



**Statutory Guidance on Joint
Strategic Needs Assessments
and Joint Health and Wellbeing
Strategies**

DH INFORMATION READER BOX		
Policy HR / Workforce Management Planning / Performance	Clinical Commissioner Development Provider Development Improvement and Efficiency	Estates IT & T Finance Social Care / Partnership Working
Document Purpose	Best Practice Guidance	
Gateway Reference	1E840	
Title	Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies	
Author	Department of Health	
Publication Date	26 March 2013	
Target Audience	NHS Trust CEOs, Foundation Trust CEOs, Directors of PH, Local Authority CEOs, Directors of Adult SSs, Allied Health Professionals, GPs, Communications Leads, Directors of Children's SSs, Healthwatch England, Public Health England, LINks, CCG pathfinders, shadow HWBs, voluntary and community sector organisations	
Circulation List		
Description	The purpose of this publication is intended to support health and wellbeing boards and their partners in understanding the duties and powers in relation to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs).	
Cross Ref	The Health and Social Care Act 2012: Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. Joint Strategic Needs Assessments and Joint Health and Wellbeing	
Superseded Docs	N/A	
Action Required	N/A	
Timing	N/A	
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 First published April 2012
 Published to DH website, in electronic PDF format only.
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1. Purpose

The Health and Social Care Act 2012¹ ('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 the duties and powers relating to JSNAs and JHWSs. This guidance does not cover the wider membership of health and wellbeing boards, or what services should be commissioned in response to local JSNA findings and JHWS priorities – these decisions need to be made locally, depending on circumstances, and subject to duties to have regard to the relevant JSNAs and JHWSs. Further supporting materials, including advice on good practice will be published alongside this statutory guidance.

2. Context

In the Act, the Government has set out a new vision for the leadership and delivery of public services, where decisions about services should be made as locally as possible, involving people who use them and the wider local community. The Act supports the principle of 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 locally owned process, through which to achieve this. As such, and with duties that fall upon local parts of the system, each health and wellbeing board is likely approach them according to their own local circumstances. It would not therefore be appropriate for central Government to be prescriptive about the process or to monitor the outputs.

The purpose 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 – the core aim is to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities. Their outputs, in the form of evidence and the analysis of needs, and agreed priorities, will be used to help to determine what actions local authorities, the local 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 wellbeing².

In preparing JSNAs and JHWSs, health and wellbeing boards must have regard to guidance issued by the Secretary of State³ (this guidance, and any future revisions issued), and as such boards have to be able to justify departing from it.

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 2007 Act – section 116 (as amended by the Act – section 192) and section 116A (as inserted by the Act – section 193).

3. Duties and powers under the 2007 Act (as amended by the Act)⁴

3.1 Who is responsible for JSNAs and JHWSs?

Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare JSNAs and JHWSs, through the health and wellbeing board⁵. The responsibility falls on the health and wellbeing board as a whole and so success will depend upon all members⁶ working together throughout the process. Success will not be achieved if a few members of the board assume ownership, or conversely do not bring their area of expertise and knowledge to the process. As the duties apply across the health and wellbeing board as a whole, boards will need to discuss and agree their own arrangements for signing off the process and outputs. What is important is that the duties are discharged by the board as a whole.

Two or more health and wellbeing boards could choose to work together to produce JSNAs and JHWSs, covering their combined geographical area⁷. Some health and wellbeing boards may find it helpful to collaborate with neighbouring areas where they share common problems as this can prove to be more cost effective than working in isolation.

Local authorities and health and wellbeing boards can decide to include additional members on the board beyond the core members⁸. Additional members, such as service providers (NHS, private or voluntary and community sector), health and care professionals, representatives of criminal justice agencies, fire and rescue services, local voluntary and community sector organisations, universities, or representatives of military populations, can bring expert knowledge of the local community to enhance JSNAs and JHWSs. Membership of the board is not the only way to be involved in or influence JSNAs and JHWSs – boards will need to work with a wide range of local partners and the community beyond the board’s membership. Working with local partners will support boards not only to undertake a thorough and broad assessment of local needs by using evidence and expertise these partners can provide; but it

⁴ The duties imposed 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 potentially be used. Where ‘should’ is used it indicates 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.

