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Shadow Health and Wellbeing Board

Wednesday, 21st November, 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

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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

Proposed Municipal Year Dates

2012	2013
21 November	23 January
	27 March
	29 May
	31 July
	25 September
	27 November

Access – Access is available for disabled people. 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 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

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

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

3 STATEMENT FROM THE CHAIR

4 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 19th September 2012 and to deal with any matters arising, attached.

5 REDUCING ADMISSIONS TO HOSPITAL FROM PREVENTABLE CAUSES OF PHYSICAL AND MENTAL ILL HEALTH

Report of the Chair of the Clinical Commissioning Group detailing the reduction of admissions to hospital from preventable causes of physical and mental ill health, attached.

6 SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP PROGRESS TOWARDS AUTHORISATION

Report of the Chair of the Clinical Commissioning Group detailing progress towards the Clinical Commissioning Authorisation, attached.

7 JOINT HEALTH AND WELLBEING STRATEGY

Report of Director of Public Health establishing priorities following consultation and engagement, attached.

8 JOINT COMMISSIONING STRATEGY

Report of Chair of Clinical Commissioning Group detailing a Joint Commissioning Strategy, attached.

9 PROPOSED CONTENT OF REGULATIONS FOR HEALTH AND WELLBEING BOARDS

Report of Director of Public Health detailing proposed content of regulations for Health and Wellbeing Boards, attached.

Tuesday, 13 November 2012 Head of Legal, HR and Democratic Services

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SHADOW HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 19 SEPTEMBER 2012

Present: Councillors Rayment, Baillie, Turner, Dr S Townsend, Dr S Ward, Mr H Dymond, Mr C Webster, Ms M Geary and Dr A Mortimore

Apologies: Councillors Bogle and Stevens

1. **ELECTION OF CHAIR AND VICE-CHAIR**

RESOLVED

That Councillor Rayment be appointed as Chair and Dr Steve Townsend as Vice Chair for the remainder of the Municipal Year 2012/13.

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

RESOLVED

That the action notes from the informal meeting held on 13th June 2012 be approved as a correct record.

3. **PROPOSED CALENDAR OF FORMAL MEETINGS 2013/2014**

RESOLVED

That the proposed calendar of meetings be approved for 2013/14.

4. **IMPROVING HOUSING OPTIONS AND CONDITIONS FOR PEOPLE IN THE CITY TO SUPPORT HEALTHY LIFESTYLES**

The Shadow Board considered the report of the Senior Manager, Housing Services providing an insight into the potential for Housing to support the aspirations of the Health and Wellbeing Board through the delivery of the Strategy.

The Board noted that good housing was fundamental to the Health and Wellbeing of the City and its population. Southampton was 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 its residents.

The positive effect of involving Housing in the delivery of key strategies in the City would be significant. Housing was not a service that should be tacked on to other initiatives but could be placed directly at the heart of improving the City. As a key priority within the Health & Wellbeing Strategy the City could ensure that it was taking a holistic approach to improving the lives of its citizens. It was noted that within housing there were 4 key themes:-

- Housing and Poverty
- Homelessness and Prevention
- Addressing Poor Housing Conditions in the Private Sector
- Promoting Active Older Age

The Board noted the following points:-

- That there was a lot of good partnership work taking place across the City.

- That activity to support sheltered housing/community use were being provided such as arm chair gym but more could be done to provide an integrated health treatment service and the development of the Health and Wellbeing Strategy was the opportunity to begin a journey to provide such a service.
- Opportunities for Health trainers to link with Neighbourhood Wardens.
- Opportunities for engagement with the "Families Matter" programme and other issues such as tower block living and associated issues of isolation and non engagement.
- As part of the consultation process of the draft strategy the Children and Young People's Trust had recognised the link between all of the priorities, housing being key.
- That any regeneration programmes would need to address health concerns and identify better outcomes.
- The introduction of benefit changes may contribute to overcrowding issues and associated difficulties of moving families on.
- There was opportunity for "Handyperson plus Service to receive more referrals and to be publicised more widely. Reference was also made to the "Blue Lamp Trust" which also received under referral and provided a range of services fully funded. Health colleagues were reminded of the service and to ensure that District Nurses etc were aware.

RESOLVED

i. That the report be noted;
ii. That work be undertaken to explore how health concerns could be addressed within housing regeneration programmes to provided better outcomes; and
iii. That information be provided to the Board on the changes to the Benefit system and how these could facilitate overcrowding issues.

5. **JOINT STRATEGIC NEEDS ASSESSMENTS AND JOINT HEALTH AND WELLBEING STRATEGIES - DEPARTMENT OF HEALTH PROPOSALS FOR CONSULTATION**

The Shadow Health and Wellbeing Board considered the report of the Director of Public Health detailing the Department of Health proposals for consultation following work with stakeholders to develop and refine draft guidance to support Health and Wellbeing Boards in preparing their Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies.

The Board noted that the Joint Health and Wellbeing Strategy for Southampton appeared to be where it needed to be ahead of the draft guidance albeit the vision was slightly too wide at the moment and would be refined as part of the consultation process for the Strategy.

The Board also noted that there was little demonstrable evidence of Children and Young People properly being implied in any the wording and that these should be more explicit particularly in reference to the Young Adults agenda.

RESOLVED

That the proposed response to the Department of Health consultation be approved subject to the inclusion of the lack of evidence of Children and Young People properly being implied and more explicit particularly in reference to the Young Adults agenda.

6. **DEVELOPMENT OF HEALTHWATCH SOUTHAMPTON**

The Shadow Health and Wellbeing Board received and noted the report of the Director of Health and Adult Social Care detailing the development of Healthwatch Southampton, which was to be "the independent consumer champion for the public locally and nationally to promote better outcome in health and social care for all". The report also summarised the duties of local Healthwatch, the stakeholder engagement undertaken and the process for securing Healthwatch in Southampton.

It was noted that the Department of Health funding for local Healthwatch was expected in December 2012, although this money would not be ring-fenced and the final sum to be allocated to Healthwatch Southampton would be determined as part of the 2013/14 budget setting process. Concern was expressed in terms of expectations versus resources and what was realistically achievable.

RESOLVED

That the development of Healthwatch Southampton and the allocation of funding being given due process as part of the Council budget setting process be supported.

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DECISION-MAKER:	SHADOW HEALTH AND WELLBEING BOARD
SUBJECT:	REDUCING ADMISSIONS TO HOSPITAL FROM PREVENTABLE CAUSES OF BOTH PHYSICAL AND MENTAL ILL HEALTH
DATE OF DECISION:	21 NOVEMBER 2012
REPORT OF:	CHAIR, CLINICAL COMMISSIONING GROUP
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

Southampton City Clinical Commissioning Group will reduce avoidable admissions by improving the management of long term conditions and developing ways of increasing care available in the community. Working as part of the wider SW Hampshire system the CCG has also prioritised ensuring safe, resilient and accessible emergency and urgent care services.

