Public Document Pack

Shadow Health and Wellbeing Board

Wednesday, 19th September, 2012
at 5.30 pm

Conference Room 3

Civic Centre

This meeting is open to the public

Members

Councillor Rayment, Cabinet Member for Communities
Councillor Bogle, Cabinet Member for Children's Services
Councillor Stevens, Cabinet Member for Adult Services
Councillor Baillie, Opposition Member
Councillor Turner, Opposition Member
Dr S Townsend, Clinical Commisioning Group
Dr S Ward, SHIP PCT Cluster
Mr H Dymond, Local Health Watch
Mr C Webster, Director of Children's Services
Ms M Geary, Director of Health and Adult Social Services
Dr A Mortimore, Director of Public Health

Contacts
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Democratic Support Officer
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BACKGROUND AND RELEVANT INFORMATION

Purpose of the Board

The purpose of the Southampton Shadow Health and Wellbeing Board is:

- To bring together Southampton City Council and key NHS commissioners to improve the health and wellbeing of citizens, thereby helping them live their lives to the full, and to reduce health inequalities.
- To ensure that all activity across partner organisations supports positive health outcomes for local people and keeps them safe.
- To hold partner organisations to account for the oversight of related commissioning strategies and plans.
- To have oversight of the environmental factors that impact on health, and to influence the City Council, its partners and Regulators to support a healthy environment for people who live and work in Southampton

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

Responsibilities

The shadow board is responsible for developing mechanisms to undertake the duties to be placed on the health and wellbeing board from April 2013, in particular:

- Promoting joint commissioning and integrated delivery of services;
- Acting as the lead commissioning vehicle for designated service areas;
- Ensuring an up to date JSNA and other appropriate assessments are in place
- Ensuring the development of a Health and Wellbeing Strategy for Southampton and monitoring its delivery.
- Oversight and assessment of the effectiveness of local public involvement in health, public health and care services
- Ensuring the system for partnership working is working effectively between health and care services and systems, and the work of other partnerships which contribute to health and wellbeing outcomes for local people.
- Testing the local framework for commissioning for:
    - Health care
    - Social care
    - Public health services
    - Ensuring safety in improving health and wellbeing outcomes

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.
Fire Procedure – In the event of a fire or other emergency, a continuous alarm will sound and you will be advised, by officers of the Council, of what action to take
Access – Access is available for disabled people.

Proposed Municipal Year Dates

2012	2013
13 June	16 January
19 September	20 March
21 November	

Please contact the Democratic Support Officer who will help to make any necessary arrangements.

CONDUCT OF MEETING

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 Executive Procedure Rules as set out in Part 4 of the Council's Constitution.

QUORUM

The minimum number of appointed Members required to be in attendance to hold the meeting is one third of the membership

DISCLOSURE OF INTERESTS

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

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 Council's Website

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

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

2 ELECTION OF CHAIR AND VICE-CHAIR

To confirm the appointment of Chair and Vice-Chair for the remainder of the Municipal Year 2012/13.

3 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.

4 STATEMENT FROM THE CHAIR

5 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the action notes from the informal meeting held on 13th June 2012 and to deal with any matters arising, attached.

6 PROPOSED CALENDAR OF FORMAL MEETINGS 2013/2014

To approve the proposed calendar of meetings for 2013/2014, attached

7 IMPROVING HOUSING OPTIONS AND CONDITIONS FOR PEOPLE IN THE CITY TO SUPPORT HEALTHY LIFESTYLES

Report of Senior Manager, Housing Services detailing a brief insight into the potential for Housing to support the aspirations of the Health & Wellbeing Board, attached.

8 JOINT STRATEGIC NEEDS ASSESSMENTS AND JOINT HEALTH AND WELLBEING STRATEGIES - DEPARTMENT OF HEALTH PROPOSALS FOR CONSULTATION

Report of the Director of Public Health detailing draft consultation guidance which the Department of Health has published to support health and wellbeing boards in preparing their Joint Strategic Needs Assessments and Joint Health and Wellbeing

Strategies, attached.

9 DEVELOPMENT OF HEALTHWATCH SOUTHAMPTON

Report of Director of Health and Adult Social Care detailing the development of Healthwatch Southampton, which is to be “the independent consumer champion for the public – locally and nationally - to promote better outcomes in health and social care for all”, attached.

Tuesday, 11 September 2012 Head of Legal, HR and Democratic Services

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Southampton Shadow Health and Wellbeing Board
Notes of the Informal Meeting Held on 13th June 2012

Present: Councillor Peter Baillie, Councillor Sarah Bogle, Harry Dymond, Margaret Geary, Dr. Andrew Mortimore, Councillor Jacqui Rayment, Councillor Matthew Stevens, Dr Dan Tongue, Councillor Maureen Turner, Dr Stuart Ward, Clive Webster

Officers in attendance: Martin Day, Claire Heather, Dr Noreen Kickham, Dr Graham Watkinson

Apologies for absence: Dr Steve Townsend, Rob Kurn

	Item	Actions
1.	**Notes of Previous Informal Meeting** The notes of the informal meeting held on 21st March 2012 were confirmed as a correct record.	
2.	**Joint Health and Wellbeing Strategy – Consultation Draft and Engagement and Consultation Process** The shadow board considered an outline version of the consultative draft joint health and wellbeing strategy. The following amendments were agreed: • Inclusion of a summary of the resources in the city health economy from the CCG, local authority and National Commissioning Board; • Including reference to people being empowered to take control of their health and being part of the solution in relation to rising demands for services; • Reviewing the scope and ambition of priority 1 (sustaining work to support vulnerable families with young children) to provide it with a better focus; • The inclusion of an additional consultation question asking	• Incorporate changes and circulate updated document to Board members prior to publication. (NK/GW)

	Item	Actions
	respondents whether they can identify activities that are working to address the priorities in the strategy; • Including reference to personalisation of services It was also suggested that school governors should be added to the list of stakeholders to be sent the consultation document. A question was raised as to whether the consultation could also be used to be able to prioritise the priorities?	• Add school governing bodies to consultation plan (MD) • The feasibility of this to be assessed. (MD/NK/GW)
2.	**Arrangements for Stakeholder Events** The shadow board considered a report setting out proposals for an initial stakeholder event in October 2012. It was agreed that: • A half day event should be held; • The title of the event should be re-drafted from that proposed in paragraph 4 of the report and a tighter focus on the content be developed; • Work should be undertaken to identify how conversations on the outcomes might continue after the event; • Work be undertaken with the LINk to evaluate whether a meeting on this topic might be held to engage the general public in discussion.	• Further planning for the event be undertaken taking account of HWB views (MD)
3.	**Arrangements for Formal Shadow Board Meetings 2012/13** The shadow board considered practical arrangements for forthcoming formal meetings, which would require ratification at the first formal meeting.	

	Item	Actions
	It was agreed that: • Cllr Rayment be appointed as Chair and Steve Townsend as Vice-Chair; • Alternative venues would be required for formal meetings of the Board to allow for members of the public to attend in managed way; • Quorum of the Board would include the need for a health representative to be in attendance the principal of which would be the Clinical Commissioning Group. Also attendance of the Healthwatch representative or nominated deputy. • Voting would be on a consensus basis but in the event of a formal vote being required then it would be on the basis of one person one vote. • Names of nominated deputies would be re-affirmed outside of the meeting. • Date of the March 2013 meeting would need to be re-scheduled, preference of dates would be canvassed outside of the meeting.	• Identify venues and book rooms (CH) • Collate list of nominated deputies (CH) • Identify appropriate date and notify all board members. (CH)

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HEALTH AND WELLBEING BOARD

PROPOSED CALENDAR OF FORMAL MEETINGS 2013/14

Wednesday 29th May 2013

Wednesday 31st July 2013

Wednesday 25th September 2013

Wednesday 27th November 2013

Wednesday 29th January 2014

Wednesday 26th March 2014

NB: All meetings to start at 5.30pm and to be held in the Civic Centre.

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DECISION-MAKER:	SHADOW HEALTH AND WELLBEING BOARD
SUBJECT:	IMPROVING HOUSING OPTIONS AND CONDITIONS FOR PEOPLE IN THE CITY TO SUPPORT HEALTHY LIFESTYLES
DATE OF DECISION:	19TH SEPTEMBER 2012
REPORT OF:	SENIOR MANAGER, HOUSING SERVICES
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

Good Housing is fundamental to the Health and Wellbeing of the city and its population. Southampton is in an almost unique position due to the level of social and private rented accommodation within the City to be able to influence the condition and delivery of housing and housing services to support the long term wellbeing of our residents.

The positive effect of involving Housing in the delivery of key strategies in the City will be significant. Housing is not a service that should be tacked on to other initiatives but can be placed directly at the heart of improving the City. As a key priority within the Health & Wellbeing Strategy the City can ensure that it is taking a holistic approach to improving the lives of its citizens.

This report provides a brief insight into the potential for Housing to support the aspirations of the Health & Wellbeing Board through the delivery of the strategy.

RECOMMENDATIONS:

(i) The content of the report is noted.