⁵ The 2007 Act – section 116 (as amended by the Act – section 192) require a “responsible local authority” and each of its partner CCGs to prepare JSNAs and JHWSs; and section 116A (as inserted by the Act – section 193); and the Act – section 196 provides that these functions are to be exercised by the health and wellbeing board established by the local authority. Section 103 of the 2007 Act provides that each of the following is a “responsible local authority”: a county council in England, a district council in England other than a council for a district in a county for which there is a county council; a London borough council, the Council of the Isles of Scilly and the Common Council of the City of London in its capacity as a local authority.

⁶ The Act – section 194: each “responsible local authority” in England (see footnote 4) must set up a health and wellbeing board, with a core membership of: a) at least one elected representative – a 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 will 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. Other members may be appointed by the local authority or health and wellbeing board.

⁷ The Act – section 198(a) allows two or more health and wellbeing boards to make arrangements for any of their functions to be exercisable jointly.

⁸ ‘Core members’ is a reference to the members referred to on the face of the Act (section 194) – see Footnote 5. A local authority or health and wellbeing board can appoint other members to the board – section 194.

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will also provide an opportunity to influence the work of these partners to support addressing the identified needs.

Although the NHS Commissioning Board (NHS CB) is not a core statutory member of health and wellbeing boards, prescribed by the Act, it must participate in JSNAs and JHWSs. If the health and wellbeing board agrees, the NHS CB may be represented by someone who is not from the NHS CB; such as from a CCG or a local Commissioning Support Unit (CSU)⁹.

3.2 What are Joint Strategic Needs Assessments (JSNAs)?

JSNAs are assessments of the current and future health and social care needs of the local community. – these are needs that could be met by the local authority, CCGs, or the NHS CB¹⁰. JSNAs are produced by health and wellbeing boards¹¹, and are unique to each local area. The policy intention is for health and wellbeing boards to also consider wider factors that impact on their communities' health and wellbeing, and local assets that can help to improve outcomes and reduce inequalities. Local areas are free to undertake JSNAs in a way best suited to their local circumstances – there is no template or format that must be used and no mandatory data set to be included.

A range of quantitative and qualitative evidence should be used in JSNAs. There are a number of data sources and tools that health and wellbeing boards may find useful for obtaining quantitative data¹². Qualitative information can be gained via a number of avenues, including but not limited to views collected by the local Healthwatch organisation or by local voluntary sector organisations, feedback given to local providers by service users; and views fed in as part of community participation within the JSNA and JHWS process.

JSNAs 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 employment, crime, community safety, transport, planning or housing. Evidence of service outcomes collected where possible from local commissioners, providers or service users could also inform JSNAs. Boards will need to ensure that staff supporting JSNAs have easy access to the evidence they need to undertake any analysis they needed to support the board's decisions.

Health and wellbeing boards are also required to undertake Pharmaceutical Needs Assessments (PNAs)¹³; and although many may choose to combine the process with JSNAs,

⁹ 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.

¹⁰ The 2007 Act – section 116 (as amended by the Act – section 192). Section 116 requires an assessment of “relevant needs” – a “relevant” need is a) a need capable of being met to a significant extent by the local authority's exercise of functions; and which could also be met or affected, to a significant extent, by the partner CCG or NHS CB's exercise of functions; or b) a need which is capable of being met to a significant extent by the partner CCG or NHS CB's exercise of functions; and which could also be met or affected, to a significant extent by the local authority's exercise of functions.

¹¹ 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.

¹² Links to existing sources and tools for quantitative data will be available within the suite of resources to support health and wellbeing boards. This will be hosted on the [Knowledge Hub](#).

