COUNTIES MANUKAU HEALTH

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More Effective Social Services Inquiry
New Zealand Productivity Commission
PO Box 8036
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WELLINGTON 6143

Submission from Counties Manukau Health on the New Zealand Productivity Commission's Issues Paper on More Effective Social Services, October 2014

Thank you for the opportunity to provide feedback on the **More Effective Social Services Issues Paper.** This feedback represents views of Counties Manukau Health (CM Health; Counties Manukau District Health Board).

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Yours sincerely

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KEY RESPONSES

There are limited references in the issues paper to cross-sectoral or intersectoral work. However it is CM Health's assumption that to improve efficiency and effectiveness of social services and importantly to improve experience of those services for patients/clients/whaanau/families, joining up work across sectors, as well as addressing issues within sectors, will be key. We therefore make reference to issues relevant to improving cross-sectoral responses to population need as well as intrasectoral issues.

Key, interrelated, issues that CM Health raises are

- **Differences between institutional arrangements for health and those of other sectors.** Working across sectors is challenged by varying degrees of autonomy and discretion between agencies. DHBs have a degree of discretion and autonomy to tailor national priorities to locally relevant service solutions, while most other sectors have a non-devolved model directed from the centre. Local initiatives that require flexibility can be slowed by decision making processes that require central government policy makers to agree before social sector agencies are able to exercise local flexibility. While central policy support for cross-sectoral programmes of work is important, such policies need to be informed by those experienced in service design at a local level. Consideration of the implementation of any policy will strengthen its impact.

- **The need for a common language of 'productivity'**
  Volume-based conceptions of productivity are essentially related to the 'width' of service provision but CM Health contends that in considering productivity, increased attention needs to be placed on the 'depth' of service provision – the quality of health and social service provision. The value and production of outputs need to be considered across 'the whole pathway', with attention to
  - potential unintended consequences as well as intended outcomes, and
  - the cumulative impact on vulnerable communities of efficiency initiatives across multiple sectors.

- **The nature and context dependence of 'evidence' in relation to the impact and outcomes of models of care and what is considered efficient and effective.**
  There is considerable 'experience' with various models of care but still a need to build 'evidence' about impacts and outcomes. This is not surprising if innovation is to be supported but makes commitment to robust evaluation key. All evidence is generated in a particular context and setting and it is important to understand the 'fit' between the evidence being considered and the national and local population and system context.

- **The difference between outcomes-focused contracts and outcome-based contracts.**
  It is important that particular services are not held accountable for population outcomes, which can be influenced by many things along with the work of the provider in question. However they can be held accountable for their service impacts on the population they serve. Outcome evaluation of social services will always be challenging because of the timeframes necessary for change and the challenge of attributing causality.

We also offer some contributions to development of the case study in relation to home-based care for older people based on experience in our setting. Again, we contend that careful consideration of the whole pathway and package needed for successful ageing in place is important to anticipate unintended consequences as well as desired outcomes.

Background – the 'Institutional Arrangements' of District Health Boards (DHBs)

District Health Boards (DHBs) were established under the New Zealand Public Health and Disability Act 2000. The objectives of DHBs under the Act include:

- improving, promoting and protecting the health of people and communities
- promoting the integration of health services, especially primary and secondary care
- services
- seeking the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs
- promoting effective care or support of those in need of personal health services or disability support
- promoting the inclusion and participation in society and the independence of people with disabilities
- reducing health disparities by improving health outcomes for Māori and other population groups, and reducing, with a view toward elimination, health outcome disparities between various population groups.

There are 20 DHBs in New Zealand and each DHB is responsible for providing and funding a range of health services in their district as well as planning and delivering services regionally. Funding is allocated through a Crown Funding Agreement via a Population Based Funding Formula and minimum service requirements (range and standard) are set out in a Service Coverage Schedule (SCS) by the Ministry of Health.

DHBs have flexibility around the allocation of funding to specific services within the parameters of national strategies and the SCS and are expected to match services to need at a district level. There is a clear accountability arrangement via Crown Funding Agreements between the Minister and each DHB, with an annual planning package and Minister's 'Letter of Expectations' setting performance expectations.

Governance boards for DHBs are elected three yearly in concert with Local Government elections, with Board Chairs and Deputy Chairs appointed by the Minister of Health.

Four regional shared services agencies allow DHBs to pool their resources to obtain common support for planning and Health Benefits Ltd has also been established as a national shared services agency to reduce costs of DHBs through efficient and effective delivery of administrative, support and procurement services for DHBs.