The CCG has outlined its approach to achieving a healthy and sustainable system within its Clinical Commissioning Strategy 2012-17. This prioritises the need to:

- gain more control within the system recognising that the way patients access services in the present system is too random and variable. More systematic arrangements are needed to drive up quality.
- focus service redesign work on strategic priorities in mental health, early years and care for older people. The management of long term conditions in cardiovascular health, lung health, diabetes and mental health will be centred on improving care pathways, including self care, integrated care management and complex needs, but also recognise the links across pathways so that improving one will potentially help with the others.
- bringing it all together through the transformational approach of Integrated Person-Centred Care

RECOMMENDATIONS:

(i) The Board is asked to support the areas of priority

REASONS FOR REPORT RECOMMENDATIONS

1. To improve more appropriate and safer care for patients.
2. To use hospital services more efficiently.

DETAIL (Including consultation carried out)

3. It is increasingly recognised that the benefits of hospital admission have to be weighed against the risks, particularly to frail elderly patients, of hospital acquired infections and general deterioration resulting from moving patients out of their home environment. Modern high tech hospital services are expensive and need to be used by those patients who benefit from them.

4. Southampton City CCG aims to decrease preventable admissions by :

- Developing services that provide an alternative to admission
- Improving the management of patients with long term conditions, who are the majority of patients admitted to hospital by
    - Developing integrated patient pathways
    - Using computer based risk stratification systems to identify those patients who are at risk of admission, and focussing on their care through integrated personal care provided in their own homes
- Improving services for those patients where alcohol plays a part in their illness (Supports priority 2)
- Developing services which enable ill children to be monitored at home
- Improving mental health services

5. **1. Integrated person centred care**

Advances in medical care have increased life expectancy, so that increasingly health services are dealing with long term conditions in relatively elderly patients. The scope of this term has increased, so that it extends beyond conditions such as heart failure, chronic obstructive airways disease and diabetes, but also includes mental illness, cancer (where treatment has improved to the point where patients may survive some years even though they cannot be cured) and conditions such as chronic fatigue syndrome (where we have very limited knowledge of the disease mechanism).

Increasingly, elderly patients are suffering from more than one long term condition. This adds to the complexity of caring for them, and is shifting the emphasis away from the care of individual diseases.

The benefits of seamless patient pathways, so that everyone caring for the patient is working from a common plan encompassing the whole course of an illness from prevention and self-care through to palliative care, have long been recognised. Modern information systems, such as Map of Medicine have made it easier to implement these, and Southampton is at the forefront of this innovation. We are about to implement a care pathway for chronic obstructive airway disease (the most common cause of admission to hospital) and are setting out to improve our diabetic pathways.

What is becoming increasingly evident is that there are substantial benefits from giving patients control over their own illness, and promoting. In addition, we now have a wealth of information available about our patients.

Computerised risk stratification have been developed which enable us to identify the top 5 % of patients who are at risk of hospital admission. 70% of the patients admitted urgently to hospital suffer from long term conditions, and the vast majority are admitted appropriately. By focussing our resources on vulnerable patients we will reduce the numbers of patients deteriorate to the point where admission is necessary.

Hospitals are potentially dangerous places. While the University Hospitals of Southampton Foundation trust has succeeded in controlling the spread of most hospital acquired infections, Norovirus outbreaks occur regularly. Many frail elderly patients do not tolerate the upset of being admitted. People prefer care in their own homes. We therefore want to implement an integrated model of out of hospital care, which will enable more patients to be treated at home. This is an ambitious 5 year strategy that will require cultural changes on the part of all organisations to move to a more pro-active model of care, with patients and carers having more control. Integrated systems of care, with a single system of case management and care plans will require close collaboration across the boundaries of both health and social care organisations, at operational and strategic level. It will require trust across boundaries to be able to share our resources at a time of economic stringency. It will be a challenge, but the rewards for success will be great.

6. **2. Alcohol related hospital admissions**

A key development in the Quality Innovation Productivity and Prevention programme has been the frequent attendee service, focusing on individuals who regularly attend hospital, often needing admission. Intensive support reduces the high impact these individuals have on the wider health economy (ambulance, emergency department, acute wards). There has been an emphasis on the pathway from A&E to the supported day detoxification service help is provided as a starting point to an individual's treatment journey. This helps avoid admissions, and directs the individual the local treatment system.

This work is supported by a team of Alcohol Nurses located within UHS. They work across the hospital but especially in areas where alcohol related admissions are common, such as liver wards and the acute medical unit. They support those who have been admitted, with a view to engaging them in treatment and raising their awareness to the health risks they face. They also provide training to other staff in the hospital to increase screening and prevention.

Screening and brief intervention is being developed city wide, across GP practices, pharmacies, large employees and in young people settings to help raise awareness and stem the long term increasing rise in alcohol related harm. The number of under 18 year olds being admitted to hospital is a concern which is being tackled through a web based and interactive

marketing campaign – Buzz without Booze.

7. **3. Children's Services**

The COAST (children's community nursing outreach and assessment support team) has been piloted in Southampton City since October 2011 to provide a rapid (same day) care for those children who can be cared for in the community with some additional nursing support The service operates and is specifically for gastroenteritis and respiratory infections.

The service has not yet made any impact on admission rates. We are going to change it, raise its profile with hospital and out of hour's services and extend it to 31st March 2013.

The frequent attenders' scheme which commenced in January 2012 identifies children who are regularly taken to A&E at the General Hospital and provides follow up in the community to reduce reliance on hospital services.

8. **4. Improving mental health support**

Liaison psychiatrists work with other clinicians to manage concomitant mental and physical illness. We are using payment incentives (CQUIN) to encourage the development of the service, which reduces the number of patients who present to hospital.

9. **5. Emergency and Urgent care system**

The local health and social care system has been struggling to cope with the demand for unscheduled care. Increases in emergency admissions have been funded to date but the trend is unsustainable. Despite investment, there has been some success in reducing length of stay but little traction in avoiding the need for admission.

Following a prolonged period of underperformance against the 4-hour A&E operating standard, and following discussions with Southampton City CCG, the Board of University Hospitals Southampton (UHS) commissioned the National Emergency and Urgent Care Support Team (ECIST) to undertake a review of the unscheduled care pathway within UHS. The review took place in mid-June 2012 and ECIST's subsequent report made some 25 recommendations which the trust is now implementing. Concurrent with UHS asking ECIST to review the unscheduled care pathway within the trust, the Southampton City and West Hants commissioners determined that it was also appropriate to ask ECIST to review all aspects of the unscheduled care pathway across the SW Hants health and care system using ECIST's established "Whole System" methodology. The initiation of the Whole System review recognised that while there was work to do within

UHS to optimise systems and processes, there were improvements that the wider health and care system needed identify and implement to ensure a fully integrated, efficient and patient-focussed unscheduled
care pathway.

The ECIST Whole System review report made some 29 individual recommendations which have been prioritised into a Whole System Action Plan. This includes areas such as review of pathways for specific conditions such as COPD, dementia and cardiac problems and a focus on those with mental health issues.