¹³ Section 128A of the NHS Act 2006, as amended by Section 206 of the 2012 Act. DH has laid regulations for undertaking PNAs - please refer to Regulations 3 - 9 and Schedule 1 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

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the duties for these are separate, and distinct PNAs need to be produced to inform the NHS CB's decisions on commissioning pharmaceutical services for the area.

Health and wellbeing boards can request relevant information to support JSNAs from organisations represented on the board (core members and others)¹⁴ – and when asked, they have a duty to supply the requested information, if they hold it¹⁵. Health and wellbeing boards may find it useful to develop a dialogue with their local Healthwatch organisation over time to understand what information it intends to collect. Unless the NHS CB is a board member, it is not subject to the duty to provide evidence when asked. However, as it must base its commissioning plans on JSNAs (and JHWSs) it does have an interest in the process and may wish to co-operate in sharing evidence. Boards can also request evidence they would expect other organisations (such as regulators or other local commissioners) to hold, although again unless they are members of the board, they will not have a duty to comply with the request.

Local authorities will need to interpret and analyse data and information for a number of their functions, including giving public health advice to CCGs. They may choose to use this expertise to support health and wellbeing boards; however, as the primary JSNA (and JHWS) duties sit jointly on local authorities and CCGs, they will want to discuss and agree what resources and expertise they will each provide to support their health and wellbeing board.

Public Health England (PHE) will support local authorities to deliver locally appropriate interventions and services. They will provide data, interpretation and evidence to enable local public health teams to improve the public's health. PHE is also developing clear processes for stakeholders to be able to discuss their knowledge and intelligence support needs¹⁶. From 1 April 2013, public health professionals in PHE and the wider public health system in local authorities will have access through a single portal¹⁷ to a suite of indicators, analyses and evidence to support decision-making. Through this portal local authorities will continue to be able to access the knowledge and information products currently available from the agencies coming together to form PHE on 1st April 2013, including the Public Health Observatories, Health Protection Agency, National Treatment Agency, Cancer Registries and others. PHE will be a key partner to support public health within local authorities to use these resources to increase capacity to identify local issues and make the best decisions (including prioritising local resources), to reduce inequalities and help improve the health and wellbeing outcomes of the local community, including vulnerable groups.

JSNAs must assess current and future health and social care needs¹⁸ within the health and wellbeing board area and it is important to cover the whole population, and ensure that mental health receives equal priority to physical health. This includes health protection, and upstream prevention of ill health; and it could include looking at the role of personal budgets and universal advice. Therefore health and wellbeing boards will need to consider:

¹⁴ 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) beyond 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.

¹⁵ Organisations will need to ensure that the supply of this information does not this does not override the common law duty of confidentiality and the requirements of the Data Protection Act 1998.

¹⁶ Information on the process of interacting with local authority stakeholders will be available via the [PHE website](#).

¹⁷ The web-portal will be available via the [PHE website](#).

¹⁸ See Footnote 10 as to the needs that are covered.

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- demographics of the area, and needs of people of all ages of the life course including how needs vary for people at different ages;
- how needs 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; and those with complex and multiple needs such as looked-after and adopted children, children and young people with special educational needs or disabilities, troubled families, offenders and ex-offenders, victims of violence, carers including young carers, homeless people, Gypsies and Travellers, people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging¹⁹;
- wider social, environmental and economic factors that impact on health and wellbeing – such as access to green space, the impact of climate change, air quality, housing, community safety, transport, economic circumstances, 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.

Health and wellbeing boards may find that there is a lack of evidence about some issues, and some seldom heard and vulnerable groups, which could be indicative of unmet needs and deprivation. Local partners such as voluntary sector organisations or local Healthwatch may be able to help where such evidence is lacking as they are well-placed to collect both quantitative and qualitative evidence and have good specialist knowledge of the community. They can also help boards to directly engage with some of these seldom heard and vulnerable groups. Other public sector organisations in the area can also provide relevant evidence on deprivation which may help boards develop a detailed understanding of deep inequalities in the area, such as the association between health and employment inequalities.

