network (LINk). Section 193 (3) requires consideration of the extent to which the needs could be met more effectively by the making of arrangements under section 75 of the National Health Service Act 2006 (joint working arrangements). Therefore it is essential that effective consultation and arrangements are supported to engage as many professional stakeholders as possible.

A detailed consultation plan and brief executive summary of the strategy will be developed to support the engagement process between the end of July and October 2012. This draft strategy is being published on the council and clinical commissioning group websites, with an automated feedback form. This can be access at:
http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/jsna2011/jhws/
Alternatively, you can send your response to the address on the back page of this report, or email to jhws@scpct.nhs.uk. Printed copies are also available on request.

Section Six – Conclusion

This is the consultative draft of Southampton City's first Joint Health and Wellbeing strategy. It is proposed that consultation up to October 2012 will enable a wide range of stakeholders to amend and adapt both priority areas and priorities for action.

The final strategy will go to the November 2012 meeting of Southampton's Health and Wellbeing board for approval, prior to the final decisions being taken by the Southampton City Council Cabinet and the Southampton City Clinical Commissioning Group board in December 2012. The strategy priorities and proposed actions are intended to shape and inform the commissioning intentions and business planning processes of constituent member agencies for the period 2013 to 2016.

Appendix 1

Southampton's Health and Wellbeing Strategy Consultation Questionnaire

Please give us some details about yourself

Your Name----------
Your organisation (if applicable)----------
Your email or postal address----------

Question 1 Have we identified the right priorities for Southampton City? Priority 1: Early Years and Childhood – sustaining work to support vulnerable families with young children **Yes/No** Priority 2: Adolescence and young adulthood – taking action to reduce the harm to individuals and society caused by misuse of alcohol and drugs **Yes/No** Priority 3: Working age adults – working with employers and local education providers to support people into employment and prevent people falling out of employment due to ill health **Yes/No** Priority 4: Helping people grow old and stay well **Yes/No** Priority 5: Reducing admissions to hospital from preventable causes of both physical and mental ill health **Yes/No** Priority 6: Improving housing options and conditions for people in the city to support healthy lifestyles **Yes/No** If you have answered No, what would you like to include/ replace?
Question 2. Which actions do you consider the most important for each of the six priorities?
Question 3. Are there any other actions or recommendations that should be included in this strategy? If yes, what are they and why?
Question 4. Can you identify ways in which your organisation, sector or community might help to take forward the recommendations/actions in this strategy? **Do you have any other comments on actions/recommendations'? (*please continue on another sheet if required*)**

Please feedback by 30 September 2012 using one of the following methods:
http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/jsna2011/jhws/

Email to jhws@scpct.nhs.uk

Post your questionnaire to:
Emma Wynn-Mackenzie
Business and Planning Manager
Public Health
Lower Ground Floor
Municipal Block – East
Civic Centre
Southampton
SO14 7LT

http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/jsna2011/jhws/

DECISION-MAKER:	**HEALTH OVERVIEW AND SCRUTINY PANEL**
SUBJECT:	**LOCAL AUTHORITY HEALTH SCRUTINY – PROPOSALS FOR CONSULTATION**
DATE OF DECISION:	15 AUGUST 2012
REPORT OF:	SENIOR MANAGER CUSTOMER AND BUSINESS IMPROVEMENT
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

The Department of Health is currently consulting on changes to legislation on Health Overview and Scrutiny (HOS). This paper summarises the consultation and invites the Panel to make a response.

RECOMMENDATIONS:

(i) The Panel agree to submit a response to the consultation on changes to Health Overview and Scrutiny.

(ii) The Panel considers it response to the consultation questions outlined at appendix 2.

(iii) The Panel considers if would like to contribute to a SHIP HOSCs consultation response.

REASONS FOR REPORT RECOMMENDATIONS

1. The consultation proposes changes to the way HOSCs operate. This report gives HOSP members the opportunity to respond to the consultation. The consultation runs until 7 September 2012.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. **Health and Social Care Act 2012**

The Health and Social Care Act 2012 introduced two main changes to health scrutiny:

• The scope covers new 'relevant NHS bodies' – the NHSCB and CCGs – and 'relevant health service providers' of NHS and public health services. The scope of HOSCs is thus extended to independent service providers.

• Responsibility to discharge scrutiny functions was moved directly from HOSCs to lie with the local authority. Councils can 'discharge their health scrutiny functions in the way they deem to be most suitable.' They may continue with a HOSC but could also choose alternative arrangements; this must be decided by the full council of each local authority.

4. The Act also changes the Local Government role in relation to health via the introduction of Health and Well-Being Boards (HWBBs). Through health and wellbeing boards, local authorities, the NHS and local communities will work

together to improve health and care services, joining them up around the needs of local people and improving the health and wellbeing of local people. By including elected representatives and patient representatives, health and wellbeing boards will significantly strengthen the local democratic legitimacy of local commissioning and will provide a forum for the involvement of local people. Overview and scrutiny committees of the local authority will be able to scrutinise the decisions and actions of the health and wellbeing board, and make reports and recommendations to the authority or its executive.

5. The Government feels that that the current arrangements for health scrutiny need to be updated to ensure the scrutiny provisions reflect the new structure and are appropriate to the new system.

6. **The consultation**

The consultation proposals mainly relate to the power to refer unsupported proposals for changes to NHS services to the Secretary of State. The key proposals being considered are:

• local authorities would publish a timescale for making a decision on whether a proposal will be referred to the Secretary of State (SoS)

• local authorities would be required to take account of financial considerations when considering a referral

• there would be a new intermediate referral stage for referral to the NHS commissioning board for some service reconfigurations

• the full council of a local authority would discharge the function of making a referral to the Secretary of State for Health.

7. **Timescales for decision**

Under existing regulations the HOSC can decide to refer a reconfiguration proposal to the Secretary of State at any point during the planning or development of that proposal; in practice this is generally done when the NHS has finished its consultation and decided on its preferred option.

It has been suggested that timescales should be specified in regulations, but the government does not believe that fixed timescales would be helpful. It proposes that an NHS body must publish the date by which it believes that it will be able to make a decision on its consultation proposals and notify the local authority of this. The local authority must then notify the NHS body of the date by which they intend to make a decision whether or not to refer. If timescales need to be extended the NHS would notify the local authority who would submit a revised date of response. The regulations would state that the NHS body should 'provide a definitive decision point against which the local authority can commence any decisions on referral'. The consultation seeks views on whether the proposals are helpful and their reasons for this view. It also asks for the benefits and disadvantages of setting indicative timescales.

