The King's Fund

Ideas that change health care

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April 2012

Health and wellbeing boards

System leaders or talking shops?

Key messages

- The creation of health and wellbeing boards is one aspect of the NHS reforms that enjoys overwhelming support. The boards offer new and exciting opportunities to join up local services, create new partnerships with GPs, and deliver greater democratic accountability.
- Boards need to be clear about what they want to achieve. We found potential tensions between their role in overseeing commissioning and in promoting integration across public health, local government, the local NHS and the third sector.
- Despite the rhetoric of localism, many shadow boards are concerned that national policy imperatives will over-ride locally agreed priorities and are uncertain about the extent to which they can influence decisions of the NHS Commissioning Board. Roles and responsibilities of all new bodies need to be defined much more clearly.
- Although some shadow boards are taking an imaginative approach to engaging with stakeholders, the exclusion of providers could undermine integrated working. Local authorities should look afresh at ways of working with local partners rather than re-badging previous partnership arrangements.
- Our view is that the creation of health and wellbeing boards will not automatically remove many of the barriers to effective joined-up care. For boards to succeed, a stronger national framework for integrated care is needed with a single outcomes framework to promote joint accountability.
- The discretion given to local authorities in setting up boards means that different approaches will emerge, and some will be more effective than others. Capturing and sharing lessons learned from shadow boards will be vital to avoid simply adding a further layer of unacceptable variation to the system.
- Our findings suggest that the biggest challenge facing the new boards is whether they can deliver strong, credible and shared leadership across local organisational boundaries. Unprecedented financial pressures, rising demand, and complex organisational change will severely test their political leadership. Board members need time and resources to develop their skills and relationships with other stakeholders.

Introduction

In its White Paper, *Equity and Excellence: Liberating the NHS* (Department of Health 2010a), the government set out its intention to strengthen the role of local government in local health services. Statutory health and wellbeing boards would be established across the country to encourage local authorities to take a more strategic approach to providing integrated health and local government services. The boards will bring together those involved across the NHS, public health, adult social care and children's services, as well as elected representatives and representatives from HealthWatch, to jointly plan how they can best meet local health and social care needs.

These proposals were set out in more detail in the consultation paper, *Liberating the NHS: Local democratic legitimacy in health* (Department of Health 2010b), and further amendments were made as a result of the listening exercise and the recommendations made by the NHS Future Forum (2011).

The proposal to establish health and wellbeing boards has emerged unscathed from the wider controversies surrounding the Health and Social Care Bill, and has been almost universally welcomed. A stronger emphasis on the need for integration as a principle of the reforms has seen the powers and duties of the proposed boards enhanced. In the words of the Prime Minister, David Cameron:

> *… health and wellbeing boards will help this [integration] further. They will bring together everyone from NHS commissioning groups to adult social care specialists, children's trusts and public health professionals… to design local strategies for improving health and social care integration. Integration is really important for our vision of the NHS.*
>
> (Cameron 2011)

The vision of joined-up, well-co-ordinated and jointly planned services is not new, and this is not the first time that new bodies have been created to help achieve that vision. Past efforts – including joint consultative committees and joint care planning teams, and, more recently, local strategic partnerships – have achieved mixed results. Although in most places local authorities and NHS partners have a partnership board of one kind or another, the track record on integrating health and social care has been patchy.

Health and wellbeing boards are the only component of the new and increasingly complex architecture of the reformed NHS that would bring together different organisations and interests to promote local collaboration and integration. Faced with complex organisational change, unprecedented financial pressures and rising demand for services, will the boards be able to fulfil these expectations and achieve greater success than previous bodies?

Background to this report

This report forms part of a wider programme of work being carried out by The King's Fund on health and wellbeing boards. The programme has supported several local authorities and their health partners to develop their shadow boards. In July 2011, we held a summit attended by more than 100 delegates from local government, the NHS and the third sector.

As part of the programme, in late 2011, we conducted a survey of 50 local authority areas covering all regions of England to find out how they and their health partners are implementing the new boards. Telephone interviews were conducted in September and October 2011 with lead officers identified by local authorities themselves (the full methodology is described in Appendix 1). This report sets out the findings from that

survey (*see* Appendix 2), and presents case studies based on the experience of two early implementers, Lambeth and Surrey – each facing very different circumstances. We also explore the policy context in which the new health and wellbeing boards will operate and describe three possible scenarios that could emerge.