(ii) To seek views from the Board as to any priorities it would like to see added to this section.

REASONS FOR REPORT RECOMMENDATIONS

1. Housing has been included as priority 6 in the draft Health and Wellbeing Strategy due to the key role it plays within the City. The report is intended to provide an insight into the importance of Housing; the benefits working with Housing can bring to the City and therefore support it's inclusion within the strategy.

DETAIL (Including consultation carried out)

2 *"Housing is one of the most basic human needs. The availability, existence and condition of homes has a fundamental impact on the health and well-being, educational attainment, employment opportunities and safety of those who live within them. If affordable housing is managed effectively, social and economic development, regeneration and planning deliver far greater added value. There are also vital links between housing and social care and transport, local neighbourhoods and wider environmental impacts."*

APSE / ARCH March 2010

3 Poor housing and cold homes in particular have profound negative affects on both physical and mental health. The annual cost to the NHS of treating winter related disease due to cold private housing was estimated to be £859 million in 2009. In a review of the health impacts of cold homes and fuel poverty the Marmot team (2011) argued that because much of the UK's housing is old and cold, many have come to regard this as the norm. Cold housing and fuel poverty can be successfully tackled through policies and interventions where there is a will to do so. The Council and the Southampton Warmth for All partnership (SWAP) are working to address this issue. The time is now ripe for a more strategic approach to housing and health through the Health and Wellbeing Board.

(Ref: Marmot Review Team (2011) The Health Impacts of Cold Homes and Fuel Poverty. Friends of the Earth and Marmot Review Team.)

The health impacts of poor housing:

Cardio-vascular disease**:**

- The cold increases blood pressure.
- Increased risk of heart attacks and strokes.

Respiratory Illness**:**

- The cold lowers resistance to respiratory infections.
- Coldness impairs lung function and can trigger broncho-constriction in asthma and COPD. Dampness is associated with cold houses; damp increases mould growths, which can cause asthma and respiratory infections.

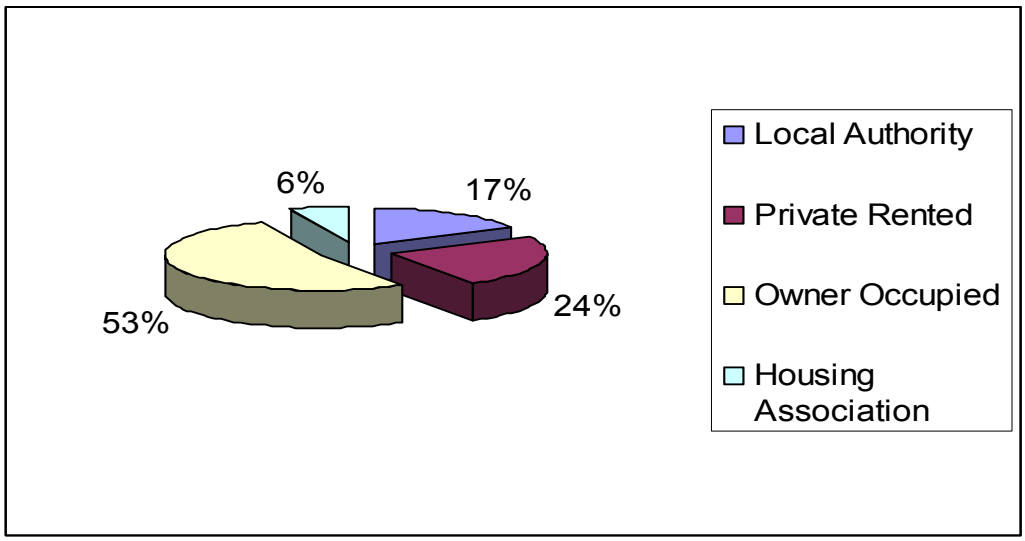
Cold houses affect mobility and increase falls and other injuries:

- Symptoms of arthritis become worse in cold damp houses.
- Strength and dexterity decrease as temperatures drop, increasing the risk of non-intentional injuries.
- A cold house increases the risk of falls in the elderly – the number of recorded falls in the city attending the Emergency Department has doubled in the past 5 years with a fractured neck of femur occurring every 26.5 hours in the City.

Mental and social health**:**

- Damp, cold housing is associated with an increase in mental health and respiratory problems
- Some people become socially isolated as they are reluctant to invite friends to a cold home.

4 **Housing Tenure in Southampton**



- The City Council has direct influence over 41% of homes in the City
- We have one of the largest private rental sectors of any non-metropolitan City
- We are the largest local authority Landlord in the South East of England outside London
- Estate Regeneration and Housing Development will see significant numbers of new homes in the City over the next 10 years

5 **Housing in numbers – private sector**

- 53,000 (53%) owner occupied homes
- 24,000 (24%) privately rented homes – over twice the national average
- 6,000 (6%) housing association homes
- Average house price (Jan 2012) - £140,000 (a fall of 2.5% over the last year)
- 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.
- There is an estimated need for 3,900 adaptations for disabled people, at an estimated cost of £21M.

6 **Housing in numbers – Council Housing**

- > 17,000 rented properties incl over 11,000 flats
- > 1,700 leasehold flats
- £68.5m turnover for 2012/13
- £200m anticipated spending on Capital and Revenue to maintain and

improve our homes in the next 4 years

- 5 LSOA's in the top 10% most deprived in the Country
- Woolston in the top 1% of LSOA's for out of work benefits
- Bitterne LSOA has over 58% of all children living in poverty (City average 28% - 2009 data)
- > 3,300 properties specifically designated for older people
- > 14,000 households waiting to access social housing
- Of which over half state medical issues are exacerbated by their current housing situation

7 **Council Housing at the heart of the city**

APSE / ARCH March 2010

8 Housing is about both people and buildings. As a Council landlord we invest a significant amount in improving the buildings but on a day to day basis our service is about the people. And Council Tenants are also citizens of Southampton and users of other services across the public sector. In some key areas of the city it would be fair to say that occupants of Council Housing are disproportional users of certain services. How much of this is about Housing as a building or is it more about Housing as a product?

9 There is a clear link between the actual building and wider issues for the residents – living in overcrowded households due to lack of suitable large properties; living in fuel poverty due to the high cost of heating some of the older buildings in the city; isolation from living on the 13th floor of a tower block or being confined to the dwelling due to lack of adaptation; and lacking a

settled home from which to put down roots and develop social networks that combat isolation and provide support.

10 However, there is far more complex link between the nature of social housing and private rented housing and wider health and wellbeing in the city. Changes in the housing market and social conditions over the last 30 years has meant that the needs threshold for accessing social housing has steadily increased leaving many of the poorest and most vulnerable residents having limited choices in their housing future. And for those not lucky enough to achieve access to social housing, high cost and low quality private rented accommodation of uncertain duration is often the only alternative.

11 Five areas in the City feature in the 10% most deprived areas in the country but the measure of deprivation has only a very limited link to the type of housing someone is in. Deprivation is more likely to be measured by health outcomes, educational attainment and poverty. The fact that in these five areas there is a large proportion of Council Housing should not be considered as the cause of the deprivation but rather the opportunity to provide the solution. The right investment, the right services and a focus on prevention joined up through a Health and Wellbeing Strategy can help lift these citizens out of deprivation and support positive life chances for the future.

12 Four illustrations below provide an insight into the key themes.

13 **Housing & poverty**

Social Housing and dependencies on state benefits have often been seen as interlinked and around 60% of all current council tenants are in receipt of some form of housing benefit to meet their housing costs. In 2011/12 around 8% of families who presented as homeless did so because they lost their home as a result of debt. In Weston over 24% of the working age population claim out of work benefits which is almost double the City average. The loss of major industries in this area of the City has radically affected the access to employment for many local residents. In addition at Weston Shore the Council has the highest concentration of high rise flats anywhere in the City (700 one and two bed flats) which has over the years shaped how this community has developed.

The opportunities in Weston are two fold:

- **Investment in the properties** – the Council tower blocks are some of the most expensive properties to heat in the City due to their age and construction. A significant investment programme is underway to dramatically improve the thermal efficiency of the buildings which will reduce residents heating bills by an estimated 50%. For those on benefits this could mean as much as an extra £10 a week in the household budget.
- **Investment in the people** – poverty is shown to lead to poorer diet and health. Colder properties are less conducive to young people and educational attainment. And living in a high-rise tower block can lead to isolation, depression and mental health. Working directly with families in Weston to develop their confidence, skills and self esteem will not only give them a better chance of gaining employment but can

help address their wider wellbeing and reduce their reliance on other public services.

14 **Homelessness & prevention**

The average life expectancy of a homeless man in the UK is 47 years. Southampton as a port and a gateway city generates a greater demand for homelessness prevention than much of the sub-region and services are focussed on prevention and early intervention. Homeless people suffer from much higher levels of illness and issues than the average population – 30% have drug issues, 48% alcohol problems and 30% mental health issues yet often they are outside of the mainstream health and support provision. The age profile of those in homeless services has changed with more young people requiring assistance. The impact of the crisis of homelessness on families in many ways is greater. The long term impacts on health, relationships, educational attainment and work prospects are not positive. Multiple issues for families affected include family breakdown, mental health difficulties, and 10% of those accepted as homeless did so as a result of suffering domestic violence. There are significant costs related to homelessness in other services, particularly Health and more detail can be found in the recent Government report 'Evidence review of the cost of Homelessness which can be found at the following link http://www.communities.gov.uk/documents/housing/pdf/2200485.pdf. For this reason the focus on preventing homeless amongst families has been operating since early 2002.