DHBs contract with a wide range of NGOs who provide primary care, mental health, personal health and disability support services, including Māori and Pacific providers. Primary Health Organisations (PHOs) are funded through DHBs to support the provision of primary health care, either through providing services directly or through provider members, mainly general practices. PHO services are expected to contribute to improving and maintaining the health of the enrolled PHO population, as well as providing services when people are unwell.

The Inquiry

The goal of the inquiry the Commission has been asked to undertake is stated as 'to find and recommend measures that would lead to improvements in the efficiency and effectiveness of the social services system'. 'Innovative approaches to commissioning and purchasing' to be examined include

- outcome-based contracts;
- results-based contracts;
- the use of information and communications technology; and
- the devolution of decisions around the commissioning and purchasing of services.

There is also a desire to apply lessons from international experience in social services commissioning, with questions about the barriers and risks in doing so.
While the term cross-sectoral only appears in the paper in a table describing selected New Zealand initiatives and the term intersectoral does not appear, it is CM Health's assumption that to improve efficiency and

effectiveness of social services and importantly to improve experience of those services for patients/clients/whaanau/families, joining up work across sectors, as well as addressing issues within sectors, will be key. We therefore make reference to issues relevant to improving cross-sectoral responses to population need as well as intrasectoral issues.

On the basis of the inquiry goals, key interrelated issues that CM Health wishes to raise are

- differences between institutional arrangements (e.g. delegation and decision making autonomy) for health and those of other sectors which need to be navigated in implementing cross sector social service initiatives
- the language of 'productivity'
- the nature and context dependence of 'evidence' in relation to the impact and outcomes of models of care and what is considered efficient and effective
- the difference between outcomes-focused contracts and outcome-based contracts.

We will also offer some contributions to development of the case study in relation to home-based care for older people based on experience in our setting.

Working across sectors is challenged by varying degrees of autonomy and discretion between agencies

As described in the background section of this submission, health is a semi-devolved, decentralised sector, with DHBs having locally elected Boards with an expectation of matching services to need at a district level within the parameters of national strategies and the Service Coverage Schedule. This allows DHBs a degree of discretion and autonomy to tailor national priorities to locally relevant service solutions. A practical example of this is our ability to get the best mix of national, District and provider funding to deliver complex programmes (e.g. rheumatic fever) without having detailed prescription from the centre. In other service areas, national goals are articulated through targets and DHBs have autonomy to determine how best to deliver locally and regionally.

This is quite different from, for instance, social services provided by the Ministry of Social Development (MSD) where services such as Work and Income are direct operational arms of MSD, functioning in a non-devolved model directed from the centre. In our experience, local initiatives that have required flexibility have sometimes been slowed by decision making processes that require central government policy makers to agree before social sector agencies are able to exercise local flexibility. A practical example recently is the process for beneficiaries to access funding for vasectomies in CM Health as part of a wider Maternity Review project. The transaction cost to beneficiaries to access funding through MSD far outweighs the value of the service. The interface of Family Start with maternity and child health services is another example where providers feel constrained to amend their referral processes without permission from policy makers.

In addition, the geographical area served by subnational divisions of the various sectors also varies; in the case of health, DHB boundaries do not necessarily coincide with regional or district boundaries for education or social services.

In addition to sectors having different levels of local autonomy, each sector has unique legislative, statutory and financial responsibilities. The health sector is responsible for the fiscal management of health resource, ensuring patient safety, clinical oversight of health professionals and addressing the health needs of the population.

These realities need to be navigated in designing cross sector services. While central policy support for cross-sectoral programmes of work is important, such policies need to be informed by those experienced in service design at a local level. Consideration of the implementation of any policy will strengthen its impact. We would encourage a greater degree of autonomy and flexibility for local service design and implementation. Most successful intersectoral initiatives – in our experience – have emerged from "bottom up" initiatives where

social services work together locally to identify pragmatic solutions to problems that are often created by policies developed in siloes.

In the case of health, the community-based and needs driven environment of DHBs has been a successful testing ground for a range of successful cross-sectoral projects/programmes. For example, the design and implementation of the successful Healthy Housing programme[1] initiated by CM Health in response to the meningococcal epidemic in the early 2000s was the result of a cross-sectoral commitment to address household crowding which had been identified as a key issue in relation to meningococcal disease. This demonstrated a centralised department (Housing NZ) was able to work with a devolved decentralised crown entity (a District Health Board). Funding for this programme was through a capital and operating appropriation held by Housing New Zealand for the delivery of the programme.