The purpose of our research for this report was:

- to gain insights into how local authorities and their health partners are implementing health and wellbeing boards in the context of the government's NHS reforms, its vision for adult social care, and the Localism Bill
- to capture the overall approach of a sample of English councils in establishing these new arrangements, supported by a more detailed examination of the experience of two early implementer sites receiving support from The King's Fund
- to identify the lessons that could be applied to the roll-out of health and wellbeing boards, the issues that local authorities and their health partners need to address in the next stage of the boards' development, and the implications for policy.

Before presenting our findings, we set out the policy context arising from the government's plans for NHS reform, the proposed role, function and membership of the new boards, and what can be learned from previous efforts to achieve better partnership working between local government and the NHS.

The policy context

The government has stated that one aim of the NHS reforms is to improve democratic legitimacy by enhancing the role of local authorities in the planning and oversight of local health services. This would see local authorities having four main areas of responsibility:

- leading the development of joint strategic needs assessments and local health and wellbeing strategies so that there is an overall strategic framework for commissioning
- supporting local voice, including commissioning the local HealthWatch and promoting patient choice
- promoting joined-up commissioning of local NHS services, social care and health improvement
- leading on local health improvement and prevention activity.

All local authorities are expected to have shadow boards in place from April 2012 and, subject to legislation, they should become fully operational from April 2013. The renaissance of local government's role in health services, which is implicit in the creation of the health and wellbeing boards, explains the relative popularity of this aspect of the reforms. More than 90 per cent of local authorities (132) have stepped forward to become early implementers of the new boards, showing, in the words of the Department of Health, '*...the appetite in local government to take on the strengthened leadership role which is at the heart of the Government's vision for health and care*' (Department of Health 2011c). However, the prospect of a stronger role for local government might also exacerbate longstanding nervousness within the NHS about local elected politicians becoming more involved in the running of local health services (NHS Confederation 2011a).

It is significant that this is the first major reorganisation of the NHS that will see local government take on new functions from the NHS. This runs counter to the trend during two previous reorganisations, in 1948 and 1974, when local government lost responsibilities for hospitals, community health services and public health. The current reforms reflect the importance of a wide range of local authority functions that impact upon the health and wellbeing of local populations such as social care, education, leisure, transport, environmental health and community safety. It also chimes with the coalition

government's localist philosophy of moving away from top-down 'one size fits all' solutions to services that are designed locally and reflect local people's needs.

What is the role of the boards?

The main functions of the health and wellbeing boards are:

- to assess the needs of their local population through the joint strategic needs assessment process
- to produce a local health and wellbeing strategy as the overarching framework within which commissioning plans are developed for health services, social care, public health and other services which the board agrees are relevant
- to promote greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate.

The NHS Operating Framework for 2012/13 describes health and wellbeing boards as central to the new system and states that they will 'provide local systems leadership across health, social care and public health' (Department of Health 2011d). The second report of the NHS Future Forum declares that '*health and wellbeing boards must become the crucible of health and social care integration*' (NHS Future Forum 2012) and the government's response confirms that it sees '*health and wellbeing boards acting as one of the engines of integration in the reformed system with the ambition of improving local care*' (Department of Health 2012).

Following the recommendations made by the NHS Future Forum, the role of the boards has been strengthened in response to concerns that they may not have sufficient powers to fulfill the functions required of them. The key areas that were strengthened are as follows.

- There is a stronger expectation for NHS commissioning plans to follow the local health and wellbeing strategy; boards will be able to refer commissioning plans back to clinical commissioning groups or the NHS Commissioning Board if they feel they do not sufficiently take account of the local health and wellbeing strategy.
- Boards must be consulted by the NHS Commissioning Board on how clinical commissioning groups have contributed to the delivery of the local health and wellbeing strategy.
- The engagement of health and wellbeing boards in clinical commissioning will be stronger – '*not a formal, one-off exercise but rather an ongoing dialogue with a view to producing a commissioning plan that is the result of a joint effort*' (Department of Health 2011c).
- The boards will provide advice to the NHS Commissioning Board over the authorisation of clinical commissioning groups.
- It has been clarified that the boundaries of clinical commissioning groups would normally be expected to be coterminous (ie, follow local authority boundaries) unless there are exceptional reasons why this is not appropriate.