Supporting active communities and encouraging people to improve their health and wellbeing is central to achieving the Government's vision. When undertaking JSNAs, health and wellbeing boards should also consider what assets local communities can offer in terms of skills, experience, expertise and resources²⁰ that could help local authorities and the NHS to address the identified needs and impact on the wider determinants of health. This could be a range of assets including formal or informal resources, social networks, community cohesion, capacity or skills in organisations or the community; such as the ability of groups to take greater control of their own health or manage long-term conditions. Local partners, especially in the voluntary sector, can help boards understand the strengths and assets within local communities.

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

JHWSs are strategies for meeting the needs identified in JSNAs²¹. As with JSNAs, they are produced by health and wellbeing boards²², are unique to each local area, and there is no

¹⁹ This is not an exhaustive list, but an example of some vulnerable groups and health and wellbeing boards may wish to consider – boards will need to develop their understanding of the vulnerable groups in their area and the issues that affect them.

²⁰ 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 of assessing assets being developed, (Local Area Co-ordination, Connected Care or Asset-Based Community Development) – these examples may be useful to health and wellbeing boards.

²¹ The 2007 Act – section 116A (as inserted by the Act – Section 193).

²² The duty falls on responsible local authorities and partner CCGs but must be discharged by health and wellbeing boards (the Act – section 196(1)). See Footnote 4. 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 partner CCGs.

mandated standard format. In preparing JHWSs, health and wellbeing boards must have regard to the Secretary of State's mandate²³ to the NHS CB²⁴ which sets out the Government's priorities for the NHS.

They should explain what priorities the health and wellbeing board has set in order to tackle the needs identified in their JSNAs. Again, it would not be appropriate to specify or dictate issues which should be prioritised. This is not about taking action on everything at once, but about setting a small number of key strategic priorities for action, that will make a real impact on people's lives. JHWSs should translate JSNA findings into clear outcomes the board wants to achieve, which will inform local commissioning – leading to locally led initiatives that meet those outcomes and address the needs.

3.4 Using JSNAs and JHWSs

The importance of JSNAs and JHWSs lies in how they are used locally – as well as identifying the local community's needs, they also provide a significant opportunity to tackle and make a real impact on extreme inequalities experienced by some vulnerable and seldom heard groups, and to integrate local services around their users.

CCGs, the NHS CB, and local authorities' plans for commissioning services will be expected to be informed by relevant JSNAs and JHWSs. Where plans are not in line with JSNAs and JHWS, CCGs, the NHS CB and local authorities must be able to explain why²⁵. The policy intention is that local services which impact upon health and wellbeing will be based on evidence of local health and wellbeing needs and assets, including the views of the community; meaning that services and the way in which they are provided meet local needs.

CCGs must involve the health and wellbeing board in preparing (or making significant changes to) their commissioning plans²⁶. This includes consulting health and wellbeing boards on whether the plans take proper account of the JSNAs and JHWSs²⁷. When consulted, boards must give a view, and their final opinion must be included in the published plan²⁸. It would also be good practice for local authorities and the NHS CB to involve boards when developing their commissioning plans, to ensure that they are properly informed by the relevant JSNAs and JHWSs. By their nature, commissioning plans will need to cover a broad range of services – plans for services which meet additional needs to those prioritised in JHWSs, does not in itself mean the plans do not take proper account of those JHWSs.

²³ The first Mandate between the Government and the NHS Commissioning Board, setting out the ambitions for the health service for the next two years, was published on the 13th November 2012. The Board is legally required to pursue the objectives [in this document](#).

²⁴ The 2007 Act – section 116A (as inserted by the Act – section 193).

²⁵ 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.

²⁶ 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).

²⁷ 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.

²⁸ 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

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If a health and wellbeing board thinks a CCG has not taken proper account of the relevant JSNAs and JHWSs it can make this clearly known to the CCG when consulted, and also to the NHS CB²⁹. 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 JHWSs, without a good reason³⁰. If a health and wellbeing board thinks that the NHS CB has not taken proper account of the relevant JSNAs and JHWSs, it can raise this directly with the NHS CB, or in extreme circumstances it could escalate this to Secretary of State³¹.