We note that the Commission's Issues Paper suggests that 'Many social service providers feel that they are closer to their clients and the communities in which they operate, and that they have a better understanding of their clients' needs than their funders'. We believe that to a certain extent this concern is less of an issue in health because it's semi-devolved nature. In addition, while service providers are well placed to address community need, it is often the funders who must ensure a strategic overview is maintained to address a wide range of issues over and above those defined by niche providers who may only see one aspect of need.

In relation to cross-sectoral engagement it is also key to determine the role of the community, as this determines processes, how outcomes are evaluated, and therefore whether services are considered 'efficient and effective'. Cross-sectoral engagement can be largely at the level of agencies (as the previous ICAH Counties Manukau initiative[2]), or community action can be a significant objective. The latter needs to be very intentional, at all stages of the process, to be meaningful and requires an ability to free up resource to address things the community identifies as important which or may not be the immediate priorities of the sector agencies (e.g. the community may want to tackle family violence and alcohol, which are important for health but the health concern at a particular time might be more directed at nutrition or health condition self-management).

Let's get a common language of productivity – social sectors see productivity differently

Productivity is generally defined as a measure of how efficiently production inputs are being used within the economy to produce output[3], the ratio of output to inputs. This volume-based conception is essentially related to the 'width' of service provision but CM Health contends that in considering productivity, increased attention needs to be placed on the 'depth' of service provision – the quality of health and social service provision. We believe there is a need to better understand and incorporate within productivity considerations, dimensions related to the value that is being added and how that value can best be assessed.

CM Health measures its performance against the three dimensions of the Triple Aim framework[4] - population health and equity, patient/whaanau experience and per capita cost of health system investment.

The value and production of outputs need to be considered across 'the whole pathway', with attention to potential unintended consequences as well as intended outcomes. For example, having a service is that more

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[1] See Jackson G, Thornley S, Woolston J, Papa D, Bernacchi A & Moore T (2011) Reduced acute hospitalisation with the healthy housing programme. Journal of Epidemiology and Community Health 10.1136/jech.2009.107441; Baker M, Zhang J, Keall M & Howden-Chapman P (2011) Health Impacts of the Healthy Housing Programme on Housing New Zealand Tenants: 2004-2008. Wellington, He Kainga Oranga/ Housing and Health Research Programme, University of Otago

[2] Ministry of Health (2008) Intersectoral Community Action for Health (ICAH) Evaluation: An Overview. Wellington: Ministry of Health

[3] http://www.stats.govt.nz/browse_for_stats/economic_indicators/productivity.aspx

[4] The IHI Triple Aim framework was developed by the Institute for Healthcare Improvement in Cambridge, Massachusetts (www.ihi.org).

easy to access may be desirable in some circumstances and improve client/patient/whaanau experience and surrogate impact markers, along with improving productivity in relation to the ratio of outputs to inputs. However it may also result in supplier-induced demand and/or the unmasking of unmet needs. Cost shifting from services which are currently privately funded may also occur. These consequences need to be considered in planning and the evaluation of the productivity and value of a service.

The consideration of inputs into a productivity assessment also needs to account for shifting of responsibilities to clients/patients/whaanau themselves. In health there are increasing expectations of patient/whaanau engagement in self-managing their health. In order for individuals to undertake self-management effectively, this is often not cost-free to them and their whaanau/families, in time or financial resource. CM Health is particularly conscious of this dynamic, given the high needs community it serves[5]. There are lessons from our own context in relation to volunteer-run community programmes under the historic HEHA (Healthy Eating, Healthy Action) Strategy. There was substantial goodwill and enthusiasm in our communities and training was provided but the realities of making and sustaining time for such commitments in the face of trying to work multiple jobs to earn enough to pay the bills along with family and other voluntary commitments such as church activities was very challenging for many. While empowerment of communities and reduction of dependency is an important goal of social services, the practicalities of this need to be carefully worked through.

Further, we believe that while individual agencies may pursue productivity enhancing initiatives impacting on service delivery in their siloes, the cumulative impact on users of services is invisible and can further entrench poverty and vulnerability. Consumers who have experienced these challenges speak of the total impact on their lives of changes in health, Work and Income, changes to eligibility for housing and income support entitlements (ACC, MSD), the transaction costs of navigating multiple entitlement regimes and the totally immobilising impact it can have on their self-esteem, family functioning and ability to fulfil their aspirations for themselves and their family. We need to join up our language and begin a common understanding of the total impact of health and social service activities on the lives of our most vulnerable consumers.