A key enablers to help gain control of the Urgent Care system will the effective use of the introduction of the NHS 111 number. The CCG intend to maximise the benefits of the new NHS '111' number for urgent, non emergency, care by using it as a single point of access, for patients and referrers, to a broad range of services that, efficiently and appropriately deployed, will help to avoid the need for patients to be admitted to an acute hospital and to get rapid access to the care they need.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

10. None.

RESOURCE IMPLICATIONS

Capital/Revenue

11. None.

Property/Other

12. None.

LEGAL IMPLICATIONS

Statutory Power to undertake the proposals in the report:

13. None

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	

DECISION-MAKER:	SHADOW HEALTH AND WELLBEING BOARD
SUBJECT:	SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP PROGRESS TOWARDS AUTHORISATION
DATE OF DECISION:	21 NOVEMBER 2012
REPORT OF:	CHAIR, CLINICAL COMMISSIONING GROUP
STATEMENT OF CONFIDENTIALITY	
None.	

BRIEF SUMMARY

Southampton City Clinical Commissioning Group is currently functioning in Shadow format and working towards authorisation by March 2013.The CCG is moving towards Authorisation and will be in Wave 4 with initial documents submitted on 1st November 2012 and site visit on 14th December 2012.

The CCG has 37 constituent member GP practices working in three localities; East, West and Central serving a registered population of 265,000 with a delegated budget for 2012/13 of about £340 million. The organisations mission is to:

" To become an organisation that is focused on our communities, striving to make healthcare decisions relevant to those we serve. We will engage meaningfully with patients and the public to seek greater ownership of and personal responsibility for health choices to achieve our goal of a healthy City for all."

The SHIP PCT Cluster remains the accountable organisation for 12/13. PCT's will end April 2013 and NHS Commissioning Board local teams, wider role for Public Health England and Commissioning Support Organisations will then commence

RECOMMENDATIONS:

(i) The Board is asked to note progress of Southampton City CCG moving towards Authorisation

REASONS FOR REPORT RECOMMENDATIONS

1. The CCG has progressed through key governance processes in preparation for Authorisation. This is evidenced through the engagement of member practices, appointment of key Governing Body members and establishment of governance systems and the development of Strategic direction

DETAIL (Including consultation carried out)

2. **1. Authorisation**

The CCG will be assessed against a range of Domains to illustrate that the organisation is truly ready to take on the responsibilities for commissioning healthcare for the population of Southampton. The six areas of focus include:

- Clinical focus and multi professional focus which brings real added value
- Meaningful engagement with patients, carers and their communities/localities

- Clear and credible plans to deliver QIPP within financial resources, in line with national requirements and local joint health and wellbeing strategies
- Proper constitutional and governance arrangements to deliver all duties and responsibilities and commission effectively
- Collaborative arrangements for commissioning and appropriate commissioning support
- Great leaders who individually and collectively can make a real difference

Evidence has now been submitted against these domains. As part of the process a 360 assessment was undertaken by an independent organisation. This has shown that stakeholders are generally positive about the engagement that has taken place so far in NHS Southampton City CCG. The summary was that NHS Southampton City CCG performs well across the majority of domains and is performing in line or slightly above the average for aspiring Wave 4 CCGs. Member practices are particularly positive about the engagement. However, the CCG may wish to consider its engagement with other health professionals and its relationship with NHS providers, particularly surrounding QIPP plans. This, along with previous stakeholder surveys, have been used to develop a detailed action plan.

3. **2. Governance**

The CCG will be a completely different kind of organisation in the sense that it is constituted as a membership organisation comprised of its 37 member practices across the City. The governance arrangements for this are set out clearly in the Constitution which is now finalised and formally approved by all the Member practices.

This outlines that the CCG will have a General Assembly made up of representatives of every practice. The General Assembly will have the power to change the constitution, approve strategic direction, elect certain members of the Governing Body and will be required to hold an AGM open to the public.

The General Assembly delegate authority to the Governing Body to act on its behalf. This comprises elected clinical representatives, lay members, the Chief Officer, Chief Financial Officer, Executive Nurse, Director of Public Health and a secondary care doctor. Representatives from the Local Authority and LINKs/Healthwatch will be members with full speaking but non voting rights. These appointments have now all been made.

The Governing Body will set the vision and strategy, monitor performance and outcomes and ensure assurance and compliance with statutory duties. It will meet in public at least 8 times a year.

The Governing Body has number of formal committees as outlined in Appendix 1.

The Clinical Executive Group comprises the elected GP's who meet with the senior CCG staff to provide clinical leadership and key objectives including clinical commissioning, strategy, patient and public involvement, finance and performance targets, quality and organisational development.

The Clinical Reference Group with locality and board representatives, stimulates and champions innovation in care pathway redesign and service development.

We have three localities across the city which will contribute to shaping the commissioning strategy, identifying local needs, lead pathway re-design and support peer review and education.

Clinical leadership and engagement is integral to commissioning and the CCG will be based on a clinical perspective, threaded through everything it does. It has significant engagement from the constituent practices as well as widespread engagement of other clinical and social care colleagues. This is achieved through a number of mechanisms. So far this has led to positive changes in provision and outcomes in:

- prescribing redesign of services for patients with Dementia
- roll out of IAPT to achieve widest coverage in the region
- improved care at end of life
- redesign of musculoskeletal services - improvement in waiting times and reduction in surgical approaches
- development of Autism Strategy and redesign of service for children and adults
- redesign of health visiting service and secured growth

2.7 Collaborative Commissioning will be key to the effective running of the CCG. This is in three main areas:

- The CCG is committed to the further development of Joint Commissioning with Southampton City Council, building on a strong history of joint working and achieving outcome for the population of the city. A Memorandum of Understanding has been developed for the functions of Public Health
- As a large foundation trust hospital University Hospital of Southampton has a big impact on both West Hants and Southampton City CCG's. the two organisations will therefore work together
- The CCG will receive some of its defined commission g support form Commissioning Support South.

4. **3. Quality**

Quality is the central 'point' of clinical commissioning and the CCG intends to ensure that the experience of patients, service users and their carers of health and supporting care services will be central to the drive for further improvements and we need to ensure that patients are at the centre of decision making. We will strengthen the mechanisms for providing assurance to the CCG board and other key partners, including patients and residents (through published provider annual quality accounts) on the quality of care and safety of services commissioned from providers.

5. **4. Organisational Development**

Giving real meaning to the term 'membership organisation' is about much more than the constitutional arrangements: the organisational development challenge is about developing the roles and behaviours of the members and their management team to create a real sense of cohesion, ownership and true partnership. This is a culture change challenge that will not be achieved overnight, and requires all parties to think and behave differently:

- to truly subscribe to the agreed values and vision of the CCG, and
- to learn new ways of working together that will be characterised by, for example: co-operation, persuasion and consent

The CCG has put in place a tailored programme of organisational development to support these changes.

6. **5. Clinical Commissioning Strategy**

This is a five year strategy that sets out how the CCG approach will be new and different, led by clinicians working in partnership with patients and the public, putting quality first, and ensuring that the whole system is aligned.

Drivers for Our Strategy. The principal driver for the strategy is the local joint strategic needs assessment (JSNA) and the resultant joint Health and Wellbeing strategy, Gaining Healthier Lives in a Healthier City. As part of the wider NHS, the CCG is also driven by the requirements of the NHS Mandate. Alongside an understanding of our population's needs and the assets we have as a City, the strategy also sets out a frank assessment of the challenges faced by the healthcare system and an understanding of the demographic, technological, societal and public finance trends that will rapidly render the present system unsustainable. It recognises the need for transformational system wide change that puts quality (and people) first, liberates innovation, improves productivity and emphasises prevention.