The focus in the city includes:

- **Street Homeless Prevention Team** – 250 people are seen each month by the team who work to intervene in their circumstances to prevent them living on the streets. In many cases this is about mediation, support and intervention to help them address personal issues before they become entrenched in to a lifestyle. The team also works directly with on average 10 rough sleepers a week many of whom are not British nationals and often the solution is reconnection.
- **Homeless Healthcare Team** – provide primary care services for over 400 people including GP, practice nursing and community psychiatric provision for the homeless and rough sleepers. The team are sited in the Homeless day centre hosted by Two Saints. They deal with complex health issues including TB and Hepatitis screening and are involved in end of life care in the community. This team works closely with the Street Prevention Team.
- **Homeless advice service** – provide a response to statutory priority needs cases predominantly families and young people including providing temporary accommodation whilst waiting for a settled home to be provided. In 2011/12 249 families had to seek help following loss of their home but a further 850 families were helped to prevent homelessness by mediation with landlords, and families maximising

income or tackling debt issues.

15 **Addressing poor housing conditions in the private sector**

Approximately 7,000 houses in the city are classified as houses in multiple occupation (HMO's) and fewer than 500 of the largest are currently licensed. Whilst a large number of landlords and owners of these HMO's are responsible landlords many are not and are providing housing that is unsafe and of very low quality. The team currently focus a significant amount of their time addressing the most serious hazards under the Housing Health and Safety Rating System (HHSRS), which by definition have the potential to significantly affect the health and wellbeing of occupants such as unsanitary conditions, cold and damp, fire safety risk and risks to falls and major injury. The Council is currently consulting on extending its **HMO licensing scheme** to include all HMO's in the City with the intention of driving up housing conditions and tackling neighbourhood issues associated with high densities of HMO's over the next five years.

Over 46% of homeowners over 85 years old currently live in non-decent housing. It is also estimated that there is a need for over 3,900 major adaptations for older and disabled people in the private sector and the council currently funds and delivers these in about 200 private homes every year. Therefore some of the most vulnerable residents in the City are living in inadequate housing conditions despite being property owners. The **City's Handyperson Plus service** helps older, disabled and vulnerable residents with small scale improvements and adaptations and carries out home safety checks to help alleviate risks. Although the service has recently been extended to identify additional support needs and make the appropriate referrals, it remains a very small service and is only scratching the surface.

There has recently been a renewed focus on improving home energy efficiency and tackling fuel poverty, in particular in privately rented properties. The council offers free cavity wall and loft insulation and is working with the **Southampton Warmth For All (SWAP) Partnership** to update its fuel poverty strategy to reduce excess winter deaths and deliver further health and wellbeing improvements while reducing carbon emissions.

16 **Promoting active older age**

Older people are predicted to be the single largest growing part of the City's demography over the next 20 years. Large numbers of hospital beds are occupied by older people in the city many suffering with dementia or having been hospitalised due to injuries as a result of falls. For many an acute episode can be a life changing experience often resulting in not only a change in lifestyle but also a change in housing. For some the housing options are limited by supply or unsuitable housing is adapted either physically or by the addition of significant care and support services to allow someone to return home.

The current focus in the City is in two areas:

- **Prevention** – through the Housing Support Service targeted support is provided to residents from Telecare, floating support or specialist supported housing. Services are designed to support people for longer and include dedicated Activity Coordinators who run a programme of events and activities specifically to help promote movement, healthy eating and health information. They also promote volunteering opportunities within older people to help support active engagement and wellbeing. Services are well placed, connected and deliver support to people both short term such as early intervention and re-ablement as well as longer term e.g. living with long term illness through to end of life. Services have a good existing base of tenant involvement on which to build better delivery of services with residents, their families and neighbours in the community.
- **Design** – The City Council has over 3,300 properties that are specifically designated for older people within the city. These homes are of varying types and locations offer different levels of support and facilities. Through its Housing Investment programme the Council is modernising and refurbishing a number of complexes to take account of the longer term needs of the city both for extra care, dementia and ongoing mobility and care needs. It is crucial that this investment is best directed to help the future needs of the City with potential to make these hubs delivering health and social care for older people in the wider community.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

17 Not having Housing referenced within the Health & Wellbeing Strategy would leave a missing link in the ability of the Board to effectively address the needs of the City.

18 Housing could make individual contributions to the other 5 priorities within the Strategy but this would not give the focus and opportunity that identifying Housing as a key priority brings.

RESOURCE IMPLICATIONS

Capital/Revenue

19 There are no specific implications as a result of this report however the implementation of the Strategy will bring with it opportunities to consider the best options for future spending on initiatives to help deliver potential savings in wider public sector budgets.

Property/Other

20 There are no specific implications as a result of this report.

LEGAL IMPLICATIONS

Statutory Power to undertake the proposals in the report:

21 Not Applicable

Other Legal Implications:

22 None

POLICY FRAMEWORK IMPLICATIONS

23 Changes as a result of the Health and Wellbeing Strategy will need to be reflected in the future Housing Strategy and potentially the Housing Revenue Account Business Plan.

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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)
NONE	

WARDS/COMMUNITIES AFFECTED:	All

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DECISION-MAKER:	SHADOW HEALTH AND WELLBEING BOARD
SUBJECT:	JOINT STRATEGIC NEEDS ASSESSMENTS AND JOINT HEALTH AND WELLBEING STRATEGIES – DEPARTMENT OF HEALTH PROPOSALS FOR CONSULTATION
DATE OF DECISION:	19TH SEPTEMBER 2012
REPORT OF:	DIRECTOR OF PUBLIC HEALTH
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) are about the NHS, local government and communities working together to improve health and wellbeing outcomes and reduce inequalities. The Department of Health has worked with stakeholders to develop and refine draft guidance to support health and wellbeing boards in preparing their JSNAs and JHWSs, and this has been published for consultation and the shadow board is invited to consider whether it wishes to identify any comments for passing back to the Department.

RECOMMENDATIONS:

(i) That the shadow board examines the draft guidance issued by the Department of Health in respect of Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies and indicates whether there are any comments it would wish to feed back in response to the consultation.

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the shadow Health and Wellbeing Board to respond to the consultation opportunity offered by the Department of Health.

DETAIL (Including consultation carried out)

2. The guidance aims to support boards and their partners by:

- Laying out the statutory duties, which underpin the undertaking of JSNAs and JHWSs by clinical commissioning groups (CCGs) and local authorities through health and wellbeing boards from April 2013.

- Explaining how JSNAs, JHWSs and commissioning plans fit together in the modernised health and care system.

- Setting out how an enhanced JSNA process and JHWS will enable the NHS and local government, working with their community and partner organisations, to make real improvements to the health and wellbeing of local people.

The text of the draft guidance is attached at Appendix 1. The Department of Health has indicated that responses should be submitted by Friday 28 September.

3. The guidance covers the following matters:

- Responsibility for producing JSNAs and JHWSs
- Defining JSNAs
- Defining JHWSs
- Using JSNAs and JHWSs
- Timing the production of JSNAs and JHWSs
- Promoting integration between services
- Working in partnership to carry out JSNAs and develop JHWSs
- Transparent and accountability
- Equalities issues

4. The revised guidance is only 5 pages in length. As such it summarises what is in the Act in respect of requirements for both JSNAs and JHWSs. In contrast to previous sets of DH guidance it does not attempt to set out how this is to be done in any substantial detail. This accords with the views expressed since the Bill was first presented to Parliament that the details of make to make things work locally are best determined at a local level.

5. The consultation questions are set out below, with officer comments included to prompt discussion between Board members.

1. Does the guidance translate the legal duties in a way which is clear in terms of enabling an understanding of what health and wellbeing boards, local authorities and CCGs *must* do in relation to JSNAs and JHWSs?

The duties set out in sections 192 and 193 of the Health and Social Care Act are summarised into plain English in the guidance. The summary table provides a useful point of reference for those bodies with responsibilities to plan for meeting their obligations.

2. It is the Department of Health's (DH's) view that health and wellbeing boards should be able to decide their own timing cycles for JSNAs and JHWSs in line with their local circumstances rather than guidance being given on this; and this view was supported during the structured engagement process. Does the guidance support this?

It is helpful that paragraph 3.5 of the draft guidance indicates that the JSNA and JHWS do not need to be started from scratch each year and they should be seen as part of a continuous process. The fact that Health Overview and Scrutiny Panels can hold the Board to account means that there is a check in the system to challenge the frequency with which these processes are either updated or re-drafted.

