SHADOW HEALTH AND WELLBEING BOARD AGENDA

HARTLEPOOL BOROUGH COUNCIL

10 September 2012

10.00 a.m.

Council Chamber, Civic Centre
Victoria Road, Hartlepool

MEMBERS: SHADOW HEALTH AND WELLBEING BOARD
Voting Members (statutory members)
Directly Elected Mayor, Executive Members of the Local Authority, Chief Executive of Local Authority, Representative of Clinical Commissioning Group, Chief Executive/Director of the PCT (transitional arrangements until 2013), Director of Public Health, Director of Child and Adult Social Services, HealthWatch Board Member, Representative of the NHS Commissioning Board, Patient Representative.
Non-Voting Members (non-statutory members)
Director of Regeneration and Neighbourhoods, North Tees and Hartlepool NHS Foundation Trust, Tees Esk and Wear Valley NHS Trust, Voluntary Sector Representative(s), North East Ambulance NHS Trust, Cleveland Fire Authority.

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST**

3. **MINUTES**

   3.1 To confirm the minutes of the meeting held on 30th July 2012 *(attached)*

4. **MATTERS ARISING FROM MINUTES**

   4.1 Public Health Funding Response – Verbal Update by Director of Public Health
   4.2 Health and Wellbeing Consultation – Verbal Update by Director of Public Health
   4.3 Local Government Association Offer to Health and Wellbeing Boards – Verbal Update by Director of Public Health

5. **ITEM FOR INFORMATION**

   5.1 Clinical Commissioning Group Authorisation Process – Verbal Update

5.2 Interaction between Shadow Board and Police Commissioners Office (*attached)*
5.3 Stay Safe and Warm Campaign 2012-2013 (*attached)*
5.4 Regional Assurance Framework – Verbal Update by Director of Public Health
5.5 Health Protection Agency Annual Report – Verbal Update by Director of Public Health

6. ITEMS REQUIRING DECISION

None

7. ITEM FOR DISCUSSION

7.1 Joint Strategic Needs Assessment (JSNA)
- (i) JSNAs and Joint Health and Wellbeing Strategies – Draft Guidance – Proposals for Consultation (*attached)*
- (ii) Presentation by Director of Public Health on Progress of JSNA Refresh

7.2 Mental Health and Wellbeing
- (i) Mental Health and Social Care
- (ii) Mental Health and Health Services
- (iii) Voluntary Sector Prospective

8. FUTURE AGENDA ITEMS

9. ANY OTHER BUSINESS

SHADOW HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

30 July 2012

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

Present:

Dr Paul Pagni, Clinical Commissioning Group – In the Chair

Statutory Members

Councillors: Cath Hill (Deputy Mayor) (Children's and Community Services Portfolio Holder)
Paul Thompson (Finance and Corporate Services Portfolio Holder)
Nicola Bailey, Acting Chief Executive
Jill Harrison, Assistant Director, Adult Social Care
Louise Wallace, Director of Public Health
Christopher Akers-Belcher, Hartlepool LINK Co-ordinator

Non Statutory Members: -

Alan Foster, Chief Executive, North Tees and Hartlepool NHS Foundation Trust
Chris Willis, Chief Executive, NHS Hartlepool
Simon Featherstone, Chief Executive, North East Ambulance Service
Keith Bayley, HVDA
Dave Stubbs, Director of Regeneration and Neighbourhoods.

In attendance as substitute:-

David Brown as substitute for Martin Barkley, Tees, Esk and Wear Valley NHS Foundation Trust

Also Present:

Councillor Gerard Hall, Vice Chair, Health Scrutiny Forum
Sharon Robson, Alcohol Lead (Adults), Health Improvement Team
Simon Howard, Public Health Registrar

Officers: Catherine Frank, Performance and Partnerships Manager
Joan Stevens, Scrutiny Manager
Amanda Whitaker and David Cosgrove, Democratic Services Team.