Board membership

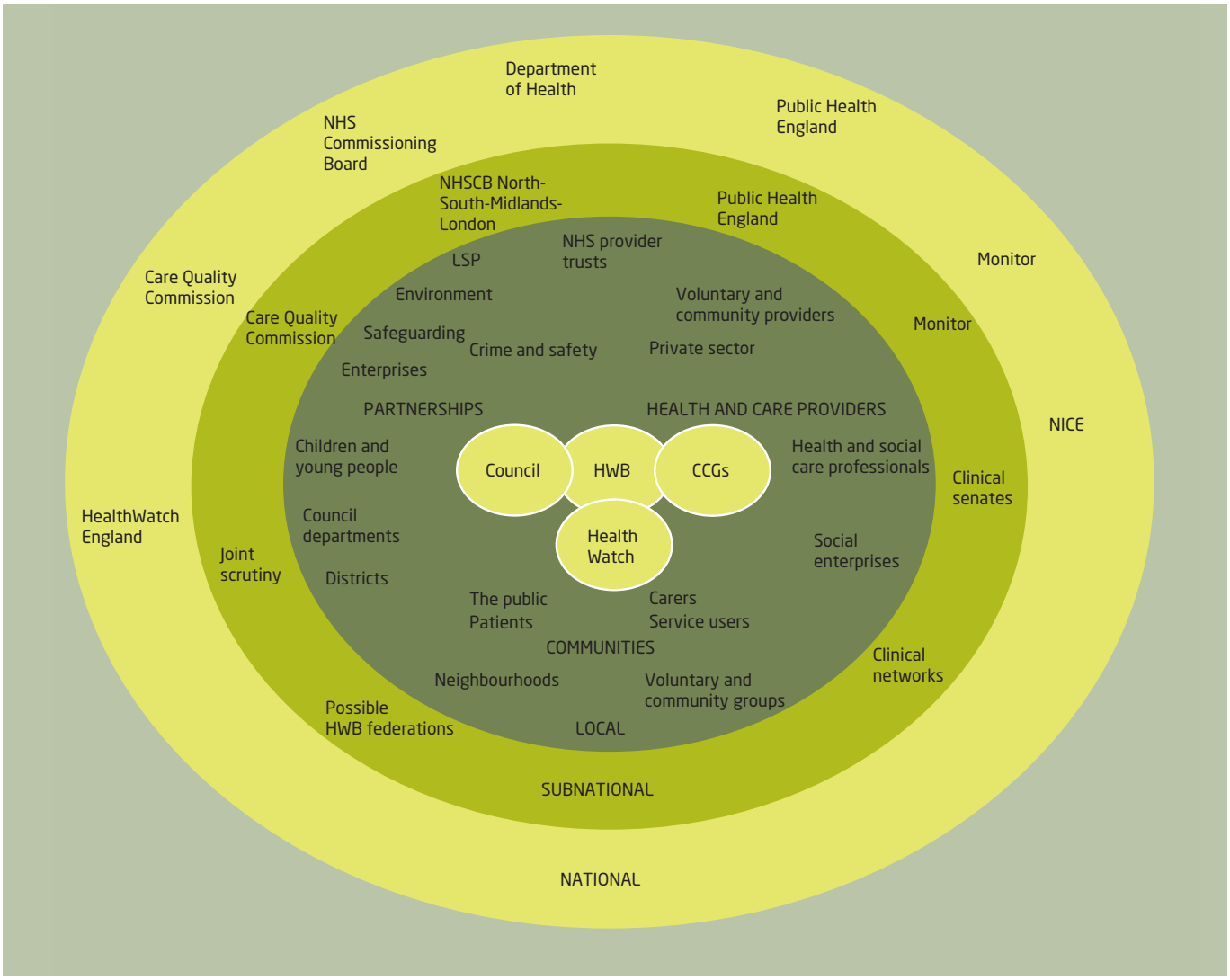
The health and wellbeing board is to be a committee of upper-tier local authorities. The Health and Social Care Bill (House of Lords Bill 2010–12) sets out the core membership required of each board, but beyond this, membership will be at the discretion of the local authority.

The core membership should consist of:

- at least one nominated councillor of the local authority
- the director of adult social services for the local authority
- the director of children's services for the local authority
- the director of public health for the local authority
- a representative of the local HealthWatch organisation
- a representative of each relevant commissioning group
- such other persons, or representatives of such other persons, as the local authority deems appropriate.

The broad remit of health and wellbeing boards means they will need to engage with a wide range of stakeholders as well as local people and communities. This cannot be done through formal board structures alone; they will need to find more imaginative ways of engaging with stakeholders, including using social media. The Bill sets out legislative duties for local clinical commissioning groups and the NHS Commissioning Board to have regard to the work of the health and wellbeing board when exercising their functions. There are also broader requirements and expectations of various local and national partners to co-operate to ensure that the health and wellbeing boards are able to achieve their objectives. Figure 1, overleaf, sets out these key relationships.