The nature and context dependence of 'evidence' in relation to the impact and outcomes of models of care and what is considered efficient and effective

Current activity in CM Health in assessing the business case for investment in information technology as a key enabler of whole of system improvements (as measured by the 'Triple Aim') will be drawn on as an example of the context dependence of evidence in relation to the impact and outcomes of new models of care. Many of the initiatives proposed in New Zealand health and social service settings have been implemented in other settings, and there are relevant lessons from that work which can increase the likelihood of success in our setting. However, many reports do not include robust costing information and there is a major paucity of cost-benefit analyses. While many interventions may be cost effective in terms of bringing improvement in quality and quantity of life, there may not be cost savings to the health and social system overall over the long term.

This lack of 'evidence' is not surprising if those models are innovative. There is considerable 'experience' with various models of care but still a need to build 'evidence' about impacts and outcomes.

This is very relevant to the Commission's Issues paper, where there are many statements that various approaches 'can' or 'may' achieve certain outcomes. It is important to be transparent if putting up a case to invest in such approaches; that in fact the 'evidence' of benefit is most often very limited. The investment may be aligned to the strategic intent of a particular policy, but the risks and opportunity costs of such investment need to be objectively considered and evidence generated during implementation to inform future investment and, where appropriate, disinvestment.

[5] 36% of our population live in areas defined as the most socioeconomically deprived, Deciles 9 and 10 on the NZDep2013 area measure; 'all things being equal' 20% of our population would live in such areas.

In seeking evidence to understand the potential benefits to be realised of strategic IT investment, CM Health has explicitly acknowledged that all evidence is generated in a particular context and setting. It has been important to understand the 'fit' between the evidence being considered and the CM Health population and system context. All health systems are struggling with increasing health care costs and demand but from different baselines of demand and service level and with different models of care.

- E.g. Arrangements for primary care in the US and UK are substantially different from New Zealand and in each setting have evolved over time. This needs to be considered if, for example, applying the findings from a study in the US 10 years ago which reduced admissions through an intervention in primary care to the CM Health context in 2014 and going forward. A US programme that reduces inpatient readmissions by 25% from a baseline readmission rate of over 20% in a context where there has been little previous work to impact the readmission rate is quite a different scenario from our context, where our readmission rate is already below the improved rate achieved by the programme in the US and there has been a decade of work to impact that rate.

Generalisability of evidence from non-social sectors to social sectors also needs careful consideration.

- E.g. Moves to automation in the banking sector may not be directly relevant to clinical situations in health where relationships are a key part of care. A lay person may need professional support or advice to seek the most appropriate care and judging the quality of care is challenging because 'you don't know what you don't know'– in economic terms there is a significant degree of information asymmetry which may not be solved with the availability of electronic information.

Recent CM Health review of some of the international experience with cross-sectoral programmes to address population need is attached in Appendix One. Some of the New Zealand experience is described in

- Ministry of Health. 2008. Intersectoral Community Action for Health (ICAH) Evaluation: An Overview. Wellington: Ministry of Health, and
- CSRE (2013). Final Evaluation Report: Social Sector Trials – Trialling New Approaches to Social Sector Change. Centre for Social Research and Evaluation, Ministry of Social Development, Wellington

Outcomes focused contracting

There has been considerable work in the last decade in health and social services in New Zealand to shift contracting processes from a focus on inputs and programme processes to a focus on outcomes. Use of the 'Results Based Accountability' (RBA) framework and methodology has been supported across MSD[6] and in some parts of the health sector. RBA draws an important distinction between service results/impacts for the population who are clients of the service and population outcomes, to which service impacts contribute. A logic model is important to describe the link between service results and the desired population outcomes.

It is important that particular services are not held accountable for population outcomes, which can be influenced by many things along with the work of the provider in question. However they can be held accountable for their service impacts on the population they serve. Quite how this approach is implemented in the contracting process is however challenging. If a provider is to be incentivised to achieve a particular client result, how does that work in relation to contract payments? Should a portion of the funding available be 'held back', considered 'at risk' and paid only on achievement of client results; and if so how is the process managed so as to minimise 'gaming' of monitoring to achieve the desired result? Does this reduce the service available to clients in comparison with a contract where all the funding available is paid throughout the year to the provider; and if this is done, is it feasible to have some kind of 'clawback' if the client results are not achieved?