72 Apologies for Absence

The Mayor, Stuart Drummond, Councillor John Lauderdale (Adult and Public Health Services Portfolio Holder), David Turton, Cleveland Fire Authority, Margaret Wrenn, Hartlepool LINK, Martin Barkley, Tees and Esk Valley NHS Trust, Sarah Bowman, Acting Consultant in Public Health (NHS Tees), Ali Wilson, Chief Officer designate, Hartlepool and Stockton Clinical Commissioning Group/Director of Health Systems Development, NHS Tees

73 Declarations of interest by Members

None

73 Minutes of the meeting held on 18 June 2012

Confirmed

74 Matters arising from Minutes

Minute 68 – Consultation Process – Health and Wellbeing Strategy – The Performance and Partnerships Manager updated the Shadow Board on the Health and Wellbeing Face the Public Event which had been held on 17th July 2012. The event had been well attended and positive feedback had been received. Comments had, however, been received in relation to engagement with members of public. Shadow Board Members agreed that lessons could be learnt from the event and engagement with residents would be considered as part of the Health and Wellbeing Strategy. Public questions which had been submitted were being collated and would be circulated to Board Members in due course.
The Director of Public Health highlighted that the event had been arranged in accordance with partnership arrangements and there would be another event later in the year.

75 Presentation on NHS Changes

The Shadow Board received a verbal update, by Chief Executive NHS Tees, on a number of senior appointments which had recently been made in relation to the key posts within the new organisational structures for the NHS. Ali Wilson had been appointed to the position of Chief Officer Designate for the Stockton and Hartlepool CCG. Amanda Hume had been appointed to the similar post for South Tees CCG and Martin Phillips had been appointed to the Darlington post. Nationally, 65 of the 68 CCG Chief Officer posts had been appointed. Appointments to the Chief Financial

Officers for the CCGs was now underway.

In relation to the NHS Commissioning Board Local Area Teams, only 16 Operational Directors of the 27 posts had been appointed. Cameron Ward had been appointed to the Durham and Tees post. Richard Baker had been appointed to a Director post covering the whole of the North Region for the NHS Commissioning Board. Steven Childs had been appointed to the Managing Director post of the Northeast Commissioning Support Organisation. In relation to the other general positions, appointments would commence soon as the HR Framework had recently been published.

Duncan Selbie had been appointed to the Chief Executive's post of Public Health England. David Flory had been appointed to the post at the head of the Trust Development Organisation.

It was highlighted that by October this year, the NHS would be a very different organisation. Consideration needed to be applied to the transitional arrangements to allow statutory duties to be undertaken to the end of March while allowing staff to undertake the transition to their new posts.

The Council's Acting Chief Executive indicated that in relation to the transition arrangements, it may be helpful to the Board if those were reported so that all groups/agencies were aware of them. In relation to the Commissioning Support Units, it was indicated that they would quickly move to being independent and competing for CCG work. The development of the North East Commissioning Support Service was understood to be well ahead of other areas.

Decision

The update was noted.

76 Feedback from Teleconference with the Local Government Association Health and Wellbeing Board's Programme

The Shadow Board was updated on the teleconference that the Mayor and Director of Public Health had held with the Local Government Association (LGA) in relation to the support that would be provided to Local Authorities as part of the transition of powers for public health from the NHS to Local Authorities. There would be resources available through the LGA but much still depended on the guidance being produced by government. The Director indicated that there was not expected to be any financial implications from the LGA support.

Decision

The update was noted.

77 Final Report into 'Cancer Awareness and Early Diagnosis' *(Health Scrutiny Forum)*

The Vice Chair of the Health Scrutiny Forum presented the final report into 'Cancer Awareness and Early Diagnosis' which had been circulated to all Members of the Shadow Board. The report outlined the overall aim of the scrutiny investigation, terms of reference, method of investigation, findings, conclusions, and subsequent recommendations. The salient findings were highlighted by Councillor Hall.

The Shadow Board welcomed the report and thanked the Scrutiny Forum for the work which had been undertaken which provided valuable information. It was agreed that the information should be shared with clinicians to promote further the benefits of early diagnosis. The Chief Executive of North Tees and Hartlepool NHS Foundation Trust commented that the Trust still struggled to meet the two week referral target, due to patients not taking up the referral immediately. The Chief Executive considered that the Trust should not be penalised for this failure to meet the target when it was out of their control. He also highlighted the need to raise awareness of lung cancer and respiratory diseases and this was an area where improved community services may assist in reducing readmissions to hospital.