8. **Financial Considerations**

The NHS will increasingly be required to produce efficiency savings, while working alongside local authorities in health and wellbeing boards. In light of this the government believes that HOSCs should have to consider whether

proposals will be financially sustainable as part of its deliberations on whether they should be approved or referred, and should look at the opportunities for savings to be made for use elsewhere in improving health services. It proposes that regulations would make the provision that local authorities would need to have regard to financial and resource considerations when deciding whether a proposal is in the best interests of the local health service.

Local authorities will need support and information to make this assessment and the regulations will enable them to require relevant information to be provided by NHS bodies and providers. This will be further addressed in the guidance.

The consultation also states:

'Where local authorities are not assured that plans are in the best interests of the local health services, and believe that alternative proposals should be considered that are viable within the same financial envelope as available to local commissioners, they should offer alternatives to the NHS. They should also indicate how they have undertaken this engagement to support any subsequent referral. This will be set out in guidance rather than in regulations.'

The consultation asks whether it is appropriate that financial considerations should form part of local authority referrals.

9. **Referral to the NHS Commissioning Board (NHSCB)**

The consultation document describes the greater autonomy for the NHS from the Department of Health, and the new roles of the SoS and the NHSCB; it indicates that the Board has an important role in supporting disputes between NHS bodies and the local authority. The government is not proposing to remove the ultimate right to refer to the SoS, however it is considering whether to introduce an intermediate referral stage in which the initial referral is made to the NHSCB (except for services commissioned directly by the NHSCB). The Board would be required to take action, such as working with local commissioners to try to address the local authority's concerns, and would have to respond to the local authority with any action it intended to take. If the local authority still wished to pursue a referral, it would identify how the Board's actions did not address its concerns.

The consultation document indicates there are some problems with this approach, including the potential for slowing down the process of change and the fact that the NHSCB will be working closely with CCGs on an ongoing basis. It suggests an alternative approach in which the Board had an informal role in facilitating dialogue about the proposed changes. The document states that the government does not have a preference between formal and informal methods.

The consultation asks whether it would be helpful to have a first referral stage to the NHSCB; would there be any additional benefits or drawbacks of this

intermediate referral; and in what other ways might the referral process more accurately reflect autonomy in the new commissioning system and the importance of local dispute resolution.

10. **Full council agreement for referrals**

Currently HOSCs make the decision to refer to the SoS. The paper indicates that referral signals a breakdown in dialogue between local authorities and the NHS and should be regarded as the last resort with all discussion exhausted; the decision should be open to debate. Given the enhanced leadership role for local authorities in health and social care the government believes that it is right that the full council should support any decision to refer a proposed service change, and that the council should not be able to delegate this to a committee. It is likely to be undesirable for one part of the council – the health and wellbeing board – to be working with the NHS on a joint strategic framework while another part – the HOSC – has the power of referral.

The change would mean that scrutiny functions would 'need to assemble a full suite of evidence to support any referral recommendation'. It would allow all councillors to contribute their views and would bring health scrutiny in line with other local authority scrutiny functions which have to have full council agreement. The government believes this would lead to more local resolution and closer working across the NHS and local government.

The consultation asks whether it would be helpful for referrals to be made by the full council and the reasons for this.

11. **Formal Joint Health Overview and Scrutiny Meetings**

Current regulations enable joint scrutiny arrangements for consultations on substantial developments or variations to health services but do not require them to be formed. Where an NHS body is carrying out a consultation across boundaries, current directions require the local authorities involved to form a joint HOSC as the body that will carry out the scrutiny functions. The government is proposing to incorporate this requirement into regulations. It asks whether respondents agree with this proposal and if not, the reasons for this view. The formation of joint committees for other purposes would continue to be discretionary.

12. **Next Steps**

The consultation period runs until 7 September 2012. The full consultation document and the consultation questions are attached at Appendix 1 and 2. The Panel are asked to provide advice on the content of any response.

Initial discussions have taken place with Hampshire HOSC regarding the possibility of additionally submitting a joint SHIP wide HOSC response to demonstrate the good joint working that already exists and provide weight to any shared views. The Panel are asked to confirm if this is something they would like officers to pursue further.

RESOURCE IMPLICATIONS

Capital/Revenue

13 None.

Property/Other

14. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

15. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

16. None.

POLICY FRAMEWORK IMPLICATIONS

17. None.

AUTHOR:	Name:	Caronwen Rees	Tel:	023 80832524
	E-mail:	Caronwen.rees@southampton.gov.uk		

KEY DECISION?

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Non-confidential appendices are in the Members' Rooms and can be accessed on-line

Appendices

1.	Department of Health Consultation Document – Local Authority Health Scrutiny.
2.	Consultation Questions.

Documents In Members' Rooms

1.	N/A

Integrated Impact Assessment

Do the implications/subject of the report require an Integrated Impact Assessment (IIA) to be carried out.	Yes/No

Other Background Documents

Integrated Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)

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Local Authority Health Scrutiny

Proposals for consultation

DH INFORMATION READER BOX

Policy	Clinical	Estates
HR / Workforce	Commissioner Development	IM & T
Management	Provider Development	Finance
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working

Document Purpose	Consultation/Discussion
Gateway Reference	17717
Title	Local Authority Health Review and Scrutiny: proposals for consultation
Author	Department of Health
Publication Date	**12 July 2012**
Target Audience	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Care Trust CEs, Foundation Trust CEs , Local Authority CEs, Directors of Adult SSs
Circulation List	PCT Cluster Chairs, NHS Trust Board Chairs
Description	This consultation document sets out a number of proposed changes to the regulations governing health overview and scrutiny. A small number of focused questions seek respondents views on these proposed changes
Cross Ref	The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002
Superseded Docs	
Action Required	N/A
Timing	**The consultation will close on 7 September 2012**
Contact Details	Scrutiny Consultation Patient and Public Engagement and Experience Room 5E62, Quarry House Quarry Hill, Leeds LS2 7UE
For Recipient's Use	

Local Authority Health Scrutiny

Proposals for consultation

Prepared by the Patient and Public Engagement and Experience Team

Contents

Introduction

1. This document sets out the Government's intentions to strengthen and streamline the regulations on local authority health scrutiny, following amendments to the National Health Service Act 2006[1] ("NHS Act 2006") by the Health and Social Care Act 2012[2] ("the 2012 Act"). These enable regulations to be made in relation to health scrutiny by local authorities.

2. The proposed changes to health scrutiny by local government will strengthen local democratic legitimacy in NHS and public health services, helping to ensure that the interests of patients and the public are at the heart of the planning, delivery, and reconfiguration of health services, as part of wider Government strategy to create a patient-centred NHS.