Process and proxy outcome indicators will give important learnings but outcome evaluation of social services will always be challenging because of the timeframes necessary for change and **the challenge of attributing causality**

[6] http://www.familyservices.govt.nz/working-with-us/funding-and-contracting/results-based-accountability/index.html

- there are often multiple initiatives happening in communities of high social needs, many of which complement each other in contributing to improvements
- appropriate data sources for locally relevant outcome indicators and baseline data are often lacking (e.g. as noted in the evaluation of the Social Sector Trials in NZ) and small numbers limit the ability to draw any conclusions.

Review of more recent work programmes tends to reflect conclusions of an earlier review by MSD, 'Mosaics Whakaāhua Papariki (2003)', of learnings from a national and international literature review and local field work in relation to collaboration and integrated service delivery - that collaboration can improve the use of existing resources but expectations need to be realistic (e.g. not expecting integration and collaboration to make up for underlying limitations in the total quantum of resource and skilled practitioners).
With increasing awareness of the need to 'join up' contract expectations across services, integrated contracts are being promoted. Where these integrated contracts include health services it is important that management of clinical risk is robustly delivered. The earlier example of the Healthy Housing programme is an example where clinical health staff (nursing and allied health) needed to manage any clinical risk identified in their work in the programme alongside the operational imperative to address housing issues.

Lessons from home-based services for older people

Across the country there is increasing discussion about, and movement towards, case-based services with outcomes-based contracts for the provision of home support services for older people. Our DHB has taken a slower approach than many to this, seeing the opportunities but also the potential risks to older people themselves as well as to funders responsible at a population level for those services. Careful consideration of the whole pathway and package needed for successful ageing in place is important to anticipate unintended consequences as well as desired outcomes. Learnings from observing the processes in other districts include

- the use of a standardised assessment tool (interRAI) provides an objective baseline assessment for decision-making but there is a need to strengthen tools to support aligning the assessment information to variety of services that need to be provided and the measurement of outcomes.
- the need for very clear expectations of agreed outcomes and sufficient checks and balances in contract monitoring to ensure those outcomes are being met
- the need for patient experience outcome measures - people are vulnerable when someone is coming into their home and may be worried that the services will be taken away if they complain. It takes a lot for many older people to make a complaint; if measuring patient/client experience of services were standard practice they would have the opportunity to give feedback on how the service was received by them and whether it met their needs in a routine way, reducing the worry about how that feedback would be received if it was not positive
- sector standard audits have been routine in hospital and resident care services for many years but are still to be fully embedded across community and home based services; these audits provide an important mechanism to ensure sustained quality of service.

While being vitally important, the need for standard procurement processes and setting up of robust monitoring of service provision does increase costs and this needs to be adequately taken into account in planning and commissioning services. Moving services into the community might be the 'right thing to do' and support people to successfully age-in-place, but that doesn't mean it is necessarily cheaper or more cost effective.

Social isolation is well documented as a risk for adverse outcomes in older people. At present some home based health services are an expensive way of providing a degree of socialisation which could likely be better met in other ways. This needs to be addressed as part of 'whole of government' approaches to support ageing in place. Affordable and appropriate housing for older people is also an important aspect of successful ageing in place which is yet to receive sufficient attention.

Appendix One: Review of some of the international experience with cross-sectoral programmes to address population need

Health Action Zones in England

Health Action Zones (HAZs) were 'established in relative haste... and intended to modernise health care and reduce health inequalities in the most disadvantaged parts of England'[7] in 26 sites in England over 1998 and 1999. There were great expectations, locally and internationally, of what they would deliver. The population covered by HAZs varied from 200,000 (Luton) to 1.4 million (Merseyside), with an average size of about 500,000. A 'guesstimate' on funding is that on average HAZs received approximately £4–5 million per year at 2004 prices – 'a very modest injection of additional funding in relation to the size of mainstream health and local authority budgets, but it was intended to provide a change management fund that would promote changes in existing services'[8].