The Acting Chief Executive stated that the Association of Northeast Councils (ANEC) had committed its support to the plain packaging campaign. The Shadow Board discussed the poster campaigns and the reach of these, particularly into workplaces. It was noted that this issue had been highlighted for consideration when developing a Community and Engagement Strategy for the Shadow Board.

In relation to the work with pregnant women, the Chief Executive of North Tees and Hartlepool NHS Foundation Trust commented that while staffing changes had seen changes to the senior midwifery post, midwifery services were still a high priority for the Trust. The Trust's smoking cessation services were still seen as one of the best in the country and the Trust did not wish to see any diminution of those services.

Decision

The Shadow Board noted the Scrutiny Forum's key recommendations to the Cabinet and partner health organisations as outlined below:-

(a) That in relation to the Teesside Cancer Awareness Roadshow:-

(i) Hartlepool Borough Council hosts a Roadshow ensuring messages are embed in the Council's health and wellbeing promotion to staff; and

(ii) Hartlepool Borough Council encourages appropriate Town based community venues and events to host a Teesside Cancer Awareness Roadshow.

(b) That Hartlepool's Health and Wellbeing Board ensures that Stop Smoking Services and smoking cessation is embedded in the JSNA;

(c) That in relation to the issue surrounding whether there is a link between high risk industrial workers and the contraction of cancers through the ingestion of particulates, such as coal dust:-

(i) The Public Health Directorate at NHS Tees carries out a literature research into the topic; and

(ii) That in relation to recommendation c(i) this information is shared with the Health Scrutiny Forum;

(d) That NHS Hartlepool and the emerging Clinical Commissioning Group:-

(i) Ensure that cancer screening levels are improved across GP Practices in Hartlepool; and

(ii) Devise and share a strategy with the Health Scrutiny Forum for targeting cancer screening and awareness activity in the workplace / venues where residents gather socially; building on the good practice of those workplaces who employ nurses.

(e) That the evidence about the impact of the role of the former Head of Community Midwifery in encouraging access to stop smoking services by pregnant women, be emphasised with North Tees and Hartlepool NHS Foundation Trust to seek assurances for its continued impact, following recent post restructuring;

(f) That Hartlepool Borough Council, through its new Public Health responsibility, ensures that young people in schools and youth groups receive appropriate hard hitting messages about the cancer risk of smoking, alcohol and poor diet;

(g) That in line with the smoke free workplace, as detailed in the Health Act 2006, Hartlepool Borough Council develops a strategy with partner organisations that:-

(i) Educates licensed taxi drivers about the effects of passive smoking, reminding them of the legislation of not smoking in the workplace; and

(ii) Determines appropriate enforcement options for licensed taxi drivers who are in breach of the smoke free workplace.

78 Scrutiny Investigation into 'Cancer Awareness and Early Diagnosis' – Action Plan *(Director of Public Health)*

The Director of Public Health reported that as a result of the Health Scrutiny Forum's investigation into 'Cancer Awareness and Early Diagnosis', a series of recommendations had been made. The recommendations included in the Final Report and the associated Action Plan had been accepted at a meeting of Cabinet on 9th July. The Action Plan was appended to the report to the Shadow Board and had been prepared in response to the Scrutiny Forum's recommendations

The Director of Public Health commented that the action plan would be submitted to the CCG as many of the indicators related to NHS services.

Decision

The Action Plan in response to the recommendations of the Health Scrutiny Forum's investigation into 'Cancer Awareness and Early Diagnosis' was noted.

79 Healthy Lives, Health People: Update on Public Health Funding (*Director of Public Health*)

The Director of Public Health informed the Shadow Board of proposals regarding future public health funding. Proposals for funding were set out in 'Healthy Lives, Healthy People: Update on Public Health Funding. Comments on the proposals were being invited by the Department of Health until mid August 2012.

The Director of Public Health highlighted that the base line mapping of actual spend by the Primary Care Trust in 2010/11 had been undertaken amounting to £7.6million. The consultation document raised concerns that there was a potential for a reduction in funding across the northeast. While spending on drug and alcohol services were not mandated spending, there was an expectation that the services would be continued. The key issues were set out in the report.