3. In this document, we will build on proposals set out in *Equity and Excellence: Liberating the NHS*[3], which set out a vision of increased accountability, and *Local Democratic legitimacy in health: a consultation on proposals*[4], which posed a number of questions around health overview and scrutiny in particular.

4. The Government recognises that health scrutiny has been an effective means in recent years of improving both the quality of services, as well as the experiences of people who use them. There is much that is good within the existing system on which to build.

5. Our aim is to strengthen and streamline health scrutiny, and enable it to be conducted effectively, as part of local government's wider responsibility in relation to health improvement and reducing health inequalities for their area and its inhabitants.

6. We are aware from engagement to date that there are a range of related matters on which the NHS and local authorities would welcome further clarification and advice that cannot be provided within regulations. We therefore intend to produce statutory guidance to accompany the new regulations that will address some of these issues.

7. Your views on the proposed revisions to health scrutiny are critical. Your participation in this consultation will help us to ensure that the new regulations and any associated guidance will be successfully implemented.

[1] http://www.legislation.gov.uk/ukpga/2006/41/contents
[2] http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted/data.htm
[3] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
[4] http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_117586

8. The proposals in this document are being consulted on until 7th September 2012. The comments received will be analysed and will inform the development of new regulations for local authority health scrutiny.

9. We would welcome your comments on the proposals outlined in this document, your suggestions as to how to improve them, together with any general points you wish to make. The document sets out a number of questions on which we would particularly like your views. These are repeated as a single list at Annex A. Details of how to respond and have your say are set out on page 22.

10. Once we have considered your views, a summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm. It is our intention to bring the new Regulations into effect from April 2013.

11. The rationale for changes to the scrutiny regulations is set out in the impact assessment published alongside *Local Democratic Legitimacy in Health: a consultation on proposals*. This consultation document is published alongside an Equalities Screening that considers the impact on equalities. The Department welcomes any information or evidence that will help further analyse the impact of the proposals contained in this document.

Increasing Local Democratic Legitimacy in Health

12. *Equity and Excellence: Liberating the NHS* set out the Government's ambition to achieve significant improvements in health outcomes and the quality of patient care. These ambitions will be delivered through a new clinically-led commissioning system and a more autonomous provider sector. Underpinning the White Paper reforms is a commitment to increasing accountability by ensuring a strong local voice for patients and local communities and putting their views and experiences at the heart of care.

13. Strengthening health scrutiny is one of the mechanisms proposed to increase accountability and enhance public voice in health. In addition, health and wellbeing boards are being established within local authorities. Through health and wellbeing boards, local authorities, the NHS and local communities will work together to improve health and care services, joining them up around the needs of local people and improving the health and wellbeing of local people. By including elected representatives and patient representatives, health and wellbeing boards will significantly strengthen the local democratic legitimacy of local commissioning and will provide a forum for the involvement of local people. Overview and scrutiny committees of the local authority will be able to scrutinise the decisions and actions of the health and wellbeing board, and make reports and recommendations to the authority or its executive.

14. Health and wellbeing boards will consist of elected representatives, representatives from clinical commissioning groups (CCGs), local authority commissioners and patient and public representatives. A primary responsibility of health and wellbeing boards is to develop a comprehensive analysis of the current and future health and social care needs of local communities through Joint Strategic Needs Assessments (JSNAs). These will be translated into action through Joint Health and Wellbeing Strategies (JHWSs) as well as through CCGs' own commissioning plans for health, public health and social care, based on the priorities agreed in JHWSs. The involvement of local communities will be critical to this process and to the work of the health and wellbeing board. It will provide on-going dialogue with local people and communities, ensuring that their needs are understood, are reflected in JSNAs and JHWSs, and that priorities reflect what matters most to them as far as possible.

15. From April 2013, local authorities will also commission local Healthwatch organisations – the new consumer champion for local health and social care services. Local Healthwatch will help to ensure that the voice of local people is heard and has influence in the setting of health priorities through its statutory seat on the health and wellbeing board.

16. *Local Democratic legitimacy in health,* a joint consultation between the Department of Health and the Department of Communities and Local Government, proposed an

enhanced role for local authorities and asked a number of questions about how the commitment to strengthen public voice in health could be delivered. It aimed to find ways to strengthen partnership working between NHS commissioners and local authorities so that the planning and delivery of services is integrated across health, public health and social care.

17. In the light of responses to that consultation, the Government decided to expand and adapt its proposals for legislation around local democratic legitimacy. *Liberating the NHS: Legislative Framework and Next Steps*[5] proposed extending the scope of scrutiny to include any private providers of certain NHS and public health services as well as NHS commissioners. It also accepted that its original proposition to confer health scrutiny powers onto health and wellbeing boards was flawed. It instead proposed conferring scrutiny functions on local authorities rather than on Health Overview and Scrutiny Committees (HOSCs) directly, giving them greater freedom and flexibility to discharge their health scrutiny functions in the way they deem to be most suitable. These intentions are encompassed within changes made by the 2012 Act to the health scrutiny provisions in the NHS Act 2006.

Aim of Health Overview and Scrutiny

18. This consultation document deals exclusively with health scrutiny. This is an essential mechanism to ensure that health services remain effective and are held to account. The main aims of health scrutiny are to identify whether:

- the planning and delivery of healthcare reflects the views and aspirations of local communities;
- all sections of a local community have equal access to health services;
- all sections of a local community have an equal chance of a successful outcome from health services; and
- proposals for substantial service change are in the best interests of local health services

The History of Health Scrutiny

19. The Local Government Act 2000[6] established the basis for the arrangements that are still in place today, where there are two groups of councillors in most local authorities;

- The Executive (sometimes called the Cabinet), responsible for implementing council policy; and

[5] http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/DH_122624
[6] http://www.legislation.gov.uk/ukpga/2000/22/contents

- The Overview and Scrutiny Committees (sometimes called Panels or Select Committees), responsible for holding the Executive to account and scrutinising matters that affect the local area.

20. This Act established that, for the first time, democratically-elected community leaders were able to voice the views of their local constituents, and require local NHS bodies to respond, as part of the council's wider responsibilities to reduce health inequalities and support health improvement.

21. The Health and Social Care Act 2001[7] subsequently amended the Local Government Act, to require local authorities to ensure that their overview and scrutiny committee or committees (OSC) had the power to scrutinise matters relating to health service. The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002[8] ("the 2002 Regulations") required NHS bodies to consult formally with the HOSC on any proposals for substantial variations or developments to local services.

