

## **LOCAL DEMOCRATIC LEGITIMACY: FACTSHEET**

**Gateway reference: 15320**

### **1. Introduction**

The NHS and Public Health white papers together provide local authorities with an enhanced role in supporting the delivery of health and social care services.

Local authorities will take on the major responsibility of improving the health and life-chances of the local populations they serve, and will lead others to work together to improve health and wellbeing.

Local authorities will lead on public health, using a new ring-fenced budget and health premium, which will reward areas who make the most progress. Directors of Public Health will move from the NHS to local authorities.

### **2. Mutually respecting partners**

Better health and wellbeing will only come from the NHS and local authorities working together, with high quality local leadership and relationships being an essential foundation for achieving better health and wellbeing outcomes.

### **3. Statutory health and wellbeing boards**

There is a need to improve the strategic coordination of commissioning services across NHS, social care, related childrens and public health services. To support this, the Health and Social Care Bill will require the establishment of a health and wellbeing board in every upper tier local authority by April 2013.

Health and wellbeing boards will bring together elected representative and the key NHS, public health, social leaders and patient representatives to work in partnership. This will ensure services are joined up around the needs of people using them, and that resources are invested in the best way to improve outcomes for local communities.

### **4. Flexible geographical scope**

The Health and Social Care Bill will give flexibility for health and wellbeing boards to choose to do their work at whatever level “makes sense locally”. This means they might choose to work together to set up a board covering more than one local authority area, or to carry out some of their work more locally, focussing on the needs of a specific district or neighbourhood.

### **5. Core membership**

To achieve the most effective integration and joint action, core members of the board must include GP consortia, the director of adult social services, the director of children’s services, the director of public health and a representative from local HealthWatch. To increase local democratic legitimacy and to represent the interests of the public the Bill prescribes there must be a minimum of at least one local elected representative.

Local authorities can decide to invite and include other members, for example other groups or stakeholders who can bring in particular skills or perspectives, such as the voluntary sector, clinicians or providers.

By making the boards statutory and specifying a core membership health and wellbeing boards provide the forum for public accountability.

The role of the boards will be to improve joint working and commissioning and increase local democratic engagement with the commissioning of services, alongside patient engagement through local HealthWatch.

## **6. Enhanced joint strategic needs assessment**

The core purpose of health and wellbeing boards is to join-up commissioning across NHS, social care, public health, children's services and other services that the board agrees have an impact on the wider determinants of health – for example leisure or housing.

The aim is to achieve better health and wellbeing outcomes for their whole population and a better quality of care for patients and other people using services.

Through new health and wellbeing boards, local government will lead in bringing together the NHS, social care, public health and children's services to understand local needs through a joint strategic needs assessment (JSNA) and to create a joint health and wellbeing strategy (JHWS) to address them. Local authorities and GP consortia will have an equal responsibility to develop the strategy.

The Bill will place a legal obligation on NHS and local authority commissioners to refer to the JSNA in exercising their commissioning functions.

## **7. The new joint health and wellbeing strategy**

The ambition is for health and wellbeing boards to go further than analysis of common problems to deep and productive partnerships that develop solutions to challenges (rather than just commenting on them).

To support this ambition the Bill specifies boards should develop a joint health and wellbeing strategy that spans the NHS, social care, public health and potentially other wider health determinants such as housing. Through the strategy, the council, NHS and other partners will agree, at a high level, how they will address the health and wellbeing needs of their community, giving the overarching framework for developing plans for the NHS, social care, public health and other relevant services.

The Bill will place a legal obligation on NHS and local authority commissioners to have regard to the JHWS in exercising their commissioning functions.

This new way of working is not about one partner on the health and wellbeing board having the power to overrule others' decisions – it's about fundamentally changing the dynamic to one of collaborative leadership. The work of the health and wellbeing boards is about influencing, shaping and driving services.

## **8. Increased joint commissioning and pooled budgets**

Health and wellbeing boards will be able to look at the totality of resources available to support local people's health and wellbeing, across the budgets the NHS, council and other partners hold. The Health and Social Care Bill and health and wellbeing boards are intended to encourage local authorities and their NHS partners to make more use of the flexibilities already available to them – such as pooling budgets or having lead commissioning arrangements – when drawing up the joint health and wellbeing strategy.

Health and wellbeing boards will be expected to consider how the mechanisms for integration already included in the NHS Act, such as pooled budgets or lead commissioning arrangements, could be used to provide more integrated commissioning across health and social care.

## **9. Health and wellbeing boards as an open-ended vehicle**

Local authorities will have freedom to delegate additional functions to the health and wellbeing board. For example, housing or other wider determinants of health could be considered by the board, with the aim of providing better (and more integrated) services to communities

GP consortia will be able to develop voluntary arrangements with a local authority to deliver services on their behalf. For example, local authorities, with their commissioning expertise may be well placed to support GPs in developing new arrangements.

## **10. Referral and enhanced security**

The Department of Health listened to feedback about the importance of having independent scrutiny functions and reconsidered its proposals. We are therefore persuaded that health and wellbeing boards will not have a health scrutiny function.

Rather than placing a duty on the health and wellbeing board, the Bill will place the powers for health overview and scrutiny with the local authority itself. Local authorities can then choose how to exercise these functions, whether through current Health Overview and Scrutiny Committees or alternative arrangements.

## **11. Implementation framework**

Subject to Parliamentary approval, health and wellbeing boards will become a statutory committee of local authorities at the same time GP consortia taken on responsibility for the NHS budget.

Although boards will only formally assume powers and duties in April 2013, the new partnership arrangements are critical to developing the new system for health and care, and need to be hardwired into it from the start. That means developing them alongside other parts of the system like GP consortia, starting now.

Legislating for change is not the same as making it happen. The benefits for local communities cannot be achieved without developing the right local relationships and leadership.

Leaders in local authorities, emerging GP consortia and PCTs need to work together now to consider and establish the right local arrangements.

In the first phase, a network of early implementers – areas who want to start work on new arrangements now – will be supported by DH to share experience and expertise. The outputs of this work will be shared with other councils and GP consortia. We will be writing to all local authorities in January, inviting them to engage in this network.

The second phase of implementation will be the establishment of “shadow” health and wellbeing boards in every upper-tier authority by the end of 2011, with shadow running during 2011/12.

The final phase will be in April 2013 onwards, when statutory duties and powers will take full effect – this will be supported by enhanced scrutiny powers for local authorities

To be successful, it is important that all key partners in a local area take this work forward together, recognising that not everybody is starting from the same point, and that some GP consortia or councils will already be further on with their plans than each other. Partners will need to build learning and share skills together as they go, investing time, effort and commitment in building relationships.

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