It was indicated that concerns had been raised through Cabinet and Scrutiny Coordinating Committee and that the Health Scrutiny Forum intended to meet prior to the date for the submission of comments to government to add its support to the retention of funding.

The Chief Executive, NHS Hartlepool commented that Middlesbrough BC had referred the issue through to the Tees Valley Joint Health Scrutiny Forum after meeting with Claire Bamburgh from Durham University. It was understood that there were no changes anticipated before 2016, though there was concern that the longer-term situation could be damaging for the region if the potential funding calculations were changed.

The Acting Chief Executive commented that the proposed letter in response to the government proposals would be circulated to partners who were encouraged to respond to the Department of Health.

Decision

The Board noted the proposals within the report and partners were requested to consider offering comments back to the Department of Health before the end of the engagement period of 14th August 2012.

80. Consultation Process for Health and Wellbeing Board Strategy *(Director of Public Health)*

The Shadow Board considered a report which outlined the proposed consultation process for the draft joint Health and Wellbeing Strategy. It was noted that the consultation process would allow for consultation with stakeholders on the strategic aims and objectives to be set out in the strategy and also to prioritise the strategic objectives to deliver the strategic aims for health and wellbeing in Hartlepool.

The Director of Public Health highlighted that the report reflected Local Authority processes and that it would be useful if partners could share their decision making processes. It was noted that the issue would be discussed at the next meeting of the Clinical Commissioning Group. There was discussion as to the difficulty of ensuring full and wide public consultation without simply revisiting the same small group of consultees. The Director of Public Health agreed to circulate a list of places where consultation would take place to all Shadow Board Members. Board Members were encouraged to add to list.

Decision

The Shadow Board noted the process of consultation for the Joint Hartlepool Health and Wellbeing Strategy.

81. Presentation by Public Health Team on Alcohol Strategy

The Shadow Board received a presentation by Sharon Robson, Alcohol Lead (Adults), Health Improvement Team, which addressed alcohol issues nationally and with a particular focus on the Hartlepool situation. It was highlighted that:-

- Hartlepool has one of the worst rates of alcohol attributable deaths amongst females in the country
- Hartlepool has one of the highest rates of alcohol attributable hospital admissions amongst females in the country

- Hartlepool has one of the worst rates of female deaths as a result of chronic liver disease i*n* the country

- Hartlepool has one of the highest rates of alcohol attributable hospital admissions amongst males in the country

- Hartlepool has one of the highest rates of alcohol attributable hospital admissions amongst under 18s in the country

- Hartlepool has one of the highest rates of binge drinking in the country

Alcohol remained the main problematic substance in Hartlepool and a diagram presented at the meeting highlighted a total of 5,133 alcohol users in the town were dependent drinkers. The issues which had been highlighted had been identified through Local Area Profile for England. The presentation included details of strategic lead for alcohol in terms of the role of the Safer Hartlepool Partnership Executive Group, the Substance Misuse Strategy Group and the strategic links with the Children's Strategic Partnership and the Health and Wellbeing Board. The presentation also detailed the services which were available in terms of medical and psychosocial interventions, service user and family support and the work on criminal justice programmes.

It was highlighted that there was insufficient capacity across all alcohol services to meet the demand for those services. It was considered that joint working with partners needed to continue to develop stronger pathways for the future. Alcohol QIPP was set up in August 2011 as a pilot to look at reducing alcohol related hospital admissions. The pilot had been extended to 31st March 2013. As a result of a gaps identified through a gap analysis, a number of recommendations had been made which were presented to the Shadow Board. In terms of future actions, work with GP's and Clinical Commissioning Groups was being developed for future development in alcohol screening and Brief Interventions to enhance referrals into treatment for GP's and to reduce alcohol related hospital admissions.

The Board discussed some of the various approaches utilised in tackling binge drinking and hospital admissions, such as the 'booze bus' where those that had drank to excess were taken to recover rather than being referred to A&E. Intervention and education programmes were discussed and the Board questioned whether the government's 'Troubled Families Initiative' would have an impact in this area.

It was also commented that while there were persistent problems with readmissions for alcohol abuse, sight could not be lost of those that were not admitted to hospital on a weekend for example but persistently drank excessively and then were admitted for serious illness. It was acknowledged that much still needed to be done to convey the messages to the public, particularly on 'units'. The link with the Clear and Credible Plan

was also highlighted together with the role for the Clinical Commissioning Group and the interface between the Safer Hartlepool Partnership and this Board.

