Report for ACTION by the Health & Wellbeing Board
Item Number: 6

Contains Confidential or Exempt Information	**NO – Part I**
Title	Update on NHS Changes and the Joint Health and Wellbeing Strategy (JHWS)
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Member reporting	Cllr Simon Dudley
For Consideration By	Shadow Health and Wellbeing Board
Date to be Considered	18th May 2012
Implementation Date if Not Called In	Immediately
Affected Wards	All
Keywords/Index	Joint Health and Wellbeing Strategy, NHS Changes, Health and Social Care Act 2012

Report Summary

1. This report deals with the national changes that impact RBWM through the Health and Social Care Act 2012
2. It recommends that the Joint Health and Wellbeing Strategy is designed around the Marmot strategic priorities for the reduction of health inequalities
3. These recommendations are being made because there is a statutory requirement to produce a JHWS and it will need to be structured in a way that is most effective for addressing health inequalities
4. If adopted, the key financial implications for the Council are that efficiencies should become apparent through coordinated approach to tackling priorities.
5. An additional point to note is that under the Health and Social Care Act there is a duty to have public engagement in the process of the development of the JHWS

If recommendations are adopted, how will residents benefit?	
Benefits to residents and reasons why they will benefit	Dates by which residents can expect to notice a difference
1. The residents will be able to have a coordinated JHWS which has been developed with their input and which is structured along the themes of the Marmot, which is one of the biggest authoritative sources on addressing health inequalities	Whilst the JHWS should be completed as a shadow document by Sept / Oct 2012, it is designed to inform commissioning cycles that would come into effect at the start of the financial year (April 2013)

1. Details of Recommendations

RECOMMENDATIONS:

1.1 That a sub-group of the SHWB is formed to design the draft JHWS, including officers from NHS Berkshire and RBWM and other key stakeholders as required

1.2 That the JHWS is designed around the Marmot strategic objectives for reducing health inequalities

2. Reason for Recommendation(s) and Options Considered

Option	Comments
A) That the SHWB does not over-see a subgroup to develop the JHWS	A) This may lead to an uncoordinated JHWS that has gaps and does not accurately reflect the strategic planning for reducing health inequalities
B) That the SHWB does over-see a subgroup to develop the JHWS **RECOMMENDED**	B) the JHWS is a unifying document that details the needs of the population sets the shared priorities and actions
A) That the JHWS is not designed around the Marmot policy objectives for reducing health inequalities	A) The national guidance has been seen as draft and has not been set a structure to the format of the JHWS. If a specific structure is not selected for the design of the JHWS there is a risk that the document may not cover all of the areas that it is required to do so.
B) That the JHWS is designed around the Marmot policy objectives for reducing health inequalities **RECOMMENDED**	B) The Marmot investigation into health inequalities is considered to be the leading current research for addressing the health needs of populations and has been used for the design of the local JSNA. Using the same structure for the JHWS continues on the nationally and locally acknowledged authorities source for addressing health inequalities

3. Key Implications
What does success look like, how is it measured, what are the stretch targets

Defined Outcomes	Unmet	Met	Exceeded	Significantly Exceeded	Date they should be delivered by
The SHWB have leadership on the development of the JHWS	The JHWS is not sufficient for coordinating the needs of the population and the document has gaps.	The JHWS is known by the SHWB and is the document that guides the commissioning plans of partners	The SHWB have clear governance for the development of the JHWS	N / A	Sept 12
The JHWS is designed around the Marmot policy objectives for reducing health inequalities	The JHWS makes loose reference to Marmot, has gaps and is not coordinated with the JSNA	The JHWS is designed around Marmot and includes the 6 policy objectives, and key groups of populations and communities	The JHWS is designed around Marmot and includes the 6 policy objectives, and key groups of populations and communities, working with and shaping the community strategy	N / A	Sept 12 (as a draft to shape from April 2013)

4. Financial Details

a) **Financial impact on the budget (mandatory) - None**

Example	**Year1 (*state year*)**	**Year2 (*state year*)**	**Year3 (*state year*)**
	Capital £000	Capital £000	Capital £000
Addition			
Reduction			

Example	**Year1 (*state year*)**	**Year2 (*state year*)**	**Year3 (*state year*)**
	* Revenue £000	Revenue £000	Revenue £000
Addition			
Reduction			

b) Financial Background (optional) – N / A

5. Legal Implications
The Health and Social Care Act achieved Royal Assent in March 2012, and it is a duty in the Act for each Shadow Health and Wellbeing Board to ensure that a JHWS is created. Whilst the full statutory powers for the SHWB do not come into effect until April 2013, by following the legislation before it comes into power, it is setting the foundations for the future working of the JHWS

6. Value For Money – N / A

7. Sustainability Impact Appraisal - None

8. Risk Management -

Risks	Uncontrolled Risk	Controls	Controlled Risk
Insufficient time to consult public widely	No strategy for communication	Develop communication plan.	