22. The 2002 Regulations also set out the health scrutiny functions of such committees and the other duties placed on NHS bodies. These regulations are still in force today. They:

    a. enable HOSCs to review and scrutinise any matter relating to the planning, provision and operation of health services in the local authority's area;

    b. require NHS bodies to provide information to and attend (through officers) before meetings of the committee;

    c. enable HOSCs to make reports and recommendations to local NHS bodies and to the local authority on any health matters that it scrutinises;

    d. to require NHS bodies to respond within a fixed timescale to the HOSC's reports or recommendations, where the HOSC requests a response;

    e. require NHS bodies to consult HOSCs on proposals for substantial developments or variations to the local health service; and

    f. enable local authorities to appoint joint HOSCs;

    g. enable HOSCs to refer proposals for substantial developments or variations to the Secretary of State where they have not been adequately consulted, or believe that the proposals are not in the best interests of the local health service.

[7] http://www.legislation.gov.uk/ukpga/2001/15/contents
[8] http://www.legislation.gov.uk/uksi/2002/3048/contents/made

Benefits

23. The current health scrutiny functions support the accountability and transparency of public services. They provide a means for councillors to engage with commissioners, providers and local people across primary, secondary and tertiary care.

24. HOSCs set their own priorities for scrutiny to reflect the interests of the people they serve. Councillors on HOSCs have a unique democratic mandate to act across the whole health economy, using pathways of care to hear views from across the system and examining priorities and funding decisions across an area to help tackle inequalities and identify opportunities for integrating services.

25. By creating a relationship with NHS commissioners, health scrutiny can provide valuable insight into the experiences of patients and service users, and help to monitor the quality and outcomes of commissioned services. It can also provide important insight that will contribute to the process of developing JSNAs and JHWSs, on which future commissioning plans will be based.

26. Where relationships between the NHS and HOSCs are mature, health scrutiny adds value by building local support for service changes. Some HOSCs also advise the NHS on appropriate forms of public engagement, including alternatives to full public consultation, thus saving NHS resources. These effective relationships are usually a result of early engagement between the NHS and the HOSC, where there is co-operation on proposals for consultation and potential areas of dispute are surfaced and solutions agreed as part of wider consultation.

Proposals for Consultation

Why are we looking at this?

27. The current reform programme is underpinned by a commitment to increasing local democratic legitimacy in health. Strengthening health scrutiny is one element of this.

28. These important reforms are taking place against a backdrop of a very challenging financial environment for public services. The need to deliver improved quality and outcomes in this economic context will be a significant challenge for both NHS commissioners and local authorities. Commissioners will need to focus on achieving the very best outcomes for every pound of health spend, meaning that complex decisions over the current and future shape of services are likely to be required. In a tax-funded system, it is important that such decisions are grounded with effective local accountability and discussed across local health economies. The role and importance of effective health scrutiny will therefore become more prominent.

29. Since the scrutiny provisions were implemented in 2003, NHS organisations, health services and local authorities have changed substantially. The 2012 Act will bring about further structural reforms with the introduction of the NHS Commissioning Board, CCGs, health and wellbeing boards and Healthwatch.

30. The Government recognises that the current arrangements for health scrutiny need to be updated to ensure the scrutiny provisions reflect the new structure and are appropriate to the new system. It is important that the new NHS bodies are made subject to effective scrutiny and held to account.

31. In updating the scrutiny regulations, we propose to retain the best of the existing system but take this opportunity to address some of the challenges that have been experienced by both local authorities and NHS bodies since 2003.

32. The 2012 Act has made changes to the regulation-making powers in the 2006 Act around health scrutiny. In future, regulations will:

    a. confer health scrutiny functions on the local authority itself, rather than on an overview and scrutiny committee specifically. This will give local authorities greater flexibility and freedom over the way they exercise these functions in future, in line with the localism agenda. Local authorities will no longer be obliged to have an overview and scrutiny committee through which to discharge their health scrutiny functions, but will be able to discharge these functions in different ways through suitable alternative arrangements, including through overview and scrutiny committees. It will be for the full council of each local authority to determine which arrangement is adopted;

b. extend the scope of health scrutiny to "relevant NHS bodies" and "relevant health service providers". This includes the NHS Commissioning Board, CCGs and providers of NHS and public health services commissioned by the NHS Commissioning Board, CCGs and the local authority, including independent sector providers.

33. These important changes to health scrutiny regulations were consulted upon widely through the White Paper, *Liberating the NHS,* and throughout the passage of the 2012 Act in Parliament. This document does not consult further upon the merits of these changes.

34. The Government recognises that the existing health scrutiny regulations have, on the whole, served the system well. Some elements of the regulations, for example around the provision of information and attendance at scrutiny meetings, are fundamental to the effective operation of health scrutiny, and will need to be retained. We propose therefore to preserve those provisions which:

a. enable health scrutiny functions to review and scrutinise any matter relating to the planning, provision and operation of health services in the local authority's area;

b. require NHS bodies to provide information to and attend (through officers) before meetings of the committee to answer questions necessary for the discharge of health scrutiny functions;

c. enable health scrutiny functions to make reports and recommendations to local NHS bodies and to the local authority on any health matters that they scrutinise;

d. require NHS bodies to respond within a fixed timescale to the HOSC's reports or recommendations;

e. require NHS bodies to consult health scrutiny on proposals for substantial developments or variations to the local health service;

35. The provisions will be modified in accordance with amendments to the 2006 Act by the 2012 Act so, for example, they will apply in relation to the NHS Commissioning Board, CCGs and providers of NHS and public health services commissioned by the NHS Commissioning Board, CCGs and local authorities, in line with paragraph 32 b) above.

36. The Health Act 2009[9] introduced the Unsustainable Providers Regime for NHS trusts and NHS foundation trusts. The purpose of this regime is to deliver a swift resolution in the unlikely event that an NHS provider is unsustainable, to ensure patients are not put at risk. Parliament accepted the principle that under these exceptional circumstances, public consultation and local authority scrutiny should be restricted to a truncated 30-working day consultation period. Therefore, the provisions in the 2002 Regulations on

[9] http://www.legislation.gov.uk/ukpga/2009/21/contents

consultation of HOSC and referrals by them, and on provision of information to them and attendance before them, do not apply in relation to a Trust Special Administrator's report.