Decision

The issues highlighted by the presentation were noted and the Director of Public Health agreed to circulate statistics to Board Members.

The meeting concluded at 11.40 p.m.

CHAIR

CLEVELAND POLICE AUTHORITY

July 2012

HEALTH AND WELLBEING BOARDS

1.0 PURPOSE OF REPORT

1.1 Highlight the opportunities and requirements of the office of the Police and Crime Commissioner to work with and pay regard to Health and Wellbeing Boards.

2.0 RECOMMENDATION

2.2 That the content of the report be noted, as part of the transition programme.

3.0 BACKGROUND

What are health and wellbeing boards?

The intention is Health and wellbeing boards will be a forum for key leaders from the health care system and linked service providers to work together to improve the health and wellbeing of their local population and reduce health inequalities.

Each top tier and unitary authority will have its own health and wellbeing board. Board members will collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way. As a result, patients and the public should experience more joined-up services from the NHS and local service providers.

Health and wellbeing shadow boards are a key part of ensuring :

- stronger democratic legitimacy and involvement
- strengthen working relationships between health and social care, and,
- encourage the development of more integrated commissioning of services.
- improved patient choice around health care providers and treatment available.
- establishing an independent commissioning body
- transfer of commissioning to GPs

- the abolition of Primary Care Trust's (PCTs) and Strategic Health Authorities (SHAs)
- transfer of public health responsibility and budget to the Local Authority
- creation of a Health and Wellbeing Board which will have statutory responsibility to drive forward health priorities for the local area
- creation of Healthwatch (at local and national levels) to promote and support the involvement of local people in health and social care decisions.
- greater integration and partnership working between key agencies

The boards will help give communities a greater say in understanding and addressing their local health and social care needs.

What will they do?

Health and wellbeing boards will have strategic influence over commissioning decisions across health, public health and social care.

Boards will strengthen democratic legitimacy by involving democratically elected representatives and patient representatives in commissioning decisions alongside commissioners across health and social care. The boards will also provide a forum for challenge, discussion, and the involvement of local people.

Boards will bring together clinical commissioning groups and councils to develop a shared understanding of the health and wellbeing needs of the community. They will undertake the Joint Strategic Needs Assessment (JSNA) and develop a joint strategy for how these needs can be best addressed. This will include recommendations for joint commissioning and integrating services across health and care.

Through undertaking the JSNA, the board will drive local commissioning of health care, social care and public health and create a more effective and responsive local health and care system. Other services that impact on health and wellbeing such as housing, education provision and community safety will also be addressed.

In the first instance key officers have indicated the shadow boards will adhere to their statutory membership requirement and follow the legislative requirements set down by the current government.

4.0 Identified areas of Commonality

4.1 It is recognised within the Police Reform and Social Responsibility Act that the Police and Crime Commissioner and Health and Wellbeing Boards will have to establish a transparent working relationship in order to achieve common objectives. The Act states

> *"10 Co-operative working*
> *The elected local policing body for a police area must, in exercising its functions, have regard to the relevant priorities of each responsible authority."*

Police Reform and Social Responsibility Act 2011 (c. 13)
Part 1 — Police reform Chapter 3 — Functions of elected local policing bodies etc

In addition to the Act, government guidance and correspondence outline an expectation for joint working arrangements between both structures this is articulated clearly in the communication from the Home Office, Department of Health and the Ministry of Justice titled " Building Recovery in Communities" *appendix A*.

> "Supporting people to recover from dependence is a key area where the public health system and the criminal justice system have common cause and can work together to deliver shared objectives. Improvement in an individual's health and a reduction in their offending go hand-in-hand. Police and Crime Commissioners will be able to work with Clinical Commissioning Groups and local authorities to promote the achievement of shared objectives and deliver a more effective, efficient system and will set out their vision in local Police and Crime Plans."