3. Is the guidance likely to support health and wellbeing boards in relation to the content of their JSNAs and JHWSs?

The guidance is very vague on detailed content. This could be a result of the Department of Health seeking to avoid being prescriptive. What is doesn't do is provide information on statutory sources of information that would be useful to include in a JSNA. It mentions qualitative information but offers no guidance on what might be included and how it might best be used. As to strategies, there is less guidance in relation to content compared with the earlier draft guidance published in January. Additional material that would be helpful in managing the expectations of others (not just the HWB) would be reference to it being a succinct document, and saying it meets some of the key needs identified in the JSNA.

It would be helpful if the values listed as underpinning good joint health and wellbeing strategies in the January 2012 draft guidance could be re-instated in the final iteration of the guidance, namely:

- 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,
- concentrate 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.

There could also be reference to the fact that both the JSNA and JHWS are likely to be tools that will inform difficult and challenging decommissioning decisions by the HWB.

Whilst there is limited reference to assets in the notes on page 14, the main body of the guidance would benefit from an explanation of the opportunities afforded by including data on assets in the JSNA, and the strategy setting out how specified assets can contribute to outcomes.

4. Does the guidance support the principle of joined-up working, between health and wellbeing board members and also between health and wellbeing boards and wider local partners in a way that is flexible and suits local circumstances?

Section 4 of the guidance does make the case for joined-up working. It is useful that it makes reference to other services that can contribute to health improvements.

As the wider resources referred to in question 5 are developed, case studies citing improved outcomes through joined-up working would be useful tools to assist boards members maximising the potential benefits of joined up working in their areas.

5. The DH is working with partners to develop wider resources to support health and wellbeing boards on specific issues in JSNAs and JHWSs, and equality is one theme being explored.

a) In your view, have past JSNAs demonstrated that equality duties have been met?

b) How do you think the new duties and powers, and this guidance will support health and wellbeing board members and commissioners to prevent the disadvantage of groups with protected characteristics, and perhaps other groups identified as in vulnerable circumstances in your area?

This and subsequent questions are not about providing feedback on the guidance, but cover wider issues. By both JSNA and JHWS being a process rather than a period event, it should be possible to identify trends which will indicated whether health inequalities are being addressed effectively addressed. However, the neither the Act, nor the guidance made the case as strongly as senior civil servants have done about the need to use the JHWS to tackle some of the extreme health inequalities experienced by some vulnerable and hard to reach groups.

6. a) In your view, have JSNAs in the past contributed to developing an understanding of health inequalities across the local area and in particular the needs of people in vulnerable circumstances and excluded groups?

b) What supportive materials would help health and wellbeing boards to identify and understand health inequalities?

If they contain the right data then the JSNA can contribute to an understanding of health inequalities and an analysis of the needs of vulnerable people and excluded groups. By definition these are not the easiest individuals to obtain reliable data on, so advice and best practice on how to obtain this could be useful.

7. It is the DH's view that health and wellbeing boards should make use of a wide range of sources and types of evidence for JSNAs and they should be able to determine the best sources to use according to local circumstances. This view was supported during the structured

engagement process. What supportive materials would help health and wellbeing boards to make the best use of a wide range of information and evidence to reach a view on local needs and assets, and to formulate strategies to address those needs?

Access to synopses of case studies which demonstrate improvements have been delivered through innovative use of information and evidence could provide a valuable resource for boards looking to maximise the value and benefit of data.

8. What do you think NHS and social care commissioners are going to do differently in light of the new duties and powers, and as a result of this guidance? – what do you think the impact of this guidance will be on the behaviour of local partners?

Overall, the guidance published for consultation is somewhat lightweight. It is the powers and duties in the Act, and local circumstances and relationships, rather than the guidance that will determine whether partners can deliver improved joined up working.

6. Several other helpful documents have also been published in support of the draft guidance. One of these is a tabulated summary if the powers and duties introduced by the Health and Social Care Act 2012 relevant to JSNAs and JHWSs. A copy of this document is attached at Appendix 2. Board members may find this a useful summary to share with their respective organisations.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

7. The shadow board could decide not to respond to the consultation.

RESOURCE IMPLICATIONS

Capital/Revenue

8. There are no direct financial implications arising from this report.

Property/Other

9. None.

LEGAL IMPLICATIONS

Statutory Power to undertake the proposals in the report:

10. The Health and Social Care Act 2012 establishes Health and Wellbeing Boards.

Other Legal Implications:

11. None.

POLICY FRAMEWORK IMPLICATIONS

12. None.

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SUPPORTING DOCUMENTATION

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

Appendices

1.	Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies – draft guidance *Proposals for consultation* (Department of Health)
2.	A summary table of the duties and powers introduced by the Health and Social Care Act 2012 relevant to JSNAs and JHWSs (Department of Health)

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)
NONE	

WARDS/COMMUNITIES AFFECTED:	All

Agenda Item 8

Appendix 1

Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies – draft guidance

Proposals for consultation

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	17858
Title	Draft Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies
Author	Department of Health
Publication Date	**31 July 2012**
Target Audience	NHS Trust CEs, Foundation Trust CEs , Directors of PH, Local Authority CEs, Directors of Adult SSs, Allied Health Professionals, GPs, Communications Leads, Directors of Children's SSs, Healthwatch England and local pathfinders, CCG pathfinders, shadow HWBs, voluntary and community sector organisations
Circulation List	
Description	The purpose of this publication is intended to support health and wellbeing boards and their partners in undertaking and contributing to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS) within the modernised health and care system.
Cross Ref	Joint Strategic Needs Assessments and joint health and wellbeing strategies explained. Equity and excellence: Liberating the NHS, Liberating the NHS: Legislative framework and next steps and The Government response to the NHS Future Forum report.
Superseded Docs	N/A
Action Required	N/A
Timing	**N/A**
Contact Details	Freya Lock People, Communities and Local Government LG05 Wellington House 133-155 Waterloo Road SE1 8UG 0207 972 4237
For Recipient's Use	

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www.dh.gov.uk/publications

Contents

1. Purpose

The Health and Social Care Act 2012[1] ('the Act') amends the Local Government and Public Involvement in Health Act 2007 ('the 2007 Act') to introduce duties and powers for health and wellbeing boards in relation to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs). This statutory guidance explains these duties and powers. Further materials, including advice on good practice will be published with this statutory guidance to support health and wellbeing boards.

2. Context

In the Act, the Government has set out a new vision for the leadership and delivery of public services – that decisions about services should be made as locally as possible, involving people who use them and the wider local community. The Act supports local clinical leadership and democratically elected leaders working together to deliver the best health and care services based on the best evidence of local needs. JSNAs and JHWSs are an important means by which they can achieve this.

The aim of JSNAs and JHWSs is to improve the health and wellbeing of the local community and reduce inequalities for all ages. They are not an end in themselves, but a continuous process of strategic assessment and planning. They will be used to help to determine what actions local authorities, the NHS and other partners need to take to meet health and social care needs and to address the wider determinants that impact on health and wellbeing[2].

3. Duties and powers under the 2007 Act (as amended by the Act)[3]

3.1 Who is responsible for JSNAs and JHWSs?

Local authorities and clinical commissioning groups (CCGs) have an equal and joint duty to prepare JSNAs and JHWSs, through the health and wellbeing board[4]. The responsibility falls on the health and wellbeing board as a whole and so success will depend upon all members[5] working together throughout the process.

Two or more health and wellbeing boards could choose to work together to produce JSNAs and JHWSs, covering their combined geographical area[6].

Local authorities and health and wellbeing boards can decide to include additional members on the board beyond the core members[7]. Additional members, such as service providers, health and care professionals, representatives of criminal justice agencies, local voluntary and community sector organisations, or representatives of military populations and their families, can bring expert knowledge to enhance JSNAs and JHWSs.

The NHS Commissioning Board (NHS CB) must participate in JSNAs and JHWSs. Someone who is not from the NHS CB can act for it. This could be someone from a clinical CCG, if the health and wellbeing board agrees[8].

3.2 What are Joint Strategic Needs Assessments (JSNAs)?

JSNAs are local assessments of current and future health and social care needs that could be met by the local authority, CCGs, or the NHS CB[9]. They are produced by health and wellbeing boards[10], and are unique to each local area.

In preparing JSNAs and JHWSs, health and wellbeing boards must have regard to any guidance issued by the Secretary of State[11]. This includes this guidance, and any future guidance issued.

A range of quantitative and qualitative evidence should be used in JSNAs. They can also be informed by more detailed local needs assessments such as at a district or ward level, looking at specific groups (such as those likely to have poor health outcomes), or on wider issues that affect health such as crime, community safety, planning or housing. Health and wellbeing boards can request relevant information from some members (and others)[12] when preparing JSNAs or JHWSs – and those asked have a duty to supply the information. They should ensure that staff supporting JSNAs and JHWSs have easy access to the evidence they need.

JSNAs must consider health and social care needs for the health and wellbeing board area. This includes mental health, health protection, and prevention; it could include looking at the role of personal budgets and universal advice. Therefore health and wellbeing boards will need to consider:

- the needs of the whole community including how needs vary for people at different ages, and may be harder to meet for those in disadvantaged areas or vulnerable groups who experience inequalities, such as people who find it difficult to access services;
- wider social, environmental and economic factors that impact on health and wellbeing – such as access to green space, air quality, housing, community safety, employment; and
- what health and social care information the local community needs, including how they access it and what support they may need to understand it.