9. Links to Strategic Objectives

The duties of the SHWB and the JHWS to promote health and well being link to all of the strategic objectives

Our Strategic Objectives are:

Residents First
- Support Children and Young People
- Encourage Healthy People and Lifestyles
- Improve the Environment, Economy and Transport
- Work for safer and stronger communities

Value for Money
- Deliver Economic Services
- Improve the use of technology
- Increase non-Council Tax Revenue
- Invest in the future

Delivering Together
- Enhanced Customer Services
- Deliver Effective Services
- Strengthen Partnerships

Equipping Ourselves for the Future
- Equipping Our Workforce
- Developing Our systems and Structures
- Changing Our Culture

10. Equalities, Human Rights and Community Cohesion
An EQUIA is not required at this time

11. Staffing/Workforce and Accommodation implications - None

12. Property and Assets - None

13. Any other implications - None

14. Consultation
The development of the JHWS has been discussed at the July 2011 meeting of the SHWB where it was agreed that the JHWS would be developed through the Director of Adult and Community Services as the chair of the corporate NHS Changes Programme Board, and with the engagement of the Director of Public Health and other key stakeholders, once the full implications of the Health and Social Care Act were understood. This was also agreed at Cabinet in December 2011

15. Timetable for Implementation
Please see below in section 17 for a full timescale for the NHS changes as stipulated through the guidance issued by central government.

The specific key dates for the JHWS strategy are as follows.

- May 212 – Strategy development begins
- September 2012 –JHWS is completed
- October 2012 – Financial and commissioning plans of partners are developed in line with the strategy

Therefore, subject to the final guidance being issued, the expected key dates for the subgroup are:

- May 2012 – subgroup established and meet to agree the Terms of Reference for the subgroup and distribution of work
- June – July 2012 – first draft of the JHWS complete
- July – August 2012 – public consultation on JHWS (as a duty under the Health and Social Care Act)
- August – September 2012 amendments and adjustments from consultation
- September – JHWS goes through partners sign off process

16. Appendices - None

17. Background Information

17.1 NHS Changes Update

The Health and Social Care Act has achieved Royal Assent and has just under 2,000 changes and amendments from the original iteration of the Bill, and which have included the recommendations from the second report of the NHS Future Forum.

Parallel to the Bill going through the parliamentary process, there have been seven national Action Learning Sets that are going to be producing guidance and products to support some of the difference aspects of the changes. The information from the ALS will be guidance that will be used to shape the work of the HWB from April 2013, when full statutory powers come into effect.

The local GP Clinical Commissioning Group is working towards Authorisation using the guidance that has been issued by the SHA. RBWM is working with the NHS to support the requirements of the process.

There are developments for the public health transfer and the development of Healthwatch that are reported to the SHWB separately

17.2 The Joint Health and Wellbeing Strategy (JHWS)

There have been several guidance documents that have been issued around the way the JHWS will work in practice and the remit of the JHWS. Contextually, the JHWS has been described as:

"The overarching framework within which commissioning plans for the NHS, Social Care, Public Health and other services which the Health and Wellbeing Board agrees are relevant, are developed"

17.2.1 The JHWS should cover:

a. the whole population; across,
b. the whole life course
c. people in the most vulnerable circumstances and excluded groups, including carers and families
d. people who live inside the area or outside it but receive or are subject to services provided by the local authority, e.g. looked after children and adults in accommodation in out of area placements
e. people who receive services in the local authority area, e.g. people who work in the Borough
f. all people of protected characteristics to ensure compliance with the Public Sector Equalities Duty
g. health, public health, social care and with wider social, environmental and economic factors that impact on health and wellbeing (see below for further information on wider determinants.

17.2.2 There are varying references to "population", "public", "patient" as "people in the local authority area", "people who use health services" and "people who live or work in that area". The most structured definition occurs in relation to Local Healthwatch which gives a qualified definition of "local people, in relation to a local authority, means—:

a. people who live in the local authority's area,
b. people to whom care services are being or may be provided in that area,
c. people from that area to whom care services are being provided in any place, and
d. people who are (taken together) representative of the people mentioned in paragraphs (a) to (c);" (*section 182 (8)*)

Locally for RBWM there is an additional consideration for those who study in the locality. RBWM is a net-importer for pupils due to the geographic location of secondary schools on the boarders.

17.2.3 With regard to definitions of "care services" these include "health services", "health-related services" and "social care services" as defined in section 195 (6) of the Health and Social Care Act as follows:

a. "health services" means services that are provided as part of the health service in England

b. "health-related services" means services that may have an effect on the health of individuals but are not health services or social care services
c. "social care services" means services that are provided in pursuance of the social services functions of local authorities (within the meaning of the Local Authority Social Services Act 1970) and which covers Children's and Adults Social Care

The terms "patient" refers to "persons to whom NHS services are being provided" and "carers" means persons who, as relatives or friends, care for other persons to whom NHS services are being provided as defined in Part 1, Chapter 1, Section 3(7) of the Health Act 2009.