Extract from letter - Building Recovery in Communities

4.2 The Government has identified initial funding streams allocated to Police and Crime Commissioners as :

Grant	**Current Recipient(s)**
Community Safety Partnership Funding	Local Authorities
Drug Intervention Programme (DIP) Main Grant	Drug Action Teams
Drug Testing Grant	Police Forces
Early Interventions Grant	Local Authorities
Positive Futures	VCSE sector and Local Authorities
Youth Offending Team Drug Workers	Youth Offending Team
Youth Offending Team Grant	Youth Offending Team

In addition the recent white paper "Swift and Sure Justice" has strongly indicated further financial allocations for Youth Offending Services and Probation are to be moved to the Police and Crime Commissioner

4.3 Areas of greatest commonality appear in the first instance to be based around commissioning services aimed at drug and alcohol interventions however there are many more shared objective areas between health and the criminal justice agencies. It is anticipated partnership working will improve the efficiency of commissioning and avoid duplication whilst utilising finite resources effectively. In addition a clear understanding of strategic working and planning will provide clarity further strengthened by the electoral mandate incorporated into both structures.

4.4 Employees of Tees, Esk & Wear valley NHS have raised concerns over the interlinking of funding hosted by Local Authorities, NHS and Police and Crime Commissioners. The main areas of concern highlighted at partnership events are focused around National Identified Vulnerabilities, those being Safeguarding, Mental Health, Substance Misuse, Behavioural and Social Vulnerabilities. The perception is the lack of understanding around the intricacies of these services may result in the withdrawal of linked funding, however partners felt close working with Health and Wellbeing Boards would ensure clarity of service provision.

4.5 The Association of Police Authorities and the Home Office have produced papers which suggested that some partners are disengaging in the local partnership arena; and that this is having a detrimental impact on policing leading to negative perceptions of policing and a shift in internal policing culture. A specific example was given related to mental health, and the impact that reduced levels of local health provision is having on policing including at the most serious end, homicides and deaths in police contact leading to increased IPCC activity It was recognised that the partnership arena will be a key area of PCCs, and that engaging local health services strategically will clearly be a priority for PCCs.

Conclusion

5.1 The report notes that only a fraction of the integrated working needs and possibilities are documented, however the intention is to create a brief overview of what is a complex and required area of partnership working. Taking into account the complexity of funding structures the advantages of joint commissioning and partnership working combined with the influence of democratic mandates, participation within the HWB structure may play a pivotal role in informed service provision.

Ian Wolstenholme

July 2012

Background Documents (available from Ian Wolstenholme, Cleveland Police Authority 01642 301786 email Police.Authority@Cleveland.pnn.police.uk)

Legislation.gov.uk - Police Reform and Social Responsibility Act 2011
Commissioning - APACE
Building Recovery in Communities

C/O Department of Health
Drugs Policy Team
7th Floor Wellington House
133-135 Waterloo Road
London SE1 8UG

DH Gateway reference number 17355

3 April 2012

To: LA chief executives
Copies: Chief Constables, Prison Governors, Probation Trust Chief Executives

Dear colleague,

Building Recovery in local Communities

In April 2013 upper tier and unitary local authorities will take on responsibility for commissioning the full range of drug and alcohol prevention, treatment and recovery services. Also, from 22 November 2012, newly elected Police and Crime Commissioners will be responsible for cutting crime and improving community safety. This note highlights the new opportunities for joint working to improve outcomes and use resources more efficiently. It outlines the support that will be available to help you meet the needs of your community.

The 2010 Drug Strategy highlighted the importance of tackling dependence on drugs and alcohol which are key causes of crime, family breakdown and poverty[1]. Promoting recovery is central to addressing drug use. A key element of government reforms is to give local areas the freedoms and powers necessary to develop a holistic, joined-up recovery system that goes beyond drug treatment and addresses the wider needs of those with dependence on drugs and/or alcohol.

As highlighted in the recent Alcohol Strategy, an effective approach to tackling substance misuse requires partnership working between local authorities (public health, social care, housing, community regeneration and other services), health bodies (Clinical Commissioning Groups and local providers) and criminal justice agencies (including probation, prisons and police) and Job Centre Plus and the Work Programme. The object is to prevent misuse, and to ensure that those who become dependent are supported to

[1] Drug Strategy 2010 – *Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug-Free Life*

recover, be in employment, have stable accommodation, look after their families, and cease committing crime and anti-social behaviour.