Within JSNAs, health and wellbeing boards should also consider what local communities can offer in terms of assets and resources[13] to help meet the identified needs.

3.3 What are Joint Health and Wellbeing Strategies (JHWSs)?

JHWSs are strategies for meeting the needs identified in JSNAs[14]. As with JSNAs, they are produced by health and wellbeing boards[15], and are unique to each local area. They should explain what health and wellbeing priorities the health and wellbeing board has set in order to tackle the needs identified in their JSNAs. This is not about taking action on everything at once, but about setting priorities for joint action and making a real impact on people's lives.

Outcome measures from the separate NHS, Adult Social Care and Public Health Outcomes Frameworks, the Commissioning Outcomes Framework and outcome strategies, will be useful to help inform joint priorities, although they should not overshadow local evidence.

In preparing JHWSs, health and wellbeing boards must have regard to the Secretary of State's mandate[16] to the NHS CB[17].

3.4 Using JSNAs and JHWSs

JSNAs and JHWSs are fundamental to the new system because of how they are used, and the evidence base they provide for the planning of services.

CCGs, the NHS CB, and local authorities' plans for commissioning services must be informed by JSNAs and JHWSs. Where plans are not in line with JSNAs and JHWSs, CCGs, the NHS CB and LAs must be able to explain why[18].

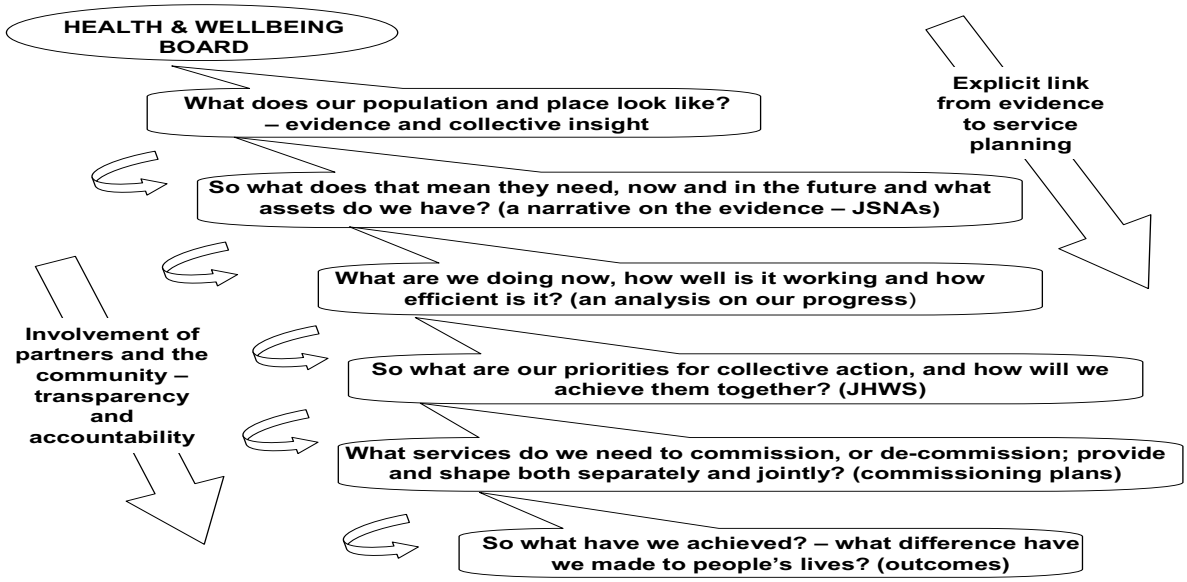
CCGs must also involve the health and wellbeing board in the preparation of (or when making significant changes to) their commissioning plans[19]. CCGs must consult health and wellbeing boards on whether their commissioning plans take proper account of the JHWSs[20]. When asked, health and wellbeing boards must give a view on this, which must be included in the published plan[21]. It would be good practice for local authorities and the NHS CB to also involve health and wellbeing boards when developing their plans for commissioning to make sure that each plan is informed by the JHWS. By their nature, commissioning plans will need to cover a broad range of services – inclusion of plans for services which meet needs in addition to those prioritised in the JHWS does not in itself mean the plans do not take account of the JHWS

If a health and wellbeing board thinks that a CCG has not taken proper account of the relevant JHWSs it can make this known in very clear and certain terms to the CCG, and also to the NHS CB[22]. As mentioned above, the CCG must be able to justify any parts of their plans which are not consistent. The NHS CB can take action if it believes that the plan is not in line with the JHWS, without a good reason[23].

Under the Act, upper-tier local authorities are required to work to improve the health of their populations[24]. This duty is an opportunity for local authorities to embed health improvement in all policy- and decision-making, which will also help address needs identified in JSNAs and priorities agreed in JHWSs.

If the health and wellbeing board does not believe that a local authority has taken account of the JSNAs or JHWSs, it can raise its concerns with the local authority[25].

Figure 1 – How JSNAs, JHWSs and commissioning plans fit together



3.5 Timing

JSNAs and JHWSs are continuous processes, and are an integral part of CCG and local authority commissioning cycles [26]. Health and wellbeing boards will need to decide for themselves when to update JSNAs and JHWSs or undertake fresh ones to ensure that they are able to inform local commissioning plans over time - JSNAs and JHWSs do not need to be done from scratch every year.

4. Promoting integration between services

JHWSs can help health and social care services to be joined up with each other and with health-related services[27], such as housing, the economy or the environment.

Health and wellbeing boards must encourage integrated working between health and social care commissioners, and support and encourage partnership arrangements for health and social care services[28], such as pooled budgets, lead commissioning, or integrated provision[29]. In JHWSs, health and wellbeing boards must consider how far needs can be met more effectively by working together in this way[30].

Health and wellbeing boards can encourage close working between commissioners of health-related services and themselves; and commissioners of health and social care services[31]. This could potentially involve considering the commissioning of health-related services either with or by a broad range of local partners, such as district councils, local authority housing commissioners, local community safety partnerships, Police and Crime Commissioners, local probation trusts, prisons, children's secure estates and schools. In this way health and wellbeing boards can use the priorities agreed in JHWSs to influence other services that also affect health to improve outcomes and also to encourage the integration of services.

The NHS CB must encourage partnership arrangements between CCGs and local authorities[32] where it considers this would ensure the integrated provision of health services and that this would improve the quality of services or reduce inequalities[33] and CCGs must integrate services to achieve this, where possible. This should help encourage joint working between CCGs and local authorities in order to tackle the priorities jointly agreed in JHWSs.

The Act supports joint working by allowing local authorities to delegate functions to the health and wellbeing board[34]. This could result in health and wellbeing boards taking on health-related functions, such as preparing housing strategies, which could help in tackling the agreed local priorities. To avoid potential conflicts of interest the power of delegation does not include health scrutiny functions[35]. Health scrutiny is an important way that the local authority (and through it, local people) can hold some health and wellbeing board members to account for delivering health services, or consider how the JSNA and JHWS process is used to plan services.

JHWSs could consider how services might be reshaped and redesigned to address needs identified in JSNAs and reduce inequalities. Using local JSNA evidence and agreed JHWS priorities means local service change plans will complement other local commissioning, and this will encourage greater integration across health and social care services.

5. Working in partnership to carry out JSNAs and develop JHWSs

Health and wellbeing boards for county councils must involve the relevant district councils in developing JSNAs[36]. They should seek to work with district councils when preparing JHWSs and to agree with district councils how they will do this.

Health and wellbeing boards must involve the local Healthwatch organisation[37] and the local community[38], and this should be continuous throughout the JSNA and JHWS process. When involving the local community, health and wellbeing boards should consider inclusive ways to involve people from different parts of the community to ensure that differing health and social care needs are reflected and can be addressed by commissioners, recognising the need to engage with parts of the community that are socially excluded and vulnerable[39].

Health and wellbeing boards should also work closely with other partners such as Police and Crime Commissioners, criminal justice agencies, youth justice services, troubled families co-ordinators, local authority housing services, schools, voluntary and community organisations, Local Nature Partnerships, representatives of military populations and their families; and Department for Work and Pensions local partnership teams[40], to get a thorough understanding of local needs and how to address them.

Local Healthwatch and the voluntary and community sector (including organisations that represent specific groups) can provide information to help JSNAs better reflect the needs and views of people in vulnerable circumstances and this can support the development of a JHWS to meet those needs. Most local areas will have a Compact agreement[41] setting out how local authorities and the NHS will work with voluntary and community organisations for mutual benefit and these should be considered during the process.

Service providers[42] can also provide important evidence about local needs and take action to improve outcomes, although health and wellbeing boards will need to consider how any conflicts of interest will be managed.