Figure 1 Some of the national, subnational and local bodies with which health and wellbeing boards will need to develop relationships



Source: Local Government Association (2011).
HWB: health and wellbeing boards; CCG: clinical commissioning groups; LSP: local strategic partnership

Considering the roles of the health and wellbeing board in the context of this wider map of relationships, it is clear that their primary purpose is not to directly manage the commissioning activities of clinical commissioning groups or the local authority itself. Rather, it is to establish a strategic framework within which resources from across organisational boundaries are applied to the outcomes identified in the health and wellbeing strategy. This will be achieved through using skills in influencing and relationship-building rather than formal managerial control or accountabilities (health and wellbeing boards have no powers to sign off the commissioning plans of clinical commissioning groups, for example). This role is described more fully in the operating principles developed by national organisations for establishing effective boards (NHS Confederation 2011b).

Back to the future?

Health and wellbeing boards have been hailed as a new and innovative vehicle for partnerships, with the unusual feature of local elected members sitting alongside senior officers of the local authority and local NHS. The history of joint working does, however, offer some interesting precedents. The 1974 NHS reorganisation placed a new statutory duty on health and local authorities to co-operate with each other and required them to

establish joint consultative committees to facilitate co-operation and joint planning. These began as advisory rather than executive decision-making bodies, with echoes of today's concerns that health and wellbeing boards may not have sufficient decision-making powers. It was hoped that the involvement of senior elected members would signal the influence and importance of these new joint committees.

The initial impact of the new arrangements under the 1974 reorganisation was limited, with the then Secretary of State (the late Barbara Castle) referring to the '*somewhat patchy progress... being made in getting the Joint Consultative Committees and local authorities fully operational*'. She went on '*to plead with (health authorities) to regard co-operation with local authorities as a high priority, for without it the concept of community care to which we are all committed will become another empty cliché*' (Castle in Wistow and Fuller (1983)).

Joint consultative committees were later strengthened through the addition of joint care planning teams and joint finance – the latter an early attempt to 'nudge' partners towards collaboration by making NHS money available for jointly agreed projects, managed either by the local authority or the voluntary sector, that would also benefit the NHS. However, the sums involved were small and the main impact appeared to be offsetting local authority budget cuts rather than pioneering new forms of joint investment (Webb and Wistow 1987). The high hopes of the early 1970s were quickly dashed by economic crisis and the resulting public spending cuts. There are potential parallels here, as nascent health and wellbeing boards are beginning their functions in a similarly if not more hostile financial climate.

Joint consultative committee arrangements were displaced by various kinds of local partnership board designed to achieve strategic co-ordination, though evidence of their effectiveness is limited. The Labour government that preceded the coalition government promoted local strategic partnerships, which sought to create the conditions that incentivised priority-focused, cost-effective joint working between local public service organisations, as well as the private, business, community and voluntary sectors (Sullivan and Turner 2011).

The Local Government and Public Involvement in Health Act 2007 reinforced the role of local strategic partnerships but did not make them compulsory. However, the Act introduced public service agreements and then statutory local area agreements with a duty on named partners – including NHS bodies and local authorities – to co-operate with the local area agreements. Results from a three-year (multipart) national evaluation (2007–10) on the effectiveness of local area agreements and local strategic partnerships in delivering better outputs and outcomes suggested that the extent of collaborative innovation and partnership working had varied across local authority areas, depending on how it was 'understood by local stakeholders, i.e. whether it is perceived to exist as a relatively autonomous entity distinct from partners and with some agency of its own, or whether it is perceived simply as a reflection of local partner interests' (Sullivan and Turner 2011, p 31).

Further, a review of these partnerships carried out by the Audit Commission (2009) highlighted the following findings.

- Each local strategic partnership has unique features, but there still are important lessons to learn from each other.
- They may not control local public services resources, but they should still be able to influence partners' mainstream spending and activity.
- There is a need to develop strong cultures to achieve shared goals.
- In multi-tier areas, there are greater challenges for these partnership arrangements than those in single tiers.

- Despite the fact that they are voluntary, unincorporated associations, they must recognise their strategic, executive and operational roles.
- As these arrangements are voluntary, government departments should not place bureaucratic burdens or expectations on them.