The principal goal of the CCG is to create a healthcare system that is healthy and sustainable into the future. That is, one based on healthy (trustful, open and businesslike) relationships, designed and integrated around the needs of people not organisations, and able to live within its means.

The main components of the change programmes are illustrated in Appendix 2.

This includes:

- "gaining control" and to reduce variation, centred around the introduction of the new NHS 111 urgent care service and the development of a system for clinical review of referrals in elective care, both of which will start to be put in place during the current year 2012/13.
- focus service redesign work on our strategic priorities in mental health, early years and care for older people. The management of long term conditions in cardiovascular health, lung health, diabetes and mental health will be centred on improving care pathways, including self care, integrated care management and complex needs.
- transformational work with Integrated Person-Centred Care.
- rethinking healthcare - the fresh and radical approach brought about by the CCG's ability to enrol liberated clinicians and empowered communities in taking control of the City's future, combined with our access to the leading academic research in the field, will generate new solutions to familiar problems.

The strategy is explicit about the measurable outcomes that will be expected in future. The CCG has recently been furnished with initial baseline information about these against which we will monitor progress.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

7. None.

RESOURCE IMPLICATIONS

Capital/Revenue

8. None.

Property/Other

9. None.

LEGAL IMPLICATIONS

Statutory Power to undertake the proposals in the report:

10. None.

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.	Overview diagram, Clinical Commissioning Strategy (p.4)
2.	Main components of the change programmes.