6. Transparency and accountability

JSNAs and JHWSs must be published[43]. Making them public will explain to the local community what the health and wellbeing board's assessment of the local needs and assets is and what their proposals to address them are, with clear measures of progress over time. It will also show what evidence has been considered, what priorities for action have been agreed and why. The publication should include a summary of community views, how they have been used; and also whether any other relevant views have been considered.

Sharing the analysis behind JSNAs, and (if appropriate) safely making the data they have used accessible, will help health and wellbeing boards make their decision-making process transparent to their community and to be held to account[44].

7. Other duties

As a local authority committee, a health and wellbeing board must meet the Public Sector Equality Duty under the Equality Act 2010 throughout the JSNA and JHWS process. This is not just about how the community is involved, but about considering the effects decisions have or are likely to have on people with protected equality characteristics[45], and perhaps other groups identified as vulnerable in JSNAs. Integrating equality considerations into the JSNA and JHWS process, can help public sector organisations to discharge their responsibilities under the Public Sector Equality Duty[46].

Preparing JSNAs and JHWSs can support other legal duties, for example, in relation to the reduction of crime (including antisocial behaviour)[47]. They can also contribute to other local partnerships such as Community Safety Partnerships (CSPs)[48] or where they exist, Local Enterprise Partnerships (LEPs)[49].

8. Conclusion

By having full engagement of all health and wellbeing board members, wider local partners and the local community, JSNAs will provide a unique picture of local needs and assets. By agreeing joint local priorities in JHWSs to inform joint action to tackle these needs, health and wellbeing boards will be able to lead action to improving people's lives and reduce inequalities.

9. Consultation Questions

1. Does the guidance translate the legal duties in a way which is clear in terms of enabling an understanding of what health and wellbeing boards, local authorities and CCGs *must* do in relation to JSNAs and JHWSs?

2. It is the Department of Health's (DH's) view that health and wellbeing boards should be able to decide their own timing cycles for JSNAs and JHWSs in line with their local circumstances rather than guidance being given on this; and this view was supported during the structured engagement process. Does the guidance support this?

3. Is the guidance likely to support health and wellbeing boards in relation to the content of their JSNAs and JHWSs?

4. Does the guidance support the principle of joined-up working, between health and wellbeing board members and also between health and wellbeing boards and wider local partners in a way that is flexible and suits local circumstances?

5. The DH is working with partners to develop wider resources to support health and wellbeing boards on specific issues in JSNAs and JHWSs, and equality is one theme being explored.
a) In your view, have past JSNAs demonstrated that equality duties have been met?
b) How do you think the new duties and powers, and this guidance will support health and wellbeing board members and commissioners to prevent the disadvantage of groups with protected characteristics, and perhaps other groups identified as in vulnerable circumstances in your area?

6. a) In your view, have JSNAs in the past contributed to developing an understanding of health inequalities across the local area and in particular the needs of people in vulnerable circumstances and excluded groups?
b) What supportive materials would help health and wellbeing boards to identify and understand health inequalities?

7. It is the DH's view that health and wellbeing boards should make use of a wide range of sources and types of evidence for JSNAs and they should be able to determine the best sources to use according to local circumstances. This view was supported during the structured engagement process. What supportive materials would help health and wellbeing boards to make the best use of a wide range of information and evidence to reach a view on local needs and assets, and to formulate strategies to address those needs?

8. What do you think NHS and social care commissioners are going to do differently in light of the new duties and powers, and as a result of this guidance? – what do you think the impact of this guidance will be on the behaviour of local partners?

9. How do you think your local community will benefit from the work of health and wellbeing boards in undertaking JSNAs and JHWSs? – what do you think the impact of this guidance will be on the outcomes for local communities?

10. Have your say

The Government has committed to publishing guidance on enhanced JSNAs and JHWSs which are to be undertaken by health and wellbeing boards. The Government wants to hear your views on whether this draft guidance supports health and wellbeing boards, and their partners in understanding the purpose of JSNAs and JHWSs, and the duties and roles of health and wellbeing boards in undertaking them.

Deadline for comments

This is an eight-week consultation running from **31 July 2012** to **28 September 2012**. In order to be considered all comments must be received by **28 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.

The eight-week consultation period (which is shorter than the full 12-week period set out in the HMGovernment Code of Practice on Consultation) is because the Government has developed the current draft in collaboration with emerging health and wellbeing boards and undertook a structured engagement exercise during January and February of this year. Over 100 responses were received as a result of the exercise and the draft guidance has been revised to reflect these.

Shadow health and wellbeing boards, once established, will want to consider and prepare for carrying out JSNAs and JHWSs ready for April 2013, when the relevant provisions of the Health and Social Care Act 2012 will come into effect. An eight-week consultation will allow the Government to publish the final guidance in time to support preparations for April 2013.

Consultation timeline

31 July	Consultation document published
28 September	Consultation ends – responses must be returned to the Department of Health by this date
Autumn 2012	Final guidance document and response to consultation published

How to respond

Please submit your responses online at JSNAs and JHWSs draft statutory guidance consultation or by email to JSNAandJHWS@dh.gsi.gov.uk

OR

By hard copy to
JSNA and JHWS development lead
People, Communities and Local Government,
Department of Health
Wellington House
133-155 Waterloo Road
London
SE1 8UG

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 members were assembled.

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

If you want the information that you provide to be treated as confidential, please be aware that, under the FOI Act, there is a statutory Code of Practice with which public authorities must comply, and which deals, among other things, with obligations of confidence. In view of this, it would be helpful if you could explain to use 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 confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

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

Criteria for consultation

This consultation follows the 'Government Code of Practice', in particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome
- consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible
- be clear about the consultation's 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.

The full text of the code of practice is on the Better Regulation website at:
Link to consultation Code of Practice

After the consultation

Once the period is complete, the Department of Health will consider the comments it has received, and the response will be published alongside the final guidance.

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:

Link to DH Consultations

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please

Contact Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds
LS2 7UE
E-mail consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

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

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).

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 confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

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.

Impact assessment

The impact assessment which accompanied the Health and Social Care Bill assesses the costs, benefits and risks of the enhanced JSNA process and the new duty to develop JHWSs. This guidance, which supports health and wellbeing boards and their partners in undertaking and contributing to JSNAs and JHWSs, will help to support the realisation of the costs and benefits set out in this impact assessment.

[1] The relevant parts of which are expected to come into force on 1 April 2013.
[2] More information can be found in *Fair Society, Healthy Lives (the Marmot Review)*, 2010
[3] The duties required by, and the powers conferred by the Act, the 2007 Act (as amended by the Act), and the NHS Act 2006 (as amended by the Act) relating to the preparation of JSNAs and JHWSs are summarised and referenced throughout. Where 'must' is used, this indicates something required by one or other of the Acts. Where 'can' is used, this indicates a power in one or other of the Acts. Where 'could' is used, this indicates an example of how that power could be used if appropriate. Where 'should' is used it indicates something that is statutory guidance – something that is not required by the Acts, but it is recommended in order to achieve the spirit of the Acts or in accordance with sector-led best practice, and to which there is a statutory duty to have regard.
[4] The 2007 Act – section 116 (as amended by the Act – section 192) and section 116A (as inserted by the Act – section 193); and the Act – section 196.
[5] The Act – section 194: each upper tier local authority in England must set up a health and wellbeing board, with a core membership of: a) at least one elected representative – councillor(s) nominated by the leader or the mayor of the local authority (and / or the leader or mayor themselves), or in some cases by the local authority; b) a representative of each clinical commissioning group (CCG) whose area is within or partly within, or coinciding with the local authority area – CCGs may be required to appoint representatives to more than one health and wellbeing board if their area falls within more than one local authority area; c) the directors of public health, adult social services, and children's services; and d) a representative of the local Healthwatch organisation.
[6] The Act – section 198(a) allows two or more health and wellbeing boards to make arrangements for any of their functions to be exercised jointly.
[7] 'Core members' is a reference to the members in the Act (section 194) – see Footnote 4. A local authority or health and wellbeing board can appoint other members to the board.
[8] The duty on the NHS CB to appoint a representative to participate in JSNAs and JHWSs is in section 197(1) and (2) of the Act. Section 197(5) provides that the representative may be someone who is not a member or employee of the NHS CB, with the health and wellbeing board's agreement.
[9] The 2007 Act – section 116 (as amended by the Act – section 192).
[10] The duty falls on local authorities and CCGs but must be discharged by health and wellbeing boards (the Act – section 196(1)). Where the guidance refers to something that health and wellbeing boards must do in relation to JSNAs, the source of this is a duty imposed on the local authority and CCG.
[11] The 2007 Act – section 116 (as amended by the Act – section 192) and section 116A (as inserted by the Act – section 193).
[12] The Act – section 199. Health and wellbeing boards have the power to request information from the local authority, or the CCGs and local Healthwatch organisations represented on the board. They also have the power to request information from members, or those organisations represented by members other than the core members. The request must be made in order to enable or assist health and wellbeing boards to perform their functions – in this context, to enable or assist health and wellbeing boards to undertake JSNAs and JHWSs.
[13] There are a range of assets within local communities that can help meet identified needs and impact on the wider determinants of health. These could include formal or informal resources, capacity in other organisations or the community; such as the ability of groups to take greater control of their own health or manage long-term conditions. Supporting communities and encouraging people to improve their health and wellbeing is central to achieving the Government's vision. Strong communities can improve health and wellbeing, and reduce inequalities *(Foot, J., What makes us healthy? The asset-based approach in practice: evidence, action, evaluation, 2012).* There are a number of methods being developed, (Local Area Co-ordination, Connected Care or Asset-Based Community Development) – these examples may be useful to health and wellbeing boards.
[14] The 2007 Act – section 116A (as inserted by the Act – Section 193).
[15] The duty falls on local authorities and CCGs but must be discharged by health and wellbeing boards (the Act – section 196(1)). Where the guidance refers to something that health and wellbeing boards must do in relation to JHWSs, the source of this is a duty imposed on the local authority and CCG.
[16] This is currently being consulted on.
[17] The 2007 Act – section 116A (as inserted by the Act – section 193).
[18] The 2007 Act – section 116B (as inserted by the Act – section 193) requires local authorities and CCGs, in exercising any functions and the NHS CB, in exercising its commissioning functions in relation to the local area, to have regard to any JSNA and JHWS which is relevant to the exercise of those functions.
[19] The NHS Act 2006 – section 14Z13 inserted by section 26 of the Act. The duty on the CCG is to involve each relevant health and wellbeing board. A relevant health and wellbeing board, in relation to a CCG, is one which is established by a local authority whose area coincides with, or includes the whole or any part of, the area of the CCG – the NHS Act 2006 - section 14Z11 (as inserted by the Act - section 26).