These conclusions echo those of an earlier assessment by the Audit Commission that although the potential benefits of partnership working are considerable, they are very hard to realise in practice. Partnership working is extremely difficult, expensive and beset by obstacles, at both local and national levels (Audit Commission 1998). A review of the governance of partnerships found that there is very little hard information about the impact of partnership working; things can easily go wrong – a third of those working in partnerships experience problems, according to auditors; leadership, decision-making, scrutiny and systems and processes such as risk management were all under-developed in partnerships (Audit Commission 2005).

The challenges of partnerships have been illustrated more recently by an evaluation of Scotland's Community Health Partnerships (CHPs), established from 2004 as statutory bodies to improve people's health and quality of life by joining up health and social care services and moving more services from hospitals into the community. Evidence of improvement was limited and patchy, reflecting numerous barriers including health boards and councils separately managing resources, such as budgets and staff, and problems in sharing information (Audit Scotland 2011).

Much of this evidence and experience is directly relevant to health and wellbeing boards, which are likely to face similar challenges. While they will differ from past arrangements in a number of important ways – including the statutory requirement for every local authority area to have a health and wellbeing board and to produce an effective joint strategic needs assessment and health and wellbeing strategy – the new boards will have to adopt a strategic approach to promoting integration and achieving better outcomes for their local population. They will have to do this not through exercising managerial authority or control, but through influencing and leading across organisational and professional boundaries. They will also grapple with the same logistical challenges as previous partnership bodies, but in the context of the much more complex organisational architecture arising from the NHS reforms, in which the roles of clinical commissioning groups, the NHS Commissioning Board and local authorities remain unclear. In addition, health and wellbeing boards begin their task in the face of even greater financial pressures than those that helped to undermine the early efforts of their joint consultative committee predecessors in the 1970s and 1980s.

Given the history of partnership working and the current financial climate, how likely is it that the new boards will succeed in bringing together the local NHS, public health and local government in effective and dynamic partnerships that achieve better health and wellbeing outcomes for their local population? In the next section, we assess how local authorities have begun to develop new arrangements with their partners. We look at the size, composition and ways of working emerging from the shadow boards. Finally, we consider the factors that are helping and hindering their effectiveness.