Under the Act, in relation to their public health functions, upper-tier local authorities are required to take appropriate steps to improve the health of their population³². This 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 proper account of the JSNAs or JHWSs, it can raise its concerns with the local authority³³. This could be raised in a number of ways, such as with the leader of the council, the full council, council members with relevant portfolios, or with any relevant scrutiny committees or arrangements.

3.5 Timing

JSNAs and JHWSs are continuous processes, and are an integral part of CCG and local authority commissioning cycles³⁴. Health and wellbeing boards will need to decide for themselves when to update or refresh JSNAs and JHWSs or undertake a fresh process to ensure that they are able to inform local commissioning plans over time. They do not need to be undertaken from scratch every year; however boards will need to assure themselves that their evidence-based priorities are up to date to inform the relevant local commissioning plans. To be transparent and enable wide participation, boards should be clear with their partners and the community what their timing cycles are and when outputs will be published.

4. Promoting integration between services

JHWSs can help health and social care services to be joined up with each other and with health-related services³⁵, such as housing, transport, the economy or the environment.

Health and wellbeing boards must encourage integrated working between health and social care commissioners, and provide appropriate support to encourage partnership arrangements

²⁹ See Footnote 26 as to the duty to consult under the NHS Act 2006 – section 14Z13 (as inserted by the Act - section 26).

³⁰ 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. The NHS CB could require documents, information or an explanation (the NHS Act 2006 – sections 14Z17 or 14Z19).

³¹ The Secretary of State for Health has intervention powers in relation to the NHS CB where the NHS CB is not exercising its functions properly or at all or is at risk of failing to do so. The NHS Act 2006 – section 13Z2 (as inserted by the Act - section 23). The Secretary of State can also request information from the Board (The NHS Act 2006 - Schedule 1A paragraph 14).

³² The NHS Act 2006 – section 2B (as inserted by the Act - section 12) requires responsible local authorities (see footnote 5) to take such steps as they consider appropriate to improve the health of their populations.

³³ The Act – section 196.

³⁴ The NHS Act 2006 – sections 14Z11 to 14Z14, 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.

³⁵ The 2007 Act – section 116A (as inserted by the 2012 Act – section 193). In the context of health and wellbeing boards' powers to encourage close working between certain commissioners, 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.

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for health and social care services³⁶, such as pooled budgets, lead commissioning, or integrated provision³⁷. In JHWSs, health and wellbeing boards must consider how far needs can be met more effectively by working together in this way³⁸.

Health and wellbeing boards can encourage close working between commissioners of health-related services and themselves; and commissioners of health and social care services³⁹. 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 authorities⁴⁰ where it considers this would ensure the integrated provision of health services and this would improve the quality of services or reduce inequalities⁴¹. CCGs also have a duty to aim to achieve such integration to improve the quality of services or reduce inequalities⁴². Combined, these duties 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 board⁴³. This could result in boards taking on health-related functions, such as preparing housing strategies; which could help to take action on the agreed local priorities. To avoid potential conflicts of interest, the power to delegate functions does not include health scrutiny functions⁴⁴, as boards will be subject to scrutiny by the local authority. This is an important way that the local authority (and through it, local people) can hold some organisations represented on the board to account for their role in delivering health services, or consider how the JSNA and JHWS process and its outputs are used to plan services.

JHWSs could be used to 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 and commissioning plans should complement other; and this will encourage greater integration across health and social care services.

³⁶ The Act – section 195.

³⁷ The NHS Act 2006 – section 75.

³⁸ The 2007 Act – section 116A (as inserted by the Act – section 193).

³⁹ The Act – section 195.

⁴⁰ 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).

⁴¹ 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. “Reducing inequalities” in this section of the Act is specifically “reducing inequalities in relation to access to or outcomes from services”.

⁴² The NHS Act 2006 – section 14Z1 (as inserted by the Act – section 26). Again this specifically is “reducing inequalities in relation to access to or outcomes from services”.