[20] The NHS Act 2006 – section 14Z13 inserted by section 26 of the Act. The duty on the CCG is to consult each relevant health and wellbeing board on whether the draft commissioning plan takes proper account of each JHWS published by the board which relates to the period (or any part of the period) to which the plan relates..
[21] The NHS Act 2006 – section 14Z13 (as inserted by section 26 of the Act). The CCG must include a statement of the final opinion of each relevant health and wellbeing board consulted upon publication of the plan
[22] The NHS Act 2006 – section 14Z13 (as inserted by the Act - section 26).
[23] Action could be taken if the NHS CB has reason to believe that the CCG might fail, have failed, be failing to discharge any of its functions. It could require documents, information or an explanation (the NHS Act 2006 – sections 14Z18 or 14Z19).
[24] The NHS Act 2006 – section 2B (as inserted by the Act - section 12).
[25] The Act – section 196.
[26] The NHS Act 2006 – sections 14Z1 and 14Z24 (as inserted by of the Act – section 26). CCGs must develop commissioning plans to be in place before the beginning of each financial year (or before a date directed by the NHS CB as regards the financial year of establishment) and most local authorities also plan yearly.
[27] The 2007 Act – section 116A (as inserted by the 2012 Act – section 193). Health-related services are those that are not health or social care services, but may have an effect on health outcomes, as defined in the Act – section 195; such as transport, planning or environmental services insofar as they may have an effect on health.
[28] The Act – section 195.
[29] The NHS Act 2006 – section 75.
[30] The 2007 Act – section 116A (as inserted by the Act – section 193).
[31] The Act – section 195.
[32] And also between CCGs where this would lead to improvements and integrated services, which may be prioritised in JHWSs. The NHS Act 2006 - section 13N (as inserted by the Act – section 23).
[33] The NHS Act 2006 – section 13N (as inserted by the Act – section 23). This also applies where the NHS CB considers that partnership arrangements would lead to integrated provision of health services with social care or health-related services, and that this would improve the quality of services or reduce inequalities.
[34] The Act – section 196.
[35] The Act – section 196.
[36] The 2007 Act – section 116 (as amended by the Act – section 192).
[37] The 2007 Act – section 116 (as amended by the Act – sections 192) and section 116A (as inserted by the Act – section 193). The duty to involve the local Healthwatch organisation for the area is separate to (ie, not discharged only by) local Healthwatch being represented on the health and wellbeing board.
[38] The 2007 Act – section 116 (as amended by the Act – sections 192) and section 116A (as inserted by the Act – section 193). The duty to involve the local community is a requirement to involve the people who live or work in the area, and does not distinguish between children and adults.
[39] Such as people with disabilities, homeless people, offenders, victims of crime, or Gypsies and Travellers.
[40] Serving both working age (through Jobcentres), and pension age clients.
[41] More information is provided by Compact Voice.
[42] For instance Foundation Trusts, care homes; and providers of domiciliary care services.
[43] The 2007 Act – section 116 (as amended by the Act – section 192) and section 116A (as inserted by the Act – section 193).
[44] Government Open Data policies provide more information.
[45] This includes age, disability, gender reassignment, pregnancy and maternity, race (includes ethnic or national origins, colour or nationality), religion or belief (includes lack of belief), sex, and sexual orientation.
[46] As public authorities, both local authorities and CCGs have general and specific duties under the Equality Act 2010, designed to integrate consideration of advancing equality; eliminating discrimination and fostering good relations into the day-to-day business of public authorities; and to help them improve their performance on the general equality duty by improving their focus and transparency. These duties will apply to health and wellbeing boards as a committee of the local authority, including when discharging functions on behalf of the local authority and CCGs. Local authorities remain responsible for ensuring that the general and specific equality duties are met.
[47] The Crime and Disorder Act 1998 ('the 1998 Act') – section 6 places a statutory duty on responsible authorities (including local authorities, the Police, Probation Trusts, Fire and Rescue Authorities, and from April 2013 CCGs) to formulate and implement strategies for the reduction of crime and disorder (including anti-social behaviour); for combating the misuse of drugs, alcohol and other substances; and for the reduction of reoffending.
[48] CSP is a term used to refer to the group of responsible authorities under section 5 of the 1998 Act which have duties to prepare the strategies referred to in footnote 50. From April 2013 CCGs will replace PCTs as responsible authorities due to amendments made to section 5 of the 1998 Act by the Act – Schedule 5 paragraph 84. They offer a way for all partners to focus on improving health and wellbeing, and crime outcomes together.
[49] LEPs are non-statutory partnerships between local authorities and business, – *Local Growth White Paper*, 2010

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Department of Health

A summary table of the duties and powers introduced by the Health and Social Care Act 2012 relevant to JSNAs and JHWSs

LOCAL DEMOCRATIC LEGITIMACY – POWERS AND DUTIES	CCGs	Local Authority	NHS Commissioning Board	Local Healthwatch	Health and Wellbeing Board
Establishment and membership of health and wellbeing board					
Representation or participation to Health and Wellbeing Board (HWB)	X (those whose areas fall within or overlap with local authority area)	X^	X (participation in JSNA and JHWS and when requested by the board)	X	
Power to appoint additional members to the board as deemed appropriate		X (with duty to consult HWB if appointing after establishment)			X
Power for two or more HWBs to exercise their functions jointly					X
Functions of health and wellbeing board					
Duty to cooperate with the HWB in the exercise of its functions	X				
Power for HWB to request information for the purposes of enabling or assisting its performance of functions from: • the local authority • certain members or those they represent with a duty to provide	X (duty to provide)	X (duty to provide)		X (duty to provide)	X (power to request)

LOCAL DEMOCRATIC LEGITIMACY – POWERS AND DUTIES	CCGs	Local Authority	NHS Commissioning Board	Local Healthwatch	Health and Wellbeing Board
Duty to prepare assessment of needs (JSNA) in relation to LA area and have regard to guidance from Secretary of State.	X*	X*	X (to participate)		X
Duty to prepare a JHWS for meeting needs included in JSNA in relation to LA area and to have regard to guidance from Secretary of State	X*	X*	X (to participate)		X
Duty to involve third parties in preparation of the JSNA: • Local Healthwatch • people living or working in the area • for County Councils – each relevant DC	X*	X*			X
Duty to involve third parties in preparation of the JHWS: • Local Healthwatch • people living or working in the area	X*	X*			X
Power to consult any persons it thinks appropriate in preparation of the JSNA	X*	X*			X
Duty to have regard to the NHS Commissioning Board mandate in developing the JSNA and JHWS	X*	X*			X
Duty to consider flexibilities under NHS Act 2006 when developing JHWS	X*	X*			X
Duty to publish the JSNA	X*	X			
Duty to publish the JHWS	X*	X			

LOCAL DEMOCRATIC LEGITIMACY – POWERS AND DUTIES	CCGs	Local Authority	NHS Commissioning Board	Local Healthwatch	Health and Wellbeing Board
Power to include in the JHWS a statement of views on how the commissioning of health and social care services, and wider health-related services**, could be more closely integrated – i.e. the ability for the JHWS to look more broadly than health and social care in relation to closer integration of commissioning	X*	X*			X
Power to delegate any local authority function (except scrutiny) to the HWB		X			X (to exercise the delegated function)
Impact of duties on other associated functions					
Duty to have regard to relevant JSNA and JHWS in the exercise of relevant functions	X [in exercising any functions]	X [in exercising any functions]	X [in exercising any relevant commissioning functions]		
Duty to encourage integrated working: • between commissioners of health services and commissioners of social care services • in particular to provide advice, assistance or other support for the purpose of encouraging use of flexibilities under NHS Act 2006					X
Power to encourage close working (in relation to wider determinants of health): • between itself and commissioners of health-related services • between commissioners of health services or social care services and commissioners of health-related services					X