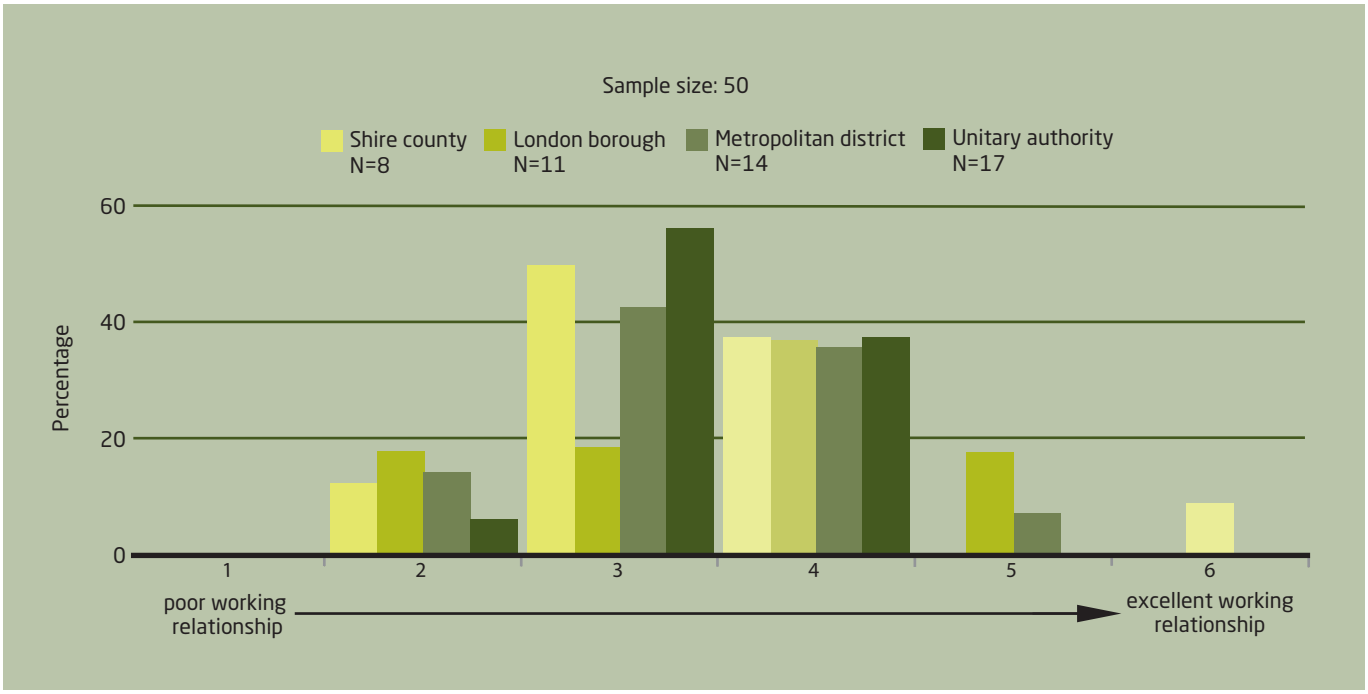
Survey findings

Existing working relationships

Most local authorities had begun to develop their board with a positive view of their current working relationship with local NHS partners. On a scale of 1 (poor) to 6 (good), 84 per cent chose a score between 4 and 6 (*see* Figure 2 opposite). This may be related to the fact that more than four-fifths had some form of strategic health and care partnership board in place prior to the reforms. Shire counties were less likely to have a board.

Several interviewees mentioned a history of good local relationships or recent progress in overcoming past difficulties that had led to improved relationships. Many were already planning to integrate health and social care and other local services like leisure, cultural services and housing, which have a direct or indirect impact on the health and wellbeing of local communities. Most interviewees (82 per cent) reported that the director of public health was jointly appointed, and the vast majority had been in post for at least one year.

Figure 2 Local authority relationships with local NHS



These findings suggest a generally optimistic and upbeat view of relationships and a positive starting point for developing these further through health and wellbeing boards. This helps to explain why local authorities in our sample had moved quickly to establish boards; all except two already had shadow arrangements in place (even though these did not have to be set up until April 2012) and 80 per cent had already held their first meeting. The extent to which these were revamped versions of pre-existing boards was not always clear. Some (including Lambeth, one of our case studies, on page 14) had decided from the outset to rethink how they wanted to work with clinical commissioning groups as new partners, aiming to develop completely new arrangements.

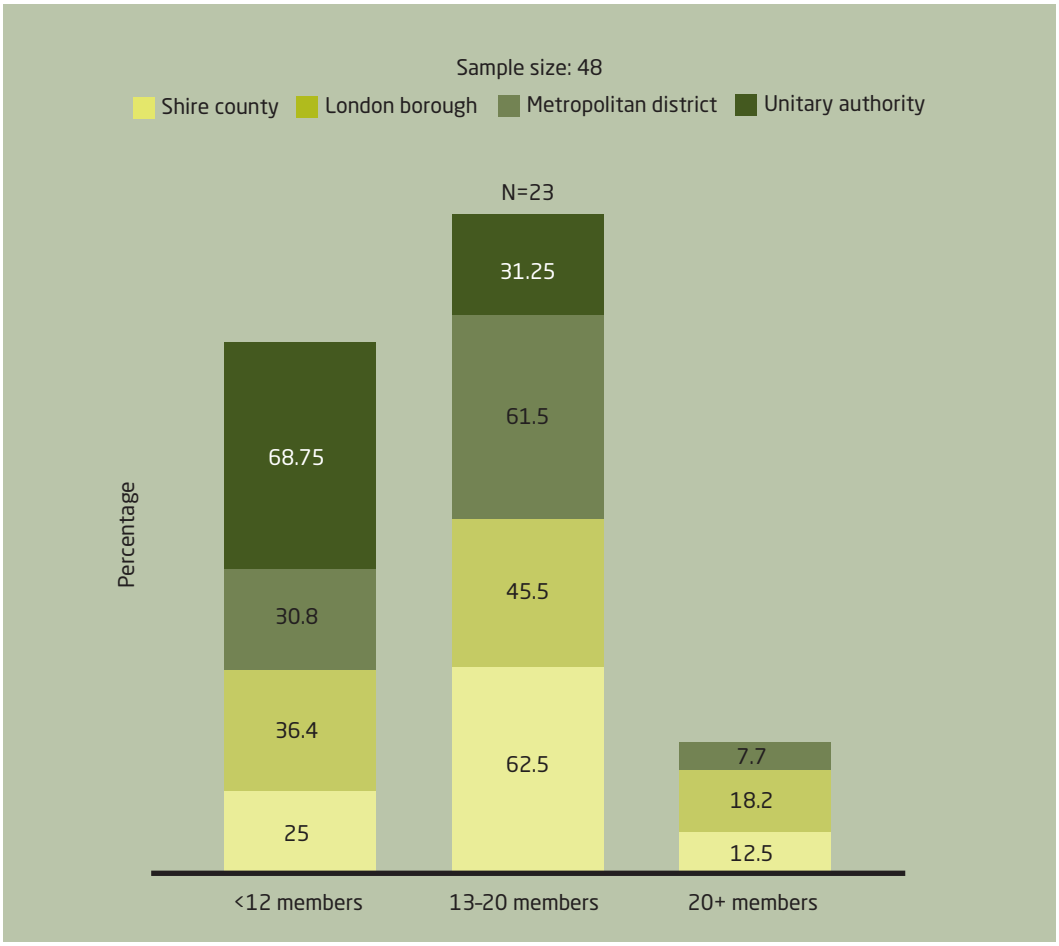
Only 7 of the 50 local authority areas included in the survey were not part of the network of early implementers set up by the Department of Health in March 2011.