Documents In Members' Rooms

1.	None

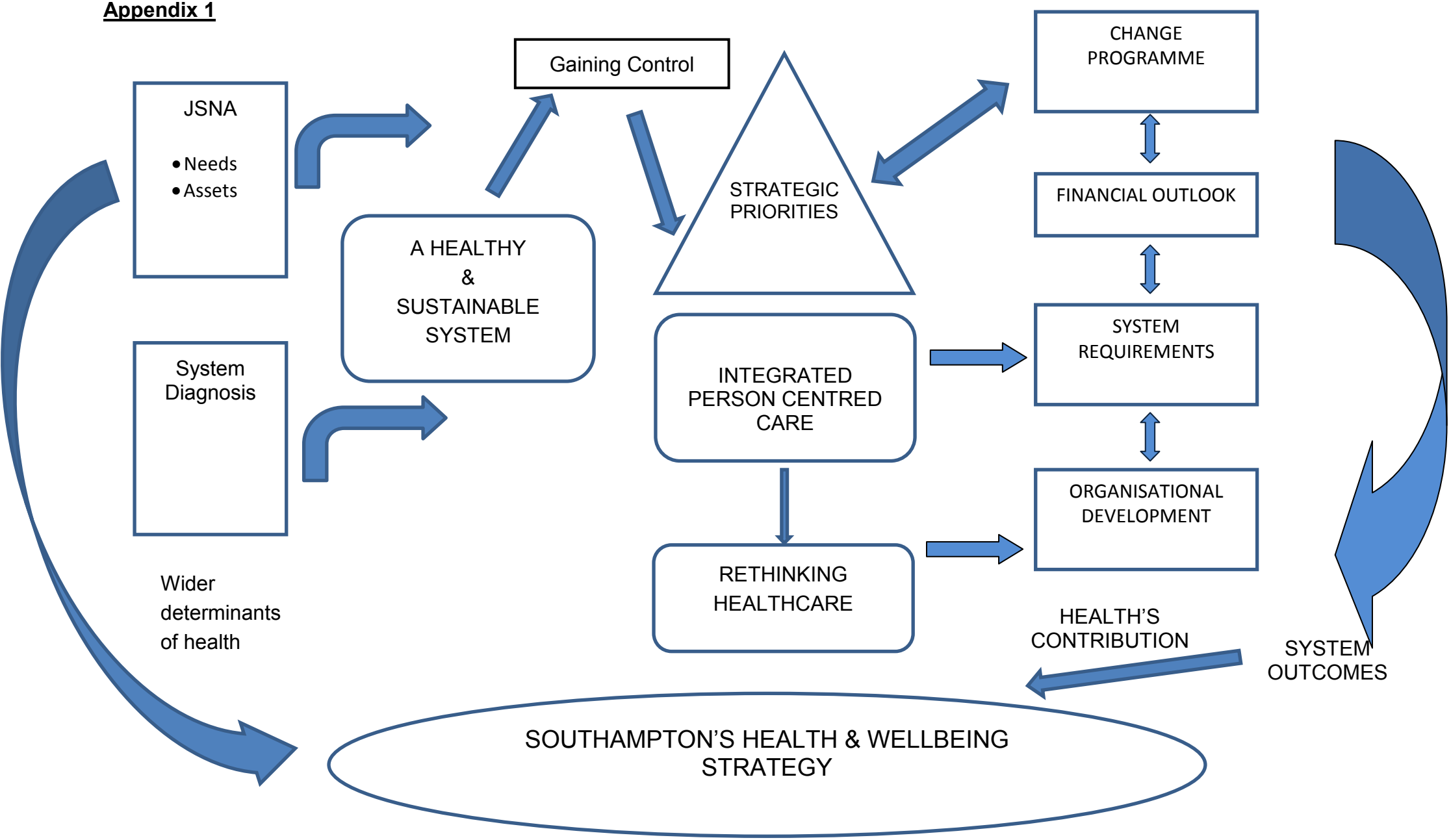
Integrated Impact Assessment

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

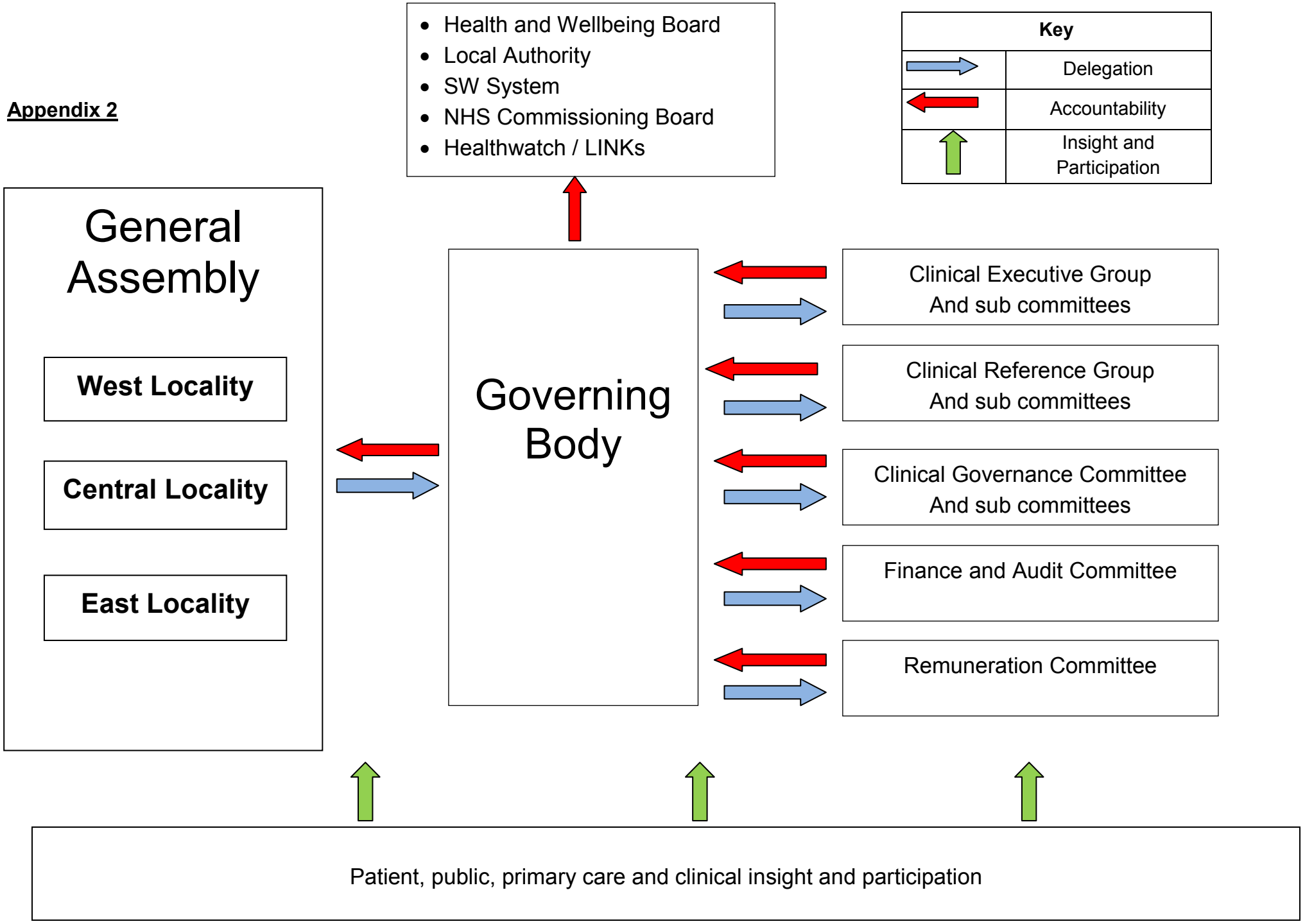
Other Background Documents

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	

Appendix 1


JSNA
• Needs
• Assets
System Diagnosis
Wider determinants of health
Gaining Control
A HEALTHY & SUSTAINABLE SYSTEM
STRATEGIC PRIORITIES
INTEGRATED PERSON CENTRED CARE
RETHINKING HEALTHCARE
CHANGE PROGRAMME
FINANCIAL OUTLOOK
SYSTEM REQUIREMENTS
ORGANISATIONAL DEVELOPMENT
HEALTH'S CONTRIBUTION
SYSTEM OUTCOMES
SOUTHAMPTON'S HEALTH & WELLBEING STRATEGY

Appendix 2


Health and Wellbeing Board
Local Authority
SW System
NHS Commissioning Board
Healthwatch / LINKs
Key
Delegation
Accountability
Insight and Participation
General Assembly
West Locality
Central Locality
East Locality
Governing Body
Clinical Executive Group And sub committees
Clinical Reference Group And sub committees
Clinical Governance Committee And sub committees
Finance and Audit Committee
Remuneration Committee
Patient, public, primary care and clinical insight and participation

To :	SOUTHAMPTON SHADOW HEALTH AND WELLBEING BOARD MEETING
Date:	21ST NOVEMBER 2012
Subject:	DRAFT JOINT HEALTH AND WELLBEING STRATEGY: POST WORKSHOP (& NOVEMBER) DIRECTION FOR STRATEGY
Report of :	DIRECTOR OF PUBLIC HEALTH

1 **Introduction**

The shadow Health and Wellbeing Board approved a draft strategy for consultation in June 2012, and the consultation and engagement process took place through July, August and September. The post consultation draft was taken to an informal Board workshop on 7 November 2012 which allowed the Board to further shape the strategy taking account of stakeholder and public feedback.

2 **Consultation and Feedback**

The Board will be aware that the draft JHWS set out 6 priorities for action, underpinned by a number of principles, including adopting a life course approach:

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

Each of these themes had a series of actions proposed actions against them, and a set of questions were asked under each priority to elicit views and opinions on:

1. Whether the actions are the right ones
2. Which actions should be prioritised
3. Whether any important actions are missing and what they should be
4. Whether there are resources and assets people are aware of that could be brought into play to address the needs.

A wide range of stakeholders were sent copies of the strategy, and briefings and presentations delivered. Key partners and partnerships, NHS organisations, public agencies, schools and governing bodies, voluntary and community organisations and the general public were all invited to comment.

The methodology for gaining public and stakeholder feedback used questionnaires, presentations and consultation events.
Questionnaire was part of the Health Matters publication – 5,695 circulated to all GP practices, libraries, pharmacies, schools, colleges and universities, NHS trusts and key stakeholders across the city. 14 completed questionnaires were returned, 25 public/stakeholder sets of comments were returned via email including 5 from our on-line survey.

Presentations were given to the Health Overview and Scrutiny Committee (HOSC), Clinical Commissioning Group (CCG), Children and Young People's Trust (CYPT), Southampton Voluntary Services (SVS) and Southampton Connect

The two public/stakeholder engagement events coordinated by Southampton Link had 110 attendees in total.

Key themes emerged from the feedback which helped to shape and inform the wide ranging discussion undertaken at the workshop session on 7 November 2012, these include:

- A strong call for the JHWS to link with other key strategies and plans across health, social care and wider systems
- General support that the strategy identifies the correct priorities
- People with learning disabilities and carers were both highlighted as priorities for action
- The limited reference in the draft document to meeting the challenge of the growing number of people with dementia
- A need to emphasis and amplify the prevention and health improvement agenda across lifestyle risk factors
- A pan-population approach should be applied to alcohol and drug issues, rather than restricting it to adolescence and young adulthood
- The substantial potential for volunteers and community groups to make a contribution to improving outcomes.

3 **Outcomes and workshop discussion 7 November 2012**

The informal Board meeting engaged in wide ranging discussions and the revised outcomes were agreed.

- Consensus on the issues covered (endorsed by wider consultation)
- Reduce the strategy from five priorities to three themes:
    - Theme 1 Building resilience and prevention to achieve better health and wellbeing to combine aspects of Priority 3 (work) and 5 housing
    - Theme 2 will be Best start in life
    - Theme 3 will be Ageing and living well

The actions that emerge from these three themes need to be:

- Achievable in number and realistic given budgetary constraints
- Actions need to stretch/transform outcomes

It was agreed that Directors would re-look at sections and actions to be

included for the next revision.

It was also agreed that the Board will hold partners to account regarding delivery of health and wellbeing actions and outcomes.