⁴³ The Act – section 196.

⁴⁴ The Act – section 196.

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 JSNAs⁴⁵. Although it is not required by the Act, they should also seek to work with district councils when preparing JHWSs, and to agree with district councils how they will do this – this should form part of the inclusive way that boards work with their partners. District councils can bring expertise on community engagement, gathering and using useful evidence to input into JSNAs; as well as providing services which can improve health and wellbeing as part of contributing to delivering JHWSs, such as housing, planning and leisure services.

Health and wellbeing boards must involve the local Healthwatch organisation⁴⁶ and the local community⁴⁷, and this should be continuous throughout the JSNA and JHWS process. When involving the local community, boards should consider inclusive ways to involve people from different parts of the community including people with particular communication needs to ensure that differing health and social care needs are understood, reflected, and can be addressed by commissioners. This should recognise the need to engage with parts of the community that are socially excluded and vulnerable⁴⁸. Involvement should aim to allow active participation of the community throughout the process – enabling people to input their views and experiences of local services, needs and assets as part of qualitative evidence; and to have a genuine voice and influence over the planning of their services.

Health and wellbeing boards should also work closely with other local partners such as Police and Crime Commissioners, criminal justice agencies, youth justice services, troubled families co-ordinators, local authority housing services, local professional representative committees such as Local Medical Committees, schools, voluntary sector organisations, Local Nature Partnerships⁴⁹, Environmental Health Officers, local planning authorities representatives of military populations; and Department for Work and Pensions local partnership teams⁵⁰. Such partners can both input evidence into JSNAs to get a thorough understanding of local needs and how to address them, as well as take action to contribute to meeting aims of JHWSs.

Local Healthwatch and voluntary sector organisations (including organisations that represent specific groups) can provide insight and information to help JSNAs better reflect the needs and views of people in vulnerable circumstances and this can support the development of JHWSs to meet those needs. Such organisations can bring great value to the process and should be

⁴⁵ The 2007 Act – section 116 (as amended by the Act – section 192). A “relevant district council” means : (a) in relation to a responsible local authority (the authority which established the health and wellbeing board in question), any district council which is a partner authority of it; and (b) in relation to a partner CCG of a responsible local authority, any district council which is a partner authority of the responsible local authority and whose district falls wholly or partly within the area of the CCG. Section 104 of the 2007 Act sets out who are partner authorities in relation to responsible local authority. These include a district council (which is not a responsible local authority) who acts or is established for an area which, or any part of which, coincides with or falls within the responsible local authority’s area.

⁴⁶ 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 (i.e., not discharged only by) local Healthwatch being represented on the health and wellbeing board.

⁴⁷ 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 and therefore should be inclusive of both.

⁴⁸ Such as people with disabilities, homeless people, offenders, victims of crime, or Gypsies and Travellers.

⁴⁹ Local Nature Partnerships are broad partnerships designed to work at a strategic scale to help manage the natural environment to produce multiple benefits for people, the economy and the environment -

www.defra.gov.uk/environment/natural/whitepaper/local-nature-partnerships/

⁵⁰ Serving both working age (through Jobcentres), and pension age clients.

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seen as a critical friend. Most local areas will have a Compact agreement⁵¹ setting out how local authorities and the NHS will work with voluntary organisations for mutual benefit and these Compacts should be considered, and recognised within the JSNA and JHWS process.

Service providers⁵², from the NHS, voluntary or private sector; hold a wealth of information which can also provide important evidence about local needs. They can also take action to improve outcomes through the services they deliver, although health and wellbeing boards will need to consider how any conflicts of interest will be managed when working with local providers.

6. Transparency and accountability

Local communities and partners can hold health and wellbeing boards to account in a number of ways. Statutory membership of elected members and local Healthwatch will be important in ensuring that the voice of local communities are heard and taken into account within JSNAs and JHWSs. Health and wellbeing boards will also be subject to scrutiny by the local authority.