Size and composition of the shadow boards

Size

Of the 48 shadow boards that had already been set up, 21 had up to 12 members, 23 had between 13 and 20 members, and 4 had more than 20 members. Unitary authorities were more likely to have smaller boards, shire counties and metropolitan boroughs larger ones (*see* Figure 3 overleaf). This seems to reflect the likelihood that shire county boards will be swelled by district council members and have several clinical commissioning groups. Many metropolitan boroughs will have more clinical commissioning groups than unitary authorities.

Figure 3 How many members are on the board?



The size of the board is important, as there are concerns that too many people around the table will reduce the effectiveness of meetings and fuel concerns that the health and wellbeing boards will just become 'talking shops'. Evidence from private sector organisations suggests that better-performing companies have fewer board members, and the general consensus seems to be that a membership of between 8 and 12 is likely to prove most effective (Eversheds 2011; Imison *et al* 2011). More than half of the boards in our survey had more members than this. However, public sector organisations are likely to be larger because of the wider range of interests they are expected to include. Striving to achieve a balance between inclusion of stakeholders and board effectiveness, most councils have avoided very large boards of 20 or more members.

One respondent explained that '*a tight core membership*' for their board had been established, but that '*a wide network which can stimulate and generate ideas*', involving the third sector and the public among others, had been engaged and was expected to remain involved in the board's work. We will return to this later (*see* page 12). Six boards had established a smaller executive or officers' group responsible for driving progress outside of board meetings.

Most boards (77 per cent) were planning to meet every six to eight weeks, with 10 per cent planning to meet as often as every month. At one level, this may reflect a strong commitment to get the boards up and running. There may be value in meeting more often in the early stages so that new working relationships can be nurtured and momentum generated. But as boards agree priorities and work programmes, it is difficult to see how this frequency can be maintained – particularly if they wish to engage with a broader group of partners and demonstrate progress beyond and between board meetings.

Composition

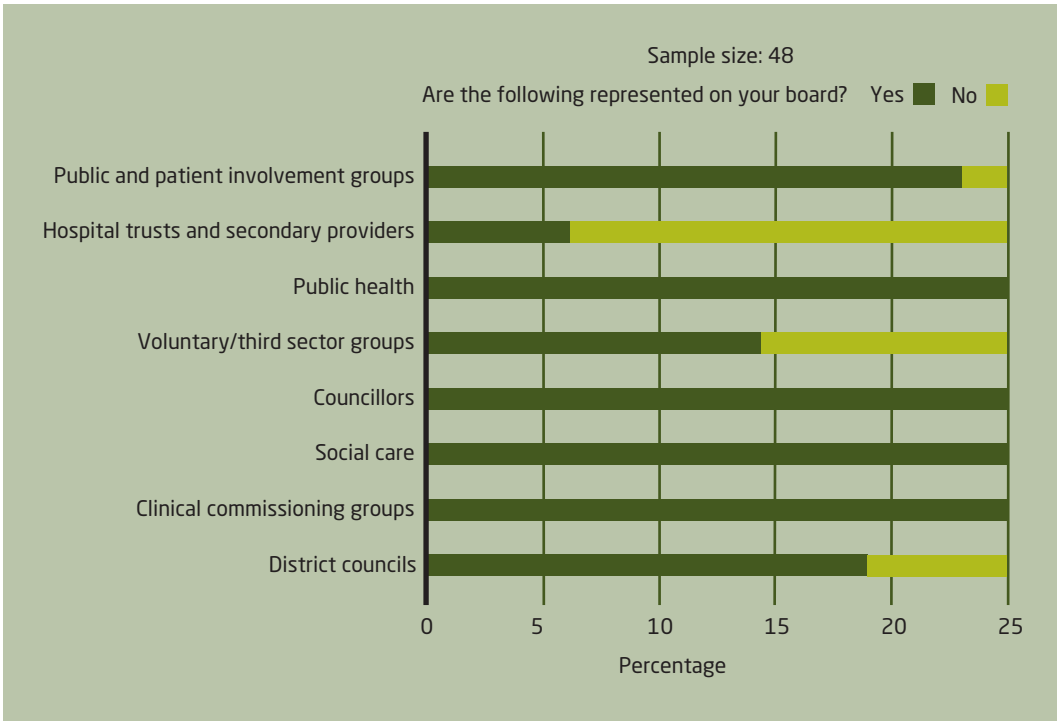
The composition of boards (as shown in Figure 4 below) largely reflects the prescribed core membership set out in the Health and Social Care Bill. The level of engagement of most stakeholders – in terms of attendance and contribution to meetings – was described very positively, and confirms that local authorities and clinical commissioning groups are forging new relationships. A very high level of engagement ascribed to adult social care is unsurprising given that policy responsibility for establishing the boards rests within this directorate in most local authorities. But engagement of public health is even higher, despite concerns about the transfer of public health functions into local government.