37. The 2012 Act introduced a framework to secure continued access to NHS services, which included a modified and improved version of the 2009 Act failure regime for NHS foundation trusts. We intend to retain the exemption from the need to consult local authority scrutiny functions on proposals contained in a Trust Special Administrator's report and the other exceptions mentioned above. In line with paragraph 32 b) above, we also intend to extend this exemption to Health Special Administration[10] proposals, which will provide equivalent continuity of service protection to patients receiving NHS care from corporate providers in the unlikely event that one such provider becomes insolvent.

Proposals under consultation

The current position on service reconfiguration and referrals

38. Throughout its history, the NHS has changed to meet new health challenges, take advantage of new technologies and new medicines, improve safety, and modernise facilities. The redesign and reconfiguration of services is an important way of delivering improvements in the quality, safety and effectiveness of healthcare.

39. The Government's policy is that service reconfigurations should be locally-led, clinically driven and with decisions made in the best interest of patients. The spirit of 'no decision about me, without me' should apply, with patients and local communities having a genuine opportunity to participate in the decision-making process.

40. Reconfigurations should also demonstrate robust evidence against the Secretary of State's four tests for major service change[11]. This means all proposals should be able to demonstrate evidence against the following criteria.

- a clear clinical evidence base, which focuses on improved outcomes for patients;
- support for proposals from the commissioners of local services;
- strengthened arrangements for patient and public engagement, including consultation with local authorities; and
- support for the development of patient choice.

41. Effective patient and public engagement is at the heart of any successful reconfiguration. NHS bodies have a legal duty to make arrangements that secure the involvement of patients and the public in the planning of service provision, the development and consideration of proposals for changes in the way services are provided and decisions to be made affecting the operation of those services.

[10] Chapter 5 of Part 3 of the 2012 Act
[11] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_118085.pdf

42. Under the current system, NHS bodies must consult the HOSC on any proposals for "a substantial variation" in the provision of the health service or "a substantial development" of the health service. The existing health scrutiny regulations do not define what constitutes 'substantial'. The Government's view, taking into account previous consultation on this issue, is that this is a matter on which NHS bodies should aim to reach a local understanding or definition with their HOSC.

43. It is normal for local stakeholders and communities to have different views on how best to reorganise and reshape services to best meet patient needs within available resources. In the majority of cases, these differences of opinion are reconciled locally through effective partnership working and engagement.

44. However, there may be occasions where a local authority scrutiny body does not feel able to support a particular set of proposals for service change or feels that consultation has been inadequate. Under the 2002 Regulations, a HOSC or a joint HOSC can refer proposals to the Secretary of State if they:

    a. do not feel that they have been adequately consulted by the NHS body proposing the service change, or

    b. do not believe that the changes being proposed are in the interests of the local health service

45. Upon receiving a referral, the Secretary of State will then usually approach the Independent Reconfiguration Panel (IRP) for advice. The IRP is an independent, advisory non-departmental public body that was established in 2003 to provide Ministers with expert advice on proposed reconfigurations. In providing advice, the IRP will consider whether the proposals will provide safe, sustainable and accessible services for the local population.

Proposed changes

46. The Government is aware through conversations with stakeholders from the NHS, local government and patient groups that existing dispute resolution and referral mechanisms do not always work in the best interests of improving services for patients. Moreover, the current referral process was developed in 2002, which pre-dates considerably the current raft of reforms and structural changes underway across the health and social care system. It is essential that the system changes so that local conversations on service reconfiguration are embedded into commissioning and local accountability mechanisms.

47. More integrated working between clinical commissioners, local authorities and local patient representatives will help to move the focus of discussions about future health services much earlier in the planning process, strengthening local engagement and helping build consensus on the case for any change.

48. The introduction of health and wellbeing boards will significantly improve joint working and planning between local authorities and the NHS across health services, social care and public health. Whilst the 2012 Act is very clear that health scrutiny remains a separate function of the local authority (and cannot be delegated to health and wellbeing boards), health and wellbeing boards provide a forum for local commissioners (NHS and local authority) to explain and discuss how they are involving patients and the public in the design of care pathways and development of their commissioning plans.

49. It is sensible, therefore, that we look further at how a balance can continue to be struck between allowing services to change and providing proportionate democratic challenge that ensures those changes are in the best interests of local people.

50. We are proposing a number of changes around service reconfiguration and referral which are designed to clarify and streamline the process in the future. Our proposals on referrals break down into four main areas:

    a. requiring local authorities to publish a timescale for making a decision on whether a proposal will be referred;

    b. requiring local authorities to take account of financial considerations when considering a referral;

    c. introducing a new intermediate referral stage for referral to the NHS Commissioning Board for some service reconfigurations;

    d. requiring the full council of a local authority to discharge the function of making a referral.

Publication of timescales

51. Under the 2002 Regulations, an HOSC can decide to refer a reconfiguration proposal at any point during the planning or development of that proposal. The 2002 Regulations do not specify a time by which an HOSC must make this decision. Most referrals are done at the point where the NHS has concluded its engagement and consultation and decided on the preferred option to deliver the proposal. Where referrals have been made earlier in the process, the IRP have usually advised the Secretary of State against a full review and advised that the NHS and HOSC should maintain an on-going dialogue as options are developed.

52. We are aware from feedback from both the NHS and local authorities, that the absence of clear locally agreed timetables can lead to considerable uncertainty about when key decisions will be taken during the lifetime of a reconfiguration programme. Some have expressed a view that timescales should be specified in regulations but we believe that imposing fixed timescales in this way would be of limited value. Each reconfiguration

scheme is different and it is right to allow local flexibility for the adoption of timetables that are appropriate to the nature and complexity of any change.

53. We therefore propose introducing a requirement in regulations that, in relation to proposals on which the local authority scrutiny function must be consulted, the NHS commissioner or provider must publish the date by which it believes it will be in a position to take a decision on the proposal, and notify the local authority accordingly. We propose that on receipt of that notification, local authorities must notify the NHS commissioner or provider of the date by which they intend to make a decision as to whether to refer the proposal.

54. If the timescales subsequently need to change – for example, where additional complexity emerges as part of the planning process – then it would be for the NHS body proposing the change to notify the local authority of revised dates as may be necessary, and for the local authority to notify the NHS organisation of any consequential change in the date by which it will decide whether to refer the proposal. The regulations will provide that the NHS commissioner or provider should provide a definitive decision point against which the local authority can commence any decisions on referral.

Q1. Do you consider that it would be helpful for regulations to place a requirement on the NHS and local authorities to publish clear timescales? Please give reasons

Q2 Would you welcome indicative timescales being provided in guidance? What would be the likely benefits and disadvantages of this?