4 **Next Steps**

- Directors to meet and go through and agree actions (Clive, Margaret Jane, John and Dawn to work with Andrew and Public Health Consultants)
- To agree the language of the strategy and target audience i.e. lay or professional
- Public Health leads to: revise the strategy in light of Director(s) discussions/decision making
- Ensure links with other strategies identified
- Ownership/leadership for actions to be SMART actions with agreed accountability

Proposed timescale

21st November - Formal H&WBB - Priority Headings (although not to be called that) to be agreed in order to allow some indication of commissioning requirements (publication of papers 13th Nov)

19th December - Informal H&WBB - Final Strategy to be discussed having covered themes, actions, funding, accountability and outcomes.

23rd January - Formal H&WBB - Approval of Final Strategy for recommendation to CCG and LA (publication of papers 15th Jan)

Beginning of February any further public consultation events that may be necessary

27th February - Informal H&WBB to discuss any tweaks that may be necessary following any public consultation event.

18th March - Cabinet Member Briefing - Approval of Cabinet report recommending adoption of the strategy

27th March - Formal H&WBB - Final approval of Strategy if required.(publication of papers 19th March)

28th March - Final submission of report to Democratic Services (all cleared) for Cabinet 16th April

5 **Recommendations**

- Revise the strategy
- Agree the three key themes as in 3 above.

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DECISION-MAKER:	HEALTH AND WELLBEING BOARD
SUBJECT:	JOINT COMMISSIONING STRATEGY
DATE OF DECISION:	21NOVEMBER 2012
REPORT OF:	CHAIR, CLINICAL COMMISSIONING GROUP
STATEMENT OF CONFIDENTIALITY	
None.	

BRIEF SUMMARY

The proposals in this document are built on the experiences of many years of partnership work between health and social care across the City of Southampton.

This started with pooled budgets, using Health Act flexibilities for mental health, substance misuse and learning disabilities and joint appointments for managers to lead this work on behalf of both organisations.

In 2009 this was further strengthened when the Primary Care Trust and Southampton City Council moved to a formal alignment of commissioning for adult health and social care services with the appointment of an Associate Director to discharge leadership for both organisations.

Recently Southampton City Council and Southampton City Clinical Commissioning Group have confirmed their commitment to continuing with joint commissioning arrangements within the newly restructured NHS arrangements and the wish to explore opportunities for developing this further.

A Joint and Integrated Commissioning Board comprising CCG Chair, Accountable Officer and Elected Members and Directors from the City Council are developing proposals based on this document to further develop Joint Commissioning including the development of a shared team.

This Joint (Southampton City Council and Southampton City Clinical Commissioning Group) Commissioning Framework sets out how the organisations will commission together. It outlines the areas of focus for Integrated Commissioning and the organisational and governance structures required to support effective and safe implementation.

RECOMMENDATIONS:

(i) The Board is asked to support the Principles outlined within the Strategy;

(ii) The Board is asked to support the areas of focus identified; and

(iii) The Board is asked to support the Strategy.

REASONS FOR REPORT RECOMMENDATIONS

1. Systems within which the local authority and health operate and the services that are commissioned are different but strongly inter-related. Both organisations want to ensure that the best outcomes are achieved for the population and wish to work together to ensure that resources are used effectively.

2. The aim is to improve decision making and develop more integrated services to achieve the best for Southampton citizens and those registered with GP practices.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. Consideration was given to a range of options.

DETAIL (Including consultation carried out)

4. **1. Scope**

The focus of the joint work is on commissioning, not on the integration of procurement processes. Commissioning is about assessing needs , available resources and priorities, and using this information to plan, buy, and review services to ensure they meet the needs of customers and provide value for money Commissioning helps set the strategic direction of organisations – it enables decisions on what to do and the best way to do it. Commissioning defines the services required and outcomes to be achieved; it is focused on “what is needed”. Procurement helps organisation/s achieve the most appropriate and cost effective way to deliver services to achieve those outcomes, summarised as “how do we get it”. The procurement process runs alongside and enables commissioning. Procurement is a route through which the commissioning organisation can appoint a provider (or providers) to deliver the commissioning strategy for a given service, however not all commissioning will be done via procurement.

Commissioning in a more joined up way is crucial to improving life for residents in Southampton. Treating health, public health, social care, and other local authority functions such as housing, education and leisure, as a whole system rather than lots of individual services will improve outcomes, make it easier for people to understand and access services and make better use of our resources. The Commissioning process is resource intensive and so there are efficiencies in doing this jointly.

5. **2. What are we doing?**

CCG and Council are launching this framework to increase the level of services we commission together. The key actions we are taking include:

- Jointly endorsing our 3 priorities for commissioning and the key actions we will take under each of these;
- Committing to increase the percentage of our budgets that we pool

and commission together;

- Putting in place an infrastructure to actively support joint commissioning;
- Developing an integrated commissioning team that brings together a number of health and local authority commissioners together under a single management structure
- Jointly signing up to the 8 principles for commissioning that will underpin everything we do.

6. **3. Why are we doing this?**

3.1 Achieving better outcomes

- to challenge existing services delivery models and review alternative and innovative new ways of working to ensure always achieving the best outcomes for customers in the most efficient ways possible.
- ensure that budget decisions are based on and understanding of needs, evidence of what works and fully informed of other changes taking place.
- put quality assurance first to enable an active focus on safety, experience and outcomes.

3.2 Earlier identification of need

- increase the use of risk stratification to support future planning and best target joint resources. This will help to support demand management, focus on prevention and reduce and delay the need for intensive high cost interventions.

3.3. Shared aims to avoid cost shunting

- increasing the use of joint budgets will ensure that we are working together to achieved shared aims and help avoid cost shunting.

3.4 Improve transition

- transitions between children's and adult services, both within and across organisations, are not always planned for in a way that best meets the customer's needs.

3.5 Seamless delivery of services

- the links between different services such as housing, social care and healthcare can be confusing for customers and patients and services can feel disjointed. The aim is to move towards a seamless delivery of services from multiple providers and move towards single points of access for customers. Commissioning together across organisations and services will enable incentivisation of providers to work together to ensure the experience of services provided is holistic.

3.6 Value for money

- to review contract and procurement processes to ensure they are in line with the principles outlined in this framework.
- to ensure best value from contracts, especially where both the Council and CCG have contracts with the same providers.
- ensure contracts are outcome focused and flexible enough to respond to changing needs.. Personalisation will be promoted and duplication removed.

3.7 Improved market management

3.8 Efficient Commissioning structures

7. **4. Commissioning Principles**

A set of 8 key principles have been agreed that will guide all commissioning undertaken by both the City Council and the Clinical Commissioning Group, whether it is done jointly or individually.

Consideration has been given to a number of structural options including :

- No change in current practice with elements of joint commissioning for specific client groups
- Aligned Commissioning - separating commissioning to each agency undertaking their own
- Joint Commissioning - Virtual team working to shared strategy , increas pooled budgets and shared posts with joint appointment to lead the wor for both organisations
- Fully integrated Commissioning with either organisation acting on behalf of the other or based in a stand-alone organisation

RESOURCE IMPLICATIONS

8. **Capital/Revenue**

Initial assessments have been made as to the influencable commissioning spend that will be impacted upon within this. for Southampton City Council spends £82m* on commissioning services in the City every year and the CCG commissions £300m* worth of activity in Southampton every year.