During the three to four years that most of the zones existed (they were initially supposed to be for seven years), they sponsored hundreds of workstreams and thousands of projects. Commentators have expressed concern that rather than being seen as a failure, the complex circumstances that surrounded HAZs need to inform views on their impact or otherwise. 'A recurrent question in our minds concerns whether or not HAZs were given a fair opportunity to demonstrate what they might have been able to achieve. From the outset they were encouraged to outbid each other in the scale of their ambitions. Most of them tried to tackle too many seemingly intractable problems simultaneously, and they were further hampered by regular attempts by Whitehall to increase and or to change the focus of their activities. Overall there was little evidence that strategic directions were shaped by communities or service users. On reflection, HAZs cannot be so strongly characterised as a community-led initiative as a partnership initiative'[9].

Perhaps one of the key learnings in relation to Health Action Zones is in relation to evaluation:

> Too many users of policy research still expect clear answers about impact when a more realistic product of evaluations is that they contribute to a process of enlightenment about highly complex processes that are interpreted by different actors in multiple ways[10].

Commentators have also highlighted the lengthy time needed to build capacity of voluntary and community agencies to support the development of genuine partnerships[11].

Health and Well-being Strategies in Wales and England

Health, Social Care and Wellbeing Strategies have been part of the landscape of health and social care planning in Wales since 2003, formulated and implemented by local authorities and local health boards together with their wider community partners (eg. The Health, Social Care and Well-being Strategy 2011-2014 for Swansea which is the third such plan that has been developed by partners in Swansea[12]). However more recently the Welsh Government has indicated in its white paper 'Sustainable Social Services for Wales: a framework for action' that the way in which commissioning, procurement and service delivery is organised

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[7] Bauld L, Judge K, Barnes M, Benzeval M et al (2005) Promoting social change: the experience of health action zones in England. Journal of Social Policy, 34 (3). pp. 427-445. ISSN 0047-2794.

[8] Ibid

[9] Ibid

[10] Judge K, Bauld L (2006) Learning from Policy Failure? Health Action Zones in England. European Journal of Public Health 16(4):341–344

[11] Matka E, barnes M, Sullivan H (2002) Health Action Zones: Creating alliances to achieve change. Policy Studies 23(2): 97-106

[12] Health Challenge Swansea (2011) The Health, Social Care and Well-being Strategy 2011-2014. Making Swansea a Healthier City.

must change[13]. A recent review of commissioning for social services in Wales found that 'whilst most local authorities articulate an intention to transform services, at this stage they have not evolved into robust and financially sustainable plans. The move towards integrating health and social care services is evident, but progress is slow...

> Good intentions are proclaimed but there is, as yet, little evidence of true joint commissioning between the health boards and local authorities. The partnership between health and social services has helped to secure good examples of joint working such as co-located, or jointly appointed managers and some good service arrangements. It has not, however, delivered a coherent joint commissioning approach, integrated teams of staff under single line management, or an approach focused on the longer term across health and social care across Wales[14].

The Social Services and Well-being (Wales) Bill (2014) became law as of 1 May 2014[15] and is said to be 'a complete change of approach built on citizen centred services, a focus on delivery and greater collaboration and integration of services'[16].

In England the recently formed Health and Wellbeing Boards have been described by the Minister of Care Services as being 'at the heart of our plans to transform health and care and achieve better population health and wellbeing'[17]. From April 2013, health and wellbeing boards have taken over from PCTs the statutory responsibility for undertaking the Joint Strategic Needs Assessment and developing the Joint Health and Wellbeing Strategy for their area.

The health and wellbeing boards have operated in shadow form from April 2012, and comprise joint local leadership of Clinical Commissioning Groups and local authorities. They will be 'the forum for councillors, commissioners and communities work with wider partners to address the determinants of health and reduce health inequalities...to explore together the local issues that they have not managed to tackle on their own'[18]. The boards have a duty to involve users and the public in the development of both the JSNA and the joint health and wellbeing strategy. The intention is the Boards make decisions about action, investment and disinvestment that are 'genuinely local, rather than a reflection of national priorities'[19].

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[13] Welsh Assembly Government (2011) Sustainable Social Services for Wales: A Framework for Action
[14] Care and Social Services Inspectorate Wales (2014) National Review of Commissioning for Social Services in Wales 2014
[15] http://wales.gov.uk/topics/health/socialcare/act/?lang=en
[16] Care and Social Services Inspectorate Wales (2014) National Review of Commissioning for Social Services in Wales 2014
[17] Department of Health (2011) Joint Strategic Needs Assessments and joint health and wellbeing strategies explained. Social Care, Local Government and Care Partnerships Directorate, NHS
[18] Ibid
[19] Ibid