17.3 What Are the Principles of the JHWS?

Draft Department of Health guidance states that the JHWS should:

a. Be the agreement between the HWB and the community, increasing local legitimacy of services and ownership of decisions through broad and representative involvement
b. Be the common, and accessible, resource that informs commissioning decisions and holds commissioners to account
c. Be strategic and set out shared agreed priorities
d. Focus on wellbeing outcomes and reducing health inequalities and the wider determinants of health
e. Take into account current and future health and social care needs with a view to promoting innovation and securing continuous improvement
f. Be based on the "*post hoc*" principle of cyclical development (i.e. must be iterative and take into account the outcomes of the strategy itself)
g. Involve all relevant sectors and agencies in an integrated manner to consider the entire population, including future Police and Crime Commissioners, probation service, Job Centre Plus and schools, the third (VCS), fourth (social enterprise) and fifth (user groups) sectors and providers.
h. Promote the involvement of patients, their carers and representatives in decisions and monitoring of outcomes
i. Prioritise issues requiring the greatest attention, concentrate on an achievable amount to maximise resources and focus on issues where the greatest outcomes can be achieved
j. Take an asset based approach to development and delivery of solutions, considering how assets can be identified, coordinated and mobilised to maximise outcomes through combined commitment, effort and resource
k. Pool resources (including people) and focus on things that can be done together
l. Deliver increased choice and control with independence, prevention and integration as core drivers of support solutions
m. Reflect local need but also outcomes set out in the Outcomes Frameworks for health, public health, social care (and anticipated framework for Children and Young People and emerging framework for GP Commissioning)
n. Build upon and align with other assessments as appropriate to avoid duplication and maximise the existing deployment of resources to join up commissioning and delivery

17.4 Alignment with existing plans and assessments

A range of assessments and research has been undertaken to develop the JSNA. Statutory partners will already be implementing strategies and plans to which resource will already be committed. Such arrangements should also be built upon and aligned as appropriate to avoid duplication and to maximise the outcomes from existing deployment of resources. Therefore there is a strong argument for having a JHWS that is aligned with the format of the JSNA.

Additionally the JHWS will need to align with the overarching strategy for the locality, being the Community Partnership Strategy, this will ensure that the wider influences on health inequalities are incorporated into the design of the document.

17.5 How should the JSNA and JHWS fit together?

The **JSNA** is a public document that sets out the "picture of place" in terms of health and wellbeing needs of the whole community. It is the foundation for joined up and collective commissioning. As every area is different, the design process will be designed to suit each locality.

A JSNA is not to be considered a static document output or simply an end in itself. It is a "**process"** of objective assessment that identifies local needs based on a range of high quality and impartial quantitative evidence as well as qualitative information such as other local assessments and non-health data.

This quality of this assessment is as important as the output document and must be viewed as **ongoing process** as information and intelligence is fed into the HWB, particularly through patient and public involvement mechanisms. Tension will be anticipated between the expressed needs of communities and the intelligence from data and robust mechanisms for consideration and prioritisation of new intelligence for a balanced over all assessment of needs will be required.

The **JHWS** is the public document that outlines health and social care **priorities** identified through the assessment of evidence set out in the JSNA and data capture processes.

It sets out actions, outputs and outcomes to be delivered by key commissioners across local health, public health, social care services and any other services that have a health related outcome. The JHWS is to be determined through a robust and collective process of prioritisation and outcome measurement.

There is no requirement to produce JSNA and JHWS on an annual basis, but as iterative documents, the SHWB will need to agree a refresh process and cycle to inform annual planning and commissioning arrangements.

17.6 Timescales for development - The guidance for the JHWS has illustrated a national timescale, please see below for a full breakdown

Report History

Decision type:	Urgency item?
Non-key decision	No

Full name of report author	Job title	Full contact no:
Catherine Mullins	NHS Changes Project Manager	01628 68 3664

	Dec 2011	Jan 2012	Apr	May	Jul	Oct	Feb 2013	Mar	Apr
HWB		Continuous engagement with stakeholders and public	Non-statutory						Statutory
JSNA	Draft guidance available	JSNA refresh gets underway							
JHWS	Draft guidance available		Priorities from JSNA emerge	Strategy to be developed for commissioning plans					
CCG			Non-statutory		Start of authorisation submissions	Authorisation process begins	Commissioning plans to be agreed		Statutory Commissioning plans implemented
LA			Data collection and analysis		Review priorities	Financial planning		Business Plan published	
NHSCB	Special Health Authority status preparing for Oct launch		Limited statutory responsibility as Non-Departmental Public Body			Partial operation as Non-Departmental Public Body			Statutory