Property/Other

9. None.

LEGAL IMPLICATIONS

10. **Statutory power to undertake proposals in the report:**

Formal partnership between NHS and Local Authority – Section 75 NHS Act 2006

Other Legal Implications:

11. None.

POLICY FRAMEWORK IMPLICATIONS

12. None.

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KEY DECISION No

WARDS/COMMUNITIES AFFECTED:	all

SUPPORTING DOCUMENTATION

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

Appendices

1.	Commissioning Priorities (p. 21,22,2)
2.	Joint Commissioning Plans (p. 28)

Documents In Members' Rooms

1.	None

Integrated Impact Assessment

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

Other Background Documents

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

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

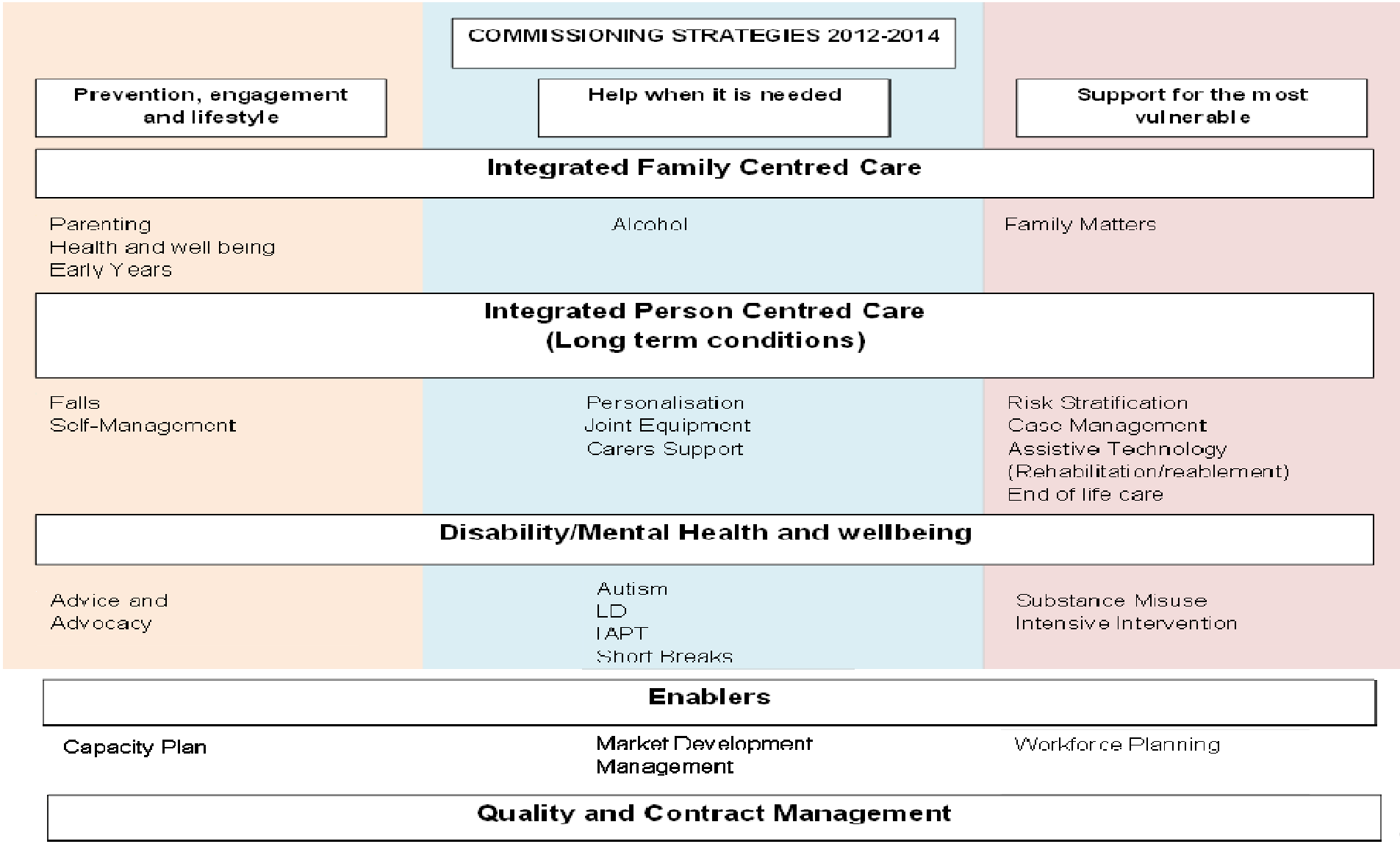
Appendix 1

CURRENT	WHAT WE WILL DO	FUTURE
PRIORITY 1 - FOCUSING ON PREVENTION, ENGAGEMENT AND LIFESTYLE		
Collective resources tend to focus on high risk and high cost support rather than prevention and early help. People on lower incomes living in the most deprived areas in the city have shorter lives Excessive alcohol consumption is impacting negatively on the city's population in a number of ways including health, mortality, and crime. Too many of our residents have illnesses or accidents that were preventable There is still a long way to go in closing the gaps in inequalities in childhood and ensuring every child has the best start in life.	Promote healthy lifestyles that encourage people to take self responsibility Address the wider determinants of health including poor housing, worklessness, community safety and economic regeneration Focus on tackling alcohol and substance abuse within the City. Continue to invest in the prevention of long term conditions. Sustain prevention programmes around smoking, obesity and physical activity and cardiovascular disease Improve advice and information to support good decision making and lifestyle choices Develop a more joined-up multi-agency service approach to improve prevention and early help to families in order to reduce escalation of problems to the costly, high risk and safeguarding levels. Continue to strengthen the delivery of high quality integrated services to children and families. Build capacity working to support good parenting Working together to deliver more cohesive support to improve parental issues and experiences that adversely impact on their children & young people such as unemployment, housing needs and re-offending	People feel supported to make the right choices and stay healthier for longer The gap in health inequality between different areas in the City narrows A reduction in residents with long term conditions A decrease in the harm caused by alcohol abuse People are supported stay healthy and actively involved in their communities for as long as possible, thus helping prevent, reduce or delay the need for more specialist care services Improved health, wellbeing, safety, economic and social outcomes for parents, and improved educational and social outcomes for children. Services and activities to improve educational outcomes for children including reduced school absence and attainment are part of the wider support to families

CURRENT	WHAT WE WILL DO	FUTURE
PRIORITY 2 – HELP WHEN IT IS NEEDED		
There are too many unplanned and preventable hospital admissions. Services need to focus more on sustainable recovery. Direct health and social care needs are the major focus of service delivery. Little planned use of universal services and links with community associations. Despite some systems and services seeking to provide whole family interventions too many services approach the issues in a family from either the child or the adult perspective.	Redesign support to increase early identification of disease to prevent or delay specialist services Redesign of pathways to care to provide cradle to grave integrated support and improve outcomes for example in relation to alcohol and drug treatment, mental health services, and learning disabilities. Increase systems to improve recovery and reach more people at earlier stages Increase the choice of quality services within a sustainable market Increasing use of direct payments and personal health budgets improving access to services, e.g. therapies, mental health support and equipment	Early detection and effective support to minimise effects of disease and frailty and reduce complications Cost savings (medium term) and improved services through both more efficient processes and joined-up provision to enable early help Improved customer-centred and integrated responses to improve efficiencies e.g. single point of contact with single case management and care planning with integrated community teams so people receive seamless care Reduced costs (over medium/long term) to costly tier 4 services including safeguarding children and vulnerable adults and domestic violence services.