Supporting people to recover from dependence is a key area where the public health system and the criminal justice system have common cause and can work together to deliver shared objectives. Improvement in an individual's health and a reduction in their offending go hand-in-hand[2]. Police and Crime Commissioners will be able to work with CCGs and local authorities to promote the achievement of shared objectives and deliver a more effective, efficient system and will set out their vision in local Police and Crime Plans.

The government is delivering a significant devolution of financial controls which maximises the scope for aligning local approaches and using budgets in a smarter way. The key budgets, many of which already exist, will include the Public Health Grant, the Early Intervention Grant, Local Authority programmes which meet housing, social care and other needs for people with multiple problems, NHS Commissioning Board resources, Community Safety funding, Probation Service resources, and Job Centre Plus and the Work Programme.

An integrated approach

Commissioning for recovery is most successful where it is based on local need and delivered as part of an integrated local response. This will be identified through the Joint Strategic Needs Assessment (JSNA) and prioritised in the new local Joint Health and Wellbeing Strategy[3]. These provide the framework for determining the quantum of local spend and how it is used.

Government is working with eight areas over two years to pilot Payment by Results as an approach to contracting. These pilots are being formally evaluated. In addition, a number of other drug partnerships are incorporating a PbR element into their contracts with providers, and there is increasing use of PbR for other public services. The skill of local authorities and their partner agencies in developing new forms of contracts and in managing the interface between PbR schemes for different services will be crucial to the success of this approach.

Health and Wellbeing Boards are envisaged as being the forum where many such discussions should take place, but local partners will need to determine the best mechanism for coordination in their locality, bearing in mind that some services – such as prisons – may be out-of-area. As healthcare in prisons and other places of detention will be the responsibility of the NHS Commissioning Board, it is intended to draw up a formal agreement between the Department of Health and the NHSCB to ensure that prison drug and alcohol treatment is commissioned in a way which promotes coordination both with other aspects of prison healthcare and with community substance misuse treatment.

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[2] *The Impact of Drug Treatment on Reconviction.* NTA 2012

[3] The NTA has sent detailed JSNA support materials to all local drug partnerships

The principles of successful recovery
Five key principles underpin an integrated recovery system:

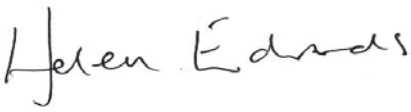
- all relevant partners, such as the drug and alcohol sector, the criminal justice system, employment, housing and education, collaborate to commission services based on outcomes for individuals, families and communities.
- recovery is initiated by ensuring drug-dependent people have prompt access to appropriate interventions, and ensuring that the transfer of drug-dependent offenders between prison and community settings is managed seamlessly.
- treatment services are high-quality and deliver a broad range of effective interventions, which prepare service-users for recovery while continuing to protect them and communities from the risks of drug misuse.
- treatment services provide individually-tailored packages of care and recovery support that are regularly reviewed, to encourage service users to successfully complete treatment without putting them at risk.
- treatment services join with community support networks and local partners to support people in sustaining long-term recovery, so they reintegrate back into society and do not need to return to treatment.

Local solutions can make increasing use of networks of support and other assets within the community, such as mutual aid groups like Narcotics Anonymous, families and carers, and other peer-led alliances. A key function is increasing the visibility of recovery to local residents and providing an important source of enduring support for individuals after treatment. Local recovery champions have a key role here.

Local areas and their partners have until the end of March 2013 to establish these new mechanisms and agree how they will operate. During this period the National Treatment Agency for Substance Misuse will provide support with transition. In addition, between now and November 2012, Police Authorities will prepare briefings for prospective PCCs, and will produce the first drafts of Police and Crime Plans and their budgets in order that they can be cleared by March 2013. From April 2013, support for local recovery systems will be provided by Public Health England, an agency of the Department of Health.

David Behan
Director General
Social Care, Local Government and Care Partnerships
Department of Health

Stephen Rimmer
Director General
Crime and Policing Group
Home Office



Helen Edwards
Director General
Justice Policy Group
Ministry of Justice

1 August 2012

Dear Colleague

STAY SAFE AND WARM CAMPAIGN 2012-2013

I am writing to you as chair of the Teeswide Safeguarding Vulnerable Adults Board to ask for your support in protecting some of the most vulnerable members of our communities by promoting to your staff this free life saving campaign.