JSNA and JHWS outputs must be published⁵³. Making them public will explain to the local community what the board's assessment of the local needs (and if they choose to include them, assets) is and what its proposals to address them are. It should also provide clear measures of progress to hold the board to account over time. Publication will show what evidence has been considered, and what priorities have been agreed and why. It should include a summary of community views, how they have been used; and also whether any other views have been considered. To increase transparency it would be good practice to include in the publication an explanation of how concerns can be raised with the board or its members.

Sharing the analysis behind JSNAs, and (if appropriate) making the data they have used accessible in a safe way, will help health and wellbeing boards make their decision-making processes transparent to their community and to be held to account⁵⁴.

The modernised health and care system will be underpinned by greater local transparency of how well health and social care services are improving people's lives through the separate NHS, Adult Social Care and Public Health Outcomes Frameworks⁵⁵, the CCG Outcomes Indicator Set and various outcome strategies. The evidence-based outcome measures set out in the frameworks and strategies will be useful to feed into the evidence base for health and wellbeing boards and inform their joint priorities; although this should not overshadow local evidence. They can also be used by boards as a way of demonstrating progress in working together to improve health and care outcomes. However, they are not performance management tools, and are primarily designed to provide transparent measurement of progress, and focus the system on improving outcomes for everyone. Boards may also wish to consider developing local measures to demonstrate progress against their JSNAs and JHWSs.

⁵¹ More information is provided by [Compact Voice](#).

⁵² For instance Foundation Trusts, care homes; and providers of domiciliary care services.

⁵³ The 2007 Act – section 116 (as amended by the Act – section 192) and section 116A (as inserted by the Act – section 193).

⁵⁴ Government [Open Data policies](#) provide more information.

⁵⁵ The Department of Health intends to republish the Public Health Outcomes Framework as statutory guidance to which relevant local authorities must have regard to within their public health responsibilities and function.

7. Other duties

Health and wellbeing boards must meet the Public Sector Equality Duty under the Equality Act 2010, and consideration should be given to this throughout the JSNA and JHWS process. This applies to boards both as a local authority committee, and due to the fact that both local authorities and partner CCGs on whom the primary JSNA and JHWS duties fall have duties under the Equality Act in their own right. This is not just about how the community is involved, but includes consideration of the experiences and needs of people with relevant protected equality characteristics, (as well as considering other groups identified as vulnerable in JSNAs); and the effects decisions have or are likely to have on their health and wellbeing⁵⁶. Integrating equality considerations into the JSNA and JHWS process can help public sector organisations to promote equality and discharge their responsibilities under the Public Sector Equality Duty⁵⁷, which is something boards should routinely do as part of their work.

Preparing JSNAs and JHWSs can support other legal duties, for example, in relation to the reduction of crime (including antisocial behaviour)⁵⁸. They can also contribute to other local partnerships such as Community Safety Partnerships (CSPs)⁵⁹ or where they exist, Local Enterprise Partnerships (LEPs)⁶⁰.

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 if boards choose to include them, 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, integrate services and reduce inequalities.

To support health and wellbeing boards in undertaking JSNAs and developing JHWSs, a suite of supportive resources will be published on the LGA Knowledge Hub from April 2013. These resources will contain case studies, as well as signposts to useful resources. They will be organised under the following categories: cross cutting good practice, assessing needs and assets, engagement and involving specific groups, process and product development and commissioning and integration. They have been developed in response to views heard during the development of this guidance, including through engagement with emerging health and wellbeing boards, and the public consultation.

⁵⁶ The relevant protected characteristics consist of 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.

⁵⁷ 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.

⁵⁸ 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 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.

⁵⁹ CSP is a term used to refer to the group of responsible authorities under section 5 of the 1998 Act (Schedule 5 paragraph 84) which have duties to prepare the strategies referred to in footnote 55. These strategies offer a way for all partners to focus on improving health and wellbeing, and crime outcomes together.

⁶⁰ LEPs are non-statutory partnerships between local authorities and business, – [Local Growth White Paper, 2010](#)