	WHAT WE WILL DO	FUTURE
PRIORITY 3 – SUPPORT FOR THE MOST VULNERABLE		
There is some focus on enabling self care but most is on caring for and treating people. People are consulted and informed about services but professionals make most of the decisions Services are too often providing single disease specific solutions rather than providing care based on the needs of individuals especially those with multiple conditions. Support to families with complex needs does not always seek to tackle the underlying cause of problems such as poverty, substance misuse or domestic abuse.	Focus on developing the services people need to keep them in their own home for longer such as rehabilitation and reablement, telecare, adaptive equipment, supported housing and improving support for carers Extend range of interventions and disease management 'closer to home' and with greater ease of access for the individual and pro-active care planning based on needs of individuals and not single disease solutions; Review of systems and pathways to provide joined-up support to families with problems or challenges including the underpinning issues that are drivers for families with complex needs such as substance misuse, domestic abuse and mental ill-health Ensure support to families with additional needs including LD, people with disabilities and SEN is integrated into a family centred approach	People are supported to access the information and the means to take more control over their health and care arrangements, and have more choice over services when there is a continuing need for such services Individuals are co designers of the support they receive Self management of conditions and sustainable recovery that reduce the need for more costly interventions and intensive support and enables people to remain independent and in their own homes for longer; Cost savings through both more efficient support processes that enable self management of conditions and as a result of better outcomes that reduce the need for more costly interventions and intensive social care support Vulnerable young people are supported to improve outcomes and move successfully into adulthood. Improved outcomes for families with multiple and complex needs

Appendix 2


COMMISSIONING STRATEGIES 2012-2014
Prevention, engagement and lifestyle
Help when it is needed
Support for the most vulnerable
Integrated Family Centred Care
Parenting
Health and well being
Early Years
Alcohol
Family Matters
Integrated Person Centred Care
(Long term conditions)
Falls
Self-Management
Personalisation
Joint Equipment
Carers Support
Risk Stratification
Case Management
Assistive Technology
(Rehabilitation/reablement)
End of life care
Disability/Mental Health and wellbeing
Advice and
Advocacy
Autism
LD
IAPT
Short Breaks
Substance Misuse
Intensive Intervention
Enablers
Capacity Plan
Market Development
Management
Workforce Planning
Quality and Contract Management

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DECISION-MAKER:	SHADOW HEALTH AND WELLBEING BOARD
SUBJECT:	PROPOSED CONTENT OF REGULATIONS FOR HEALTH AND WELLBEING BOARDS
DATE OF DECISION:	21ST NOVEMBER 2012
REPORT OF:	DIRECTOR OF PUBLIC HEALTH
STATEMENT OF CONFIDENTIALITY	
None.	

BRIEF SUMMARY

The Department of Health has published a paper outlining the issues it intends to include in regulations governing the operation of health and wellbeing boards. This report summarises the implications. It covers:

- Establishment of sub-committees and delegation
- Voting restrictions
- Political proportionality requirements
- Disqualification for membership
- Application of a code of conduct and declarations of interest
- Application of transparency provisions.

RECOMMENDATIONS:

(i) That the report be noted.

REASONS FOR REPORT RECOMMENDATIONS

1. To brief the shadow Health and Wellbeing Board on the regulatory framework within which it will be operating.

DETAIL (Including consultation carried out)

2. The creation of health and wellbeing boards as committees of a local authority does not align with the current legislation dealing with the appointment of committees. To deal with this the Department of Health is planning to implement regulations governing the operation of health and wellbeing boards. It is planning to lay the regulations before Parliament in January 2013, and they will come into force on 1st April 2013. However the Department has published a summary setting out the proposed content of the regulations. The details are subject to drafting by lawyers and as such should be viewed as current intentions rather than the final position. The key points contained in the summary are set out in this report.

3. **Establishment of sub-committees and delegation**

Unless a local authority directs otherwise, a committee can establish a sub-committee to discharge any of its functions. It is proposed that the regulations will enable health and wellbeing boards to be able to establish sub-committees and delegate functions to them. The regulations will not be

prescriptive and whether or not to establish sub-committees will be a matter for local determination.

4. **Voting restrictions**

Current legislation means that any members of a committee who are not members of the local authority should be treated as non-voting members, except in relation to a specified set of committees. The regulations are intending to remove this barrier and to enable local authorities to empower all key members of the board to vote alongside the elected representatives. This could also apply to any additional board members appointed in addition to the statutory membership set out in the Health and Social Care Act 2012.

5. **Political Proportionality**

Seats on local authority committees and sub-committees are normally allocated to reflect the prevailing political proportionality of the local authority. The Department of Health is proposing to disapply the provisions of the existing legislation requiring political balance in relation to health and wellbeing boards so that the question of political proportionality of health and wellbeing board membership is left to local determination.

6. **Disqualification for membership**

The current legislative framework states that any person who would be disqualified from being able to stand for election as a councillor shall be disqualified from be a member of a committee or sub-committee of a local authority. The Department of Health has indicated that its general policy intention is to retain the disqualifications, but the regulations will ensure the disqualifications do not apply to health and wellbeing boards in so far as they cover disqualifications in respect of members of the board:

- Holding any paid employment or office in the local authority
- Being the subject of a bankruptcy restrictions order or interim order
- Having been convicted in the United Kingdom, the Channel Islands or the Isle of Man of any offence and has had passed a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine

7. **Application of a code of conduct and declarations of interest**

The Localism Act 2011 set out provisions on a new standards regime for local authorities, and included provisions in relation to codes of conduct and the disclosure of pecuniary interests. These will align to the seven “Nolan” principles of public life: selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

The new regulations will apply these standards to health and wellbeing boards. However, the Department of Health is exploring whether a modification is necessary in relation to Clinical Commissioning Group

participation in discussions and decisions in which they could otherwise potentially be excluded.

8. **Application of transparency provisions**

There is a strict set of rules governing access to documents and meetings of local authority committees and sub-committees, and there are prescribed situations in which the public can be excluded from meetings and when local authorities can withhold documents from inspection. The regulations will not disapply or make any modifications to the existing provisions, which will apply to health and wellbeing boards unchanged.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

9. None.

RESOURCE IMPLICATIONS

Capital/Revenue

10. None.

Property/Other

11. None.

LEGAL IMPLICATIONS

Statutory Power to undertake the proposals in the report:

12. Section 194 of the Health and Social Care Act 2012 requires that upper-tier local authorities establish a health and wellbeing board. Section 194 (12) enables regulations to be made in relation to the way the board operates as a committee of the council.

Other Legal Implications:

13. None.

POLICY FRAMEWORK IMPLICATIONS

14. 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	No

Integrated Impact Assessment to be carried out.	

Other Background Documents

None	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)