Financial sustainability of services

55. Under present regulations, an HOSC can make a referral if it considers the proposal would not be in the best interest of the local health service. The regulations do not define what constitutes 'best interest' but evidence from previous referrals indicates that local authorities interpret this in terms of the perceived quality and accessibility of services that will be made available to patients, users and the public under the new proposals.

56. The Government protected the NHS in the Spending Review settlement with health spending rising in real terms. However, this does not mean that the NHS is exempt from delivering efficiency improvements - it will need to play its part alongside the rest of the public services. Delivery of these efficiencies will be essential if the NHS is to deliver improved health outcomes while continuing to meet rapidly rising demands.

57. As local authorities and the NHS will increasingly work together to identify opportunities to improve services, we believe it is right that health scrutiny be asked to consider whether proposals will be financially sustainable, as part of its deliberations on whether to support or refer a proposed service change.

58. It would not be right for a local authority to refer a reconfiguration proposal to the Secretary of State without considering whether the proposal is both clinically and financially sustainable, within the existing resources available locally. We believe health scrutiny would be improved in it was specifically asked to look at the opportunities the change offered to save money for use elsewhere in improving health services.

59. We therefore propose that in considering whether a proposal is in the best interests of the local health service, the local authority has to have regard to financial and resource considerations. Local authorities will need support and information to make this assessment and the regulations will enable them to require relevant information be provided by NHS bodies and relevant service providers. We will address this further in guidance.

60. Where local authorities are not assured that plans are in the best interests of the local health services, and believe that alternative proposals should be considered that are viable within the same financial envelope as available to local commissioners, they should offer alternatives to the NHS. They should also indicate how they have undertaken this engagement to support any subsequent referral. This will be set out in guidance rather than in regulations.

Q3. Do you consider it appropriate that financial considerations should form part of local authority referrals? Please give reasons for your views.

Referral to the NHS Commissioning Board

61. The 2012 Act ensures the Secretary of State's duty to promote a comprehensive health service remains unchanged in legislation, as it has since the founding NHS Act 1946. The NHS Commissioning Board has a parallel duty. The 2012 Act also makes clear that the Secretary of State remains ultimately accountable for the health service. However, the Secretary of State will no longer have general powers to direct the NHS. Instead, NHS bodies and the Secretary of State will have specific powers that are defined in legislation, enabling proper transparency and accountability. For example, Ministers will be responsible, not for direct operational management, but for overseeing and holding to account the national bodies in the system, backed by extensive powers of intervention in the event of significant failure. The NHS Commissioning Board and CCGs will have direct responsibility for commissioning services. The NHS Commissioning Board will help develop and support CCGs, and hold them to account for improving outcomes for patients and obtaining the best value for money from the public's investment.

62. We believe that where service reconfiguration proposals concern services commissioned by CCGs, the NHS Commissioning Board can play an important role in supporting resolution of any disputes over a proposal between the proposer of the change and the local authority, particularly where the local authority is considering a referral.

63. We are seeking views on how the NHS Commissioning Board could provide this support and help with dispute resolution. One option is to introduce an intermediate referral stage, where local authorities make an initial referral application to the NHS Commissioning Board. Upon receiving a referral, the NHS Commissioning Board could be required by regulations to take certain steps, which could include working with local commissioners to resolve the concerns raised by the local authority. The NHS Commissioning Board would be required to respond to the local authority setting out its response and any action that it had taken or proposed to take.

64. If the local authority was not content with the response from the NHS Commissioning Board, it would continue to have the option to refer the proposal to the Secretary of State for a decision, setting out in support of its application where the NHS Commissioning Board's response fell short in addressing the concerns of the authority.

65. The exception to this referral intermediate stage would be where the reconfiguration proposals relate to services commissioned directly by the NHS Commissioning Board. In such a case, any referral would be made directly to the Secretary of State.

66. The Government believes this option holds most true to the spirit of a more autonomous clinical commissioning system, strengthening independence from Ministers, and putting further emphasis on local dispute resolution. However, we are aware through testing this option with NHS and local authority groups that it is not without complexities. It may be difficult for the NHS Commissioning Board to both support CCGs with the early development of reconfiguration proposals (where CCGs request this support) and also to be able to act sufficiently independently if asked at a later date by a local authority to review those same plans. Furthermore, this additional stage could lengthen the decision-making timetable for service change, which could delay higher quality services to patients coming on stream.

67. An alternative approach would be for the NHS Commissioning Board to play a more informal role, helping CCGs (and through them, providers) and the local authority to maintain an on-going and constructive dialogue. Local authorities would be able to raise their concerns about a CCG's reconfiguration proposals with the NHS Commissioning Board and seek advice. However, that would be at the local authority's discretion rather than a formal step in advance of referral to the Secretary of State.

68. If a local authority chose to engage the NHS Commissioning Board in this way, the Board would need to determine whether it was able to facilitate further discussion and resolution, and respond to the CCG and local authority accordingly. If following the Board's intervention the local authority's concerns remained, the local authority would continue to have the option as under current regulations to refer the proposal to the Secretary of State for review.

69. The Government does not have a preference between the formal and informal methods set out above, and would welcome comments from interested stakeholders on the

advantages and disadvantages of both approaches. Irrespective of the referral route any informal dispute resolution process that may be put in place, we do not propose to fundamentally remove a local authority's power of referral to the Secretary of State. This ability to refer to Secretary of State is unique within local authority scrutiny and provides a very strong power for local authorities within the new landscape, where the Secretary of State will have fewer powers to direct NHS commissioners and providers.

Q4. Given the new system landscape and the proposed role of the NHS Commissioning Board, do you consider it helpful that there should be a first referral stage to the NHS Commissioning Board?

Q5. Would there be any additional benefits or drawbacks of establishing this intermediate referral?

Q6. In what other ways might the referral process be made to more accurately reflect the autonomy in the new commissioning system and emphasise the local resolution of disputes?

Full council agreement for referrals

70. Under existing regulations, it is for the HOSC to determine whether to make a referral to the Secretary of State for Health. A referral to the Secretary of State in many ways represents the break down in the dialogue between local authorities and the NHS. It should be regarded as a last resort and the decision itself should be open to debate.

71. Given the enhanced leadership role for local authorities in health and social care, we believe it is right that the full council should support any decision to refer a proposed service change, either to the NHS Commissioning Board or to Secretary of State. We propose that referrals are not something that the full council should be able to delegate to a committee, and that the referral function should be exercised only by the full council.

72. This will enhance the democratic legitimacy of any referral and assure the council that all attempts at local resolution have been exhausted. It is potentially undesirable for one part of the council (the health and wellbeing board) to play a part in providing the over-arching strategic framework for the commissioning of health and social care services and then for another part of the council to have a power to refer to the Secretary of State.