LOCAL DEMOCRATIC LEGITIMACY – POWERS AND DUTIES	CCGs	Local Authority	NHS Commissioning Board	Local Healthwatch	Health and Wellbeing Board
Alignment of commissioning plans					
Power of the HWB to give its opinion to the local authority which established it on whether the authority is discharging its duty to have regard to relevant JSNA and JHWS					X
Duty to involve HWB in preparing or significantly revising the commissioning plan – including consulting it on whether the plan has taken proper account of the relevant JHWS	X				X
Duty to provide opinion on whether the commissioning plan has taken proper account of the JHWS					X
Power to also write to NHSCB with that opinion on the commissioning plan (copy must also be supplied to the relevant CCG)					X
Duty to include a statement of the final opinion of the relevant HWB in the published commissioning plan	X				
Power to provide NHSCB with opinion on whether a published commissioning plan has taken proper account of the JHWS (copy must also be supplied to the relevant CCG)					X
Duty to review how far the CCG has contributed to the delivery of any JHWS to which it was required to have regard and to consult HWB on this	X				X
Duty in conducting the performance assessment, to assess how well CCG has discharged duty to have regard to JSNA and JHWS and to consult HWB on its view on CCGs' contribution to delivery of any JHWS to			X		X

LOCAL DEMOCRATIC LEGITIMACY – POWERS AND DUTIES	CCGs	Local Authority	NHS Commissioning Board	Local Healthwatch	Health and Wellbeing Board
which it was required to have regard (when conducting its annual performance assessment of the CCG)					
Other duties, which can be contributed to through the JSNA and JHWS					
Duty to exercise functions with a view to securing continuous improvement in quality of services	X				
Duty to act with a view to secure continuous improvement in outcomes achieved	X				
Duty to exercise functions with regard to need to reduce inequalities between patients in outcomes and access to services	X		X		
Duty to when exercising their functions promote the involvement of patients, their carers and representatives in decisions about the provision of health services to the patient	X				
Duty to when exercising their functions promote innovation in the provision of health services	X				
Duty to exercise functions with a view to securing integration in the provision of health services, and the provision of health and social care services, or health and health-related services, to improve the quality of the services or reduce inequalities between patients in outcomes of and or access to, services	X		X		

X*- duty must be discharged via HWB
X^ - this includes the directors of adult social services, children's services, public health and elected representatives nominated by the Leader, Mayor or in some cases the local authority itself
*** - "health services", "health-related services" and "social care services" are defined in s.195 of the Health and Social Care Act 2012:

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


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DECISION-MAKER:	SHADOW HEALTH AND WELLBEING BOARD
SUBJECT:	DEVELOPMENT OF HEALTHWATCH SOUTHAMPTON
DATE OF DECISION:	19TH SEPTEMBER 2012
REPORT OF:	DIRECTOR OF HEALTH AND ADULT SOCIAL CARE
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

This report summarises the development of Healthwatch Southampton, which is to be "the independent consumer champion for the public – locally and nationally - to promote better outcomes in health and social care for all". It summarises the duties of local Healthwatch, the stakeholder engagement undertaken and the process for securing Healthwatch in Southampton.

RECOMMENDATIONS:

(i) That the shadow Health and Wellbeing Board notes the progress being made to establish Healthwatch Southampton

REASONS FOR REPORT RECOMMENDATIONS

1. To update the shadow Health and Wellbeing Board on the progress being made to establish Healthwatch Southampton.

DETAIL (Including consultation carried out)

2. The Health and Social Care Act 2012 requires local authorities to establish Healthwatch for their areas. It is to be the independent voice of the patient and public on health and social care issues. The main functions to be delivered by local Healthwatch are:-

- Making the views and experiences of people known to Healthwatch England helping it to carry out its role as national champion;
- Making recommendations to Healthwatch England to advise the Care Quality Commission to carry out special reviews or investigations into areas of concern;
- Promoting and supporting the involvement of people in the monitoring, commissioning and provision of local care services;
- Obtaining the views of people about their needs for and experience of local care services and make those views known to those involved in the commissioning, provision and scrutiny of care services; and
- Making reports and make recommendations about how those services could or should be improved.

- Being represented on the Health and Wellbeing Board

- Providing information and advice to the public about accessing health and social care services and choice in relation to aspects of those services.

3. Much of this continues the core activities undertaken by Southampton Local Involvement Network (LINk) over recent years, but with significant additional functions. A key ambition is to carry forward as many volunteers who have contributed to LINk to local Healthwatch and secure their continuing contribution. The establishment of Healthwatch England as a national champion within the Care Quality Commission aims to provide the voice direct to government. Healthwatch England has developed a branding that is to be licensed to local Healthwatch. This should create a recognisable brand, with a service behind it tailored to local needs.

4. A series of engagement events were held in the spring to ascertain the views and expectations of the public and key stakeholders on how they thought local Healthwatch could work best for them. Some of the key issues to come out of these sessions included:

   - The importance of ensuring Healthwatch Southampton is a service rooted in Southampton, representing the whole of the city and reflecting the views of excluded and hard to reach groups
   - Connecting to, but not duplicating, other engagement, signposting and information services
   - Realistically managing expectations of what it can deliver
   - Being truly independent, with both paid staff and volunteers delivering outcomes
   - The ability to operate and offer support at a community level
   - Effectively marketing local Healthwatch to ensure it is well known across the city
   - Having a sound governance framework to make Healthwatch Southampton transparent, accountable and autonomous, with roles and responsibilities clearly defined.

5. One of the functions of interest to the Board relates to the fact that a representative of local Healthwatch must be appointed to the Health and Wellbeing Board. This is a key role, as local Healthwatch will have a major role to play ensuring the views of the public and patients are taken into account when the Board takes decisions. At the same time, the Healthwatch representative will be held to account for their role in the Board's key strategic and commissioning decisions. A person specification for this role has been developed to allow local Healthwatch to appoint an individual with the necessary skills and competencies. In order to avoid any conflict of interest that person will not be permitted to take any position on the Health Overview and Scrutiny Panel, which will be holding the HWB to account.

6. Another duty the Act places on local authorities is securing an advocacy service for complaints against the NHS. This can be part of local Healthwatch, or delivered as a separate service. It will replace the existing Independent Complaints Advocacy Service, which is commissioned by the Department of Health on a regional basis. This is a specialist service which differs in nature to the other advocacy services commissioned by the council. Discussions are currently taking place with a group of both unitary and county councils in south east England to try and secure a cross boundary service. Because of the scale of the service within city, it has been considered commissioning a service with other authorities will add resilience in the event of events such as staff sickness or an unexpected increase in complaints activity.

7. The provision of advice, information and signposting services will be shaped to avoid duplication of existing services. The engagement exercise revealed a multiplicity of information sources, many of which are providing a very successful support. The PCT cluster is commissioning a new 111 information service for health issues, and the Care and Support Bill published in the summer will require the publication of additional information on social care services and care providers. The main point that came up from consultation was that people need advice on who they need to contact for advice and support, and that this support is often needed at times of diagnosis or crisis.

8. A series of activities are currently underway to secure the best possible Healthwatch service for Southampton. A LINk legacy project is ensuring the outcomes from LINk and the experiences of LINk members are properly documented. This will provide a resource for local Healthwatch and enable it to have a clear focus on issues which have been of concern to the public, have a written knowledge of the outcomes from the LINk, and an understanding of the challenges LINk has faced during its existence. A second project is attempting to identify and bring together potential providers, to enable them to decide whether they are in a position to tender to establish Healthwatch Southampton, or whether they would wish to try and establish some sort of consortium arrangement whereby they might wish to work with another organisation with complementary strengths.

9. A specification for Healthwatch Southampton is being finalised and a tender process will then be undertaken to secure a provider. Healthwatch Southampton will then be established as a social enterprise. A final announcement on the funding for Healthwatch is expected from the Department of Health in December 2012. The funding is not ring-fenced and the local funding arrangements will be determined through the council's budget setting process.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

10. None. The Health and Social Care Act 2012 places a duty on the council to establish Healthwatch Southampton.

RESOURCE IMPLICATIONS

Capital/Revenue

11. The final announcement on the Department of Health funding for local Healthwatch is expected in December 2012. Previously published documentation giving indicative funding levels suggests a total allocation to Southampton in the region of £250,000. However, this sum is not ring-fenced and the final sum allocated to Healthwatch Southampton will be determined as part of the 2013/14 budget setting process.

Property/Other

12. None.

LEGAL IMPLICATIONS

Statutory Power to undertake the proposals in the report:

13. The duties to establish local Healthwatch and the functions for local Healthwatch are set out in sections 182 – 189 of the Health and Social Care Act 2012.

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)
NONE	

WARDS/COMMUNITIES AFFECTED:	All