Over 25,000 people in the UK die each year because they can't keep warm in their own homes in the winter months. This is due to either faulty heating or because of worries about the cost of fuel force them to turn their heating off or down to unsafe levels or because they use cheaper and less safe forms of heating which can cause fires.

Many of these people are in the most vulnerable groups, such as older people, single parents with children, people with disabilities or mental health issues and those with a long-term illness.

Led by Cleveland Fire Brigade and supported by local statutory members of the Board, the annual campaign aims to raise awareness of the dangers faced by people who struggle to keep warm during the cold months and to highlight the help and support available to them. This could range from organising safe, temporary heating to putting people in touch with specialist guidance on managing their fuel bills.

The scheme is simple to access. On recognising that there is a heating or fire safety related problem (i.e. no smoke detectors) your staff can access help by telephoning Cleveland Fire Brigade's number 01429 874063; there is no paper work to complete. On receipt of the information the Fire Brigade can offer assistance within the hour when needed.

Although this year's campaign will commence on 3 October 2012 and operate until 31 March 2013, Cleveland Fire Brigade will offer assistance with heating and fire safety matters throughout the year 24 hours a day.

To assist in promoting the campaign this year there will be opportunities for your staff to attend drop in sessions in your area; dates and locations will be advised shortly. The campaign will also be supported by literature, posters, information cards etc., and there is an opportunity for a member of Cleveland Fire Brigade to brief your staff in their work place.

I look forward to your support and will write to you again shortly to advise you of the next stages of the campaign, however if you require any further information please do not hesitate to contact Tracey Bell, Community Health and Wellbeing Manager, on 01429 872311.

Yours sincerely

JHumphreys

Jane Humphreys
Chair of the Teeswide Safeguarding Vulnerable Adults Board

Department of Health

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**
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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.
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For Recipient's Use	

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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].

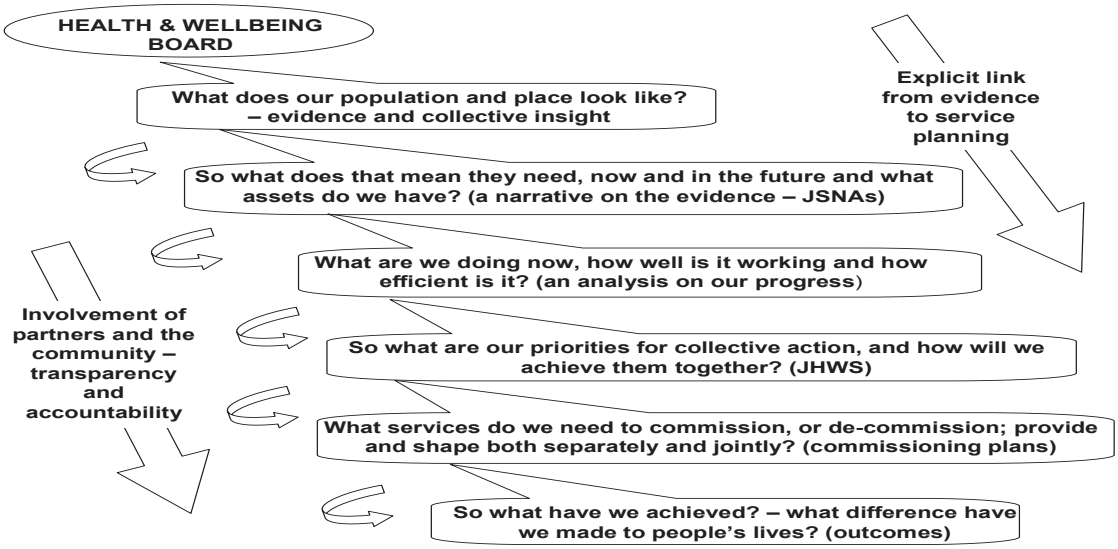
CCGs must also involve the health and wellbeing board in the preparation of (or when making significant changes to) their commissioning plans[19]. CCGs must consult health and wellbeing boards on whether their commissioning plans take proper account of the JHWSs[20]. When asked, health and wellbeing 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