73. This change would mean scrutiny functions would need to assemble a full suite of evidence to support any referral recommendation. It is important that all councillors should be able to contribute their views, to allow them to safeguard the interests of their constituents. This will also bring health oversight and scrutiny functions in line with other local authority scrutiny functions, which also require the agreement of a full council. The Government believes that this additional assurance would help encourage local resolution, and further support closer working and integration across the NHS and local government.

Q7. Do you consider it would be helpful for referrals to have to be made by the full council? Please give reasons for your view.

Joint Overview and Scrutiny

74. There are many occasions when scrutiny functions from more than one local authority area will need to work together to ensure an effective scrutiny process. Joint scrutiny is an important aspect of existing health scrutiny practice, and has been very successful in a number of places. Some regions have established standing joint OSCs, or robust arrangements for introducing joint OSCs on specific regional issues. Joint scrutiny arrangements are important in that they enable scrutineers to hear the full range of views about a consultation, and not just those of one geographical area.

75. The Government is aware from its engagement with patients and the public, the NHS and with local authorities, that there are differences of opinion as to when a joint scrutiny arrangement should be formed. The current regulations enable the formation of joint scrutiny arrangements, but do not require them to be formed. We propose to make further provision within the regulations on this issue.

76. Under the 2003 Directions to Local Authorities (Overview and Scrutiny Committees, Health Scrutiny Functions)[12] where a local NHS body consults more than one HOSC on any proposal it has under consideration for a substantial development of the health service or a substantial variation in the provision of such service, local authorities of those HOSCs must appoint a joint HOSC for the purposes of the consultation. Only that joint HOSC may make comments on the proposal, require information from the NHS body, require an officer of that NHS body to attend before the joint HOSC to answer questions and produce a single set of comments in relation to the proposals put before them. This is fundamental to the effective operation of joint scrutiny and we propose that it should be incorporated into the new regulations.

Q8. Do you agree that the formation of joint overview and scrutiny arrangements should be incorporated into regulations for substantial service developments or variations where more than one local authority is consulted? If not, why not?

77. The ability of individual local authorities to refer proposals to the Secretary of State for review has been an important enabler of local democratic legitimacy. It is important that this ability to refer is preserved, where a joint health scrutiny arrangement is formed. Should a local authority participating in a joint health scrutiny arrangement wish separately to refer a proposal either to the NHS Commissioning Board or to the Secretary of State, they will still be required to secure the backing of their full council in order to make the referral.

[12] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4006257

78. There are a range of circumstances beyond service variation or development in which two or more local authorities may wish to come together to scrutinise health matters, for example where a CCG or NHS foundation trust spans two local authority boundaries. In such circumstances, the formation of a joint scrutiny arrangement would be discretionary.

Responding to this consultation

79. The Government is proposing a number of measures to strengthen and improve health scrutiny.

80. The Government wants to hear your views on the questions posed in this document, to help inform the development of the health overview and scrutiny regulations. We are also seeking your views on the following questions:

Q9. Are there additional equalities issues with these proposals that we have not identified? Will any groups be at a disadvantage?

Q10. For each of the proposals, can you provide any additional reasons that support the proposed approach or reasons that support the current position? Have you suggestions for an alternative approach, with reasons?

Q11. What other issues relevant to the proposals we have set out should we be considering as part of this consultation? Is there anything that should be included that isn't?

Deadline for comments

81. This document asks for your views on various questions surrounding the issue of local authority health overview and scrutiny.

82. This is an 8 week consultation, running from 12th July 2012 to 7th September 2012 and building on earlier consultation on *Liberating the NHS, Local Democratic Legitimacy in Health*. In order for them to be considered, all comments must be received by 7th September 2012. Your comments may be shared with colleagues in the Department of Health, and/or be published in a summary of responses. Unless you specifically indicate otherwise in your response, we will assume that you consent to this and that your consent overrides any confidentiality notice generated by your organisation's email system.

83. There is a full list of the questions we are asking in this consultation on page 25. You can respond online at http://consultations.dh.gov.uk/public-patient-engagement-experience/http-consultations-dh-gov-uk-ppe-local-authority/consult_view by email to scrutiny.consultation@dh.gsi.gov.uk or by post to:

Scrutiny Consultation
Room 5E62
Quarry House

Quarry Hill
Leeds LS2 7UE

84. When responding, please state whether you are responding as an individual or representing the views of an organisation. If responding on behalf of a larger organisation, please make it clear whom the organisation represents and, where applicable, how the views of the members were assembled.

85. It will help us to analyse the responses if respondents fill in the questionnaire, but responses that do not follow the structure of the questionnaire will be considered equally. It would also help if responses were sent in Word format, rather than pdf.

Criteria for consultation

86. This consultation follows the Cabinet Office Code of Practice for Consultations. In particular, we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- follow as closely as possible the recommendation duration of a consultation which is at least 12 weeks (with consideration given to longer timescales where feasible and sensible) but in some instances may be shorter. In this case, it is 8-weeks in light of previous consultation referred to in paragraph 82 above and engagement undertaken by the Department throughout passage of the 2012 Act.
- be clear about the consultation process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' "buy-in" to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

87. The full text of the code of practice is on the Better Regulation website at www.bis.gov.uk/policies/better-regulation/consultation-guidance

Comments on the consultation process itself

88. If you have any concerns or comments which you would like to make relating specifically to the consultation process itself, please contact

Consultations Coordinator
Department of Health
Room 3E48
Quarry House

Quarry Hill
Leeds LS2 7UE

Email: consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address

Confidentiality of information

89. We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter.

90. Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

91. If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a Statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentially disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

92. The Department will process your personal data in accordance with the DPA and, in most circumstances, this will mean that your personal data will not be disclosed to third parties.

After the consultation

93. Once the consultation period is complete, the Department will consider the comments that it has received, and the response will be published in the Autumn

94. The consultation and public engagement process will help inform Ministers of the public opinion, enabling them to make their final decision on the content of the health scrutiny regulations.

95. A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the consultations website at http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm

Annex A - Consultation Questions

Q1. Do you consider that it would be helpful for regulations to place a requirement on the NHS and local authorities to publish clear timescales? Please give reasons

Q2 Would you welcome indicative timescales being provided in guidance? What would be the likely benefits and disadvantages of this?

Q3. Do you consider it appropriate that financial considerations should form part of local authority referrals? Please give reasons for your view.

Q4. Given the new system landscape and the proposed role of the NHS Commissioning Board, do you consider it helpful that there should be a first referral stage to the NHS Commissioning Board?

Q5. Would there be any additional benefits and drawbacks of establishing this intermediate referral?

Q6. In what other ways might the referral process be made to more accurately reflect the autonomy in the new commissioning system and emphasise the local resolution of disputes?

Q7. Do you consider it would be helpful for referrals to have to be made by the full council? Please give reasons for your view.

Q8. Do you agree that the formation of joint overview and scrutiny arrangements should be incorporated into regulations for substantial service developments or variations where more than one local authority is consulted? If not, why not?

Q9. Are there additional equalities issues with these proposals that we have not identified? Will any groups be at a disadvantage?

Q10. For each of the proposals, can you provide any additional reasons that support the proposed approach or reasons that support the current position? Have you suggestions for an alternative approach, with reasons?

Q11. What other issues relevant to the proposals we have set out should we be considering as part of this consultation? Is there anything that should be included that isn't?

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Local Authority Health Scrutiny
Consultation Questions

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DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	COMMISSIONING LOCAL HEALTHWATCH: LEARNING POINTS FROM LOCAL INVOLVEMENT NETWORKS (LINK)
DATE OF DECISION:	15TH AUGUST 2012
REPORT OF:	EXECUTIVE DIRECTOR OF HEALTH AND ADULT SOCIAL CARE
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

The Health and Social Care Act 2012 requires local authorities to establish local Healthwatch as a vehicle which will succeed the Local Involvement Networks (LINKs) as a voice for patients and the public on health and care services, in addition to it undertaking a new role providing information, advice and signposting on services. In response to a request from the Chair of the Health Overview and Scrutiny Panel this report examines some of the lessons from the LINk experience and the learning points that will be applied to the development of Healthwatch.

RECOMMENDATIONS:

(i) That the scrutiny panel notes and comments on the learning points from the Local Involvement Network.

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the scrutiny panel to understand some of the learning points from managing the contracts to support LINks.

DETAIL (Including consultation carried out)

2. Over the years legislation has established a variety of mechanisms to enable public views on the provision of health and care services to be expressed. The current system of Local Involvement Networks was established under the Local Government and Public Involvement in Health Act 2007, as a vehicle to replace the former Patient and Public Involvement Forums. LINks were empowered to look at social care issues as well as being a vehicle for collecting and expressing public views on health services, and were given "enter and view" powers for inspecting health and social care premises. The Health and Social Care Act 2012 will replace LINks with Healthwatch from 2013. Local Healthwatch will continue to have the existing responsibilities of LINks, but will also have a duty to provide an information and signposting service.

3. Since July 2011, the contract for hosting Southampton LINk has been held by Southampton Voluntary Services (SVS). During the time SVS has been supporting Southampton LINk the host service has been delivered professionally, efficiently and smoothly, and nothing in this report should be taken as any criticism of the way in which they are delivering the contract. The purpose of this report is to explain what elements the council would like to

improve on as it develops Healthwatch.

4. Three issues have been identified as being learning points to take forward into developing the specification for local Healthwatch in Southampton.

- Having a contract direct with Local Healthwatch, as opposed to any kind of hosting arrangement
- Making provision for the transfer of data relating to the individual members
- Including the ability to withhold payment in the event that local Healthwatch is not performing to the level specified.

Having A Contract Direct With Local Healthwatch

5. The Local Government and Public Involvement in Health Act 2007 specifically set up a mechanism where the LINk was a body with no legal status, but it required local authorities to procure services from a host organisation to support the activities of the LINk. Across England, many local authorities have found this a complicated system to administer. The contract is between the local authority and the host, but the activities to be undertaken are determined by the members of the LINk. There was no direct line of responsibility between the LINk and the local authority. In terms of being the independent voice of the public and service users this was logical, but the host has been in a challenging position, having to fulfil the terms of the contract with the local authority and meet the wishes of the LINk members and the LINk governing body.

6. Over the lifetime of LINks a number of local authorities expressed the complexities and weaknesses of the host arrangement to the Department of Health and bodies such as the Local Government Association. The Health and Social Care Act 2012 removes the hosting arrangement requirements. Local Healthwatch will be a legal entity in its own right. This enables the council to avoid repeating the situation with an intermediary body between the local authority and local Healthwatch, and setting up Southampton Healthwatch in such a way as to ensure it has the contract directly with the council will mean a more direct and straightforward relationship for both the council and Healthwatch.

Making Provision for the Transfer of Data Relating to Individual Members

7. The time taken for the passage of the Health and Social Care Bill through Parliament meant many LINk host contracts expired before local Healthwatch is established. At the expiry of the first contract, a new hosting contract was made with a different organisation. Once awarded the previous host organisation pointed out that there was nothing in the first contract which required them to make provision under the Data Protection Act to notify individuals that their details could be transferred to a new host organisation in the event of another body acting as LINk host at any point in the future.

8. This meant that the new host body had to rely on individuals supplying personal details afresh. Whilst the active LINk members were happy to do so, this was not possible to achieve for all those people who had signed up to LINk over the years, but were not actively attending LINk events. In setting up local Healthwatch provision will be made in the specification to ensure that contact details of members can be transferred to any successor body.

Including the ability to withhold payment in the event that local Healthwatch is not performing to the level specified

9. The specification for Healthwatch will set out a number of performance indicators for each of the activities to be undertaken. To secure delivery of the information required for effective management of the contract it is intended that there will be provision to withhold part of the payment in the event that the full information required is not supplied.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

10. None.

RESOURCE IMPLICATIONS

Capital/Revenue

11. None directly in this report. The budget for SLINk has been established through previous budget setting arrangements and the budget for Local Healthwatch will be established through the 203/14 budget setting process.

Property/Other

12. None.

LEGAL IMPLICATIONS

Statutory Power to undertake the proposals in the report:

13. Local Involvement Networks were established under the Local Government and Public Involvement in Health Act 2007. The Health and Social Care Act 2012 requires local authorities to establish Local Healthwatch.

Other Legal Implications:

14. None.

POLICY FRAMEWORK IMPLICATIONS

15. None.

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SUPPORTING DOCUMENTATION

Non-confidential appendices are in the Members' Rooms and can be accessed on-line

Appendices

1.	None.

Documents In Members' Rooms

1.	None.

Integrated Impact Assessment

Do the implications/subject/recommendations in the report require an Integrated Impact Assessment to be carried out.	No

Other Background Documents

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

Integrated Impact Assessment and Other Background documents available for inspection at:

WARDS/COMMUNITIES AFFECTED:	