Most shadow boards had not gone beyond this to appoint '*such other persons, or representatives of such other persons, as the local authority thinks appropriate*', with two significant exceptions. The first is that the voluntary and third sector was represented on just over half (57 per cent) of boards. The sector's contribution to community health and wellbeing is well documented; it ranges from supporting patient and citizen representation and advocacy, and knowledge of community needs, to specific expertise gained from their service provider role that will be valuable in informing the local joint strategic needs assessment and health and wellbeing strategy. However, the sheer range and diversity of these local groups poses challenges for securing effective membership at board level, and offers one explanation for why a substantial minority of boards in our sample did not have third sector representation.

There was a similar though less marked dividing line in the involvement of NHS acute providers, who were represented on a quarter of the shadow boards. Here, their involvement was seen as crucial to promoting integration across the local health and social care economy. Some also recognised the value of having a substantial local employer represented on the board.

Attitudes towards provider membership reveal different views about the fundamental purpose of the health and wellbeing boards. For the majority, the primary focus is on commissioning, and provider involvement was seen as inappropriate, possibly even leading to conflict of interests. Many boards were seeking instead to engage with providers outside of formal board meetings.

Figure 4 Who is represented on the board?



Beyond the board – engaging stakeholders

These different emerging trends in the size and composition of boards reflect the extent to which they are involving local stakeholders more widely beyond the membership that is formally required. Most respondents saw this development as an important way of ensuring buy-in to the new system from the wider community.

Many local authorities had held informal meetings and workshops prior to the formation of shadow boards; a small number were continuing to do so either in place of the shadow board or by alternating public meetings with board meetings. These were viewed as a useful way of bringing all the parties together to build relationships, develop and formalise membership, and agree their remit and work plans. A number of respondents highlighted the importance of working closely with new clinical commissioning groups, and four shadow boards had organised meetings and events with clinical commissioning group members to cultivate this critical relationship. As one respondent explained '*[We] started last year with a showcase of local government roles for the GPs, showing them that this is what we offer.*'

Some local authorities had organised local events and meetings with providers, voluntary organisations, schools and other relevant council services such as housing and environmental services to consult with and engage local groups. Surrey, one of our early implementer case studies (*see* pages 15–16), had worked hard to ensure that their 11 district councils with responsibility for these key functions could contribute to an understanding of the different needs of their local populations. Lambeth, our other case study (*see* page 14), had adopted citizen engagement as one of its first priorities, seeking to embed this from the beginning in the way their board should work.

A number of respondents mentioned that they would be holding board meetings alongside public meetings and workshops to involve a greater number of people or interest groups from within the community. This would help the board to understand the needs of different local population groups.

In designing the new arrangements, local authorities were thinking through how existing partnership bodies such as adult and children's safeguarding boards, children's trusts and wider groups like community safety partnerships would be positioned in relation to the shadow board. Respondents reported wide variations, with some using health and wellbeing boards as the overarching body to which other partnerships reported.

Who leads the board?

A total of 25 boards had chosen the portfolio holder for health, adult social care or children's services as their chair; 17 had opted for their local authority leader or deputy leader, and in two cases, the local elected mayor. The seniority of these roles reflects the importance that local authorities attach to the boards, and a high level of political leadership was evident in our two case studies. Some boards had made imaginative and unusual choices, such as an independent chair with experience in health and social care; one had filled this role with the local superintendent commander of police, as they felt this postholder had a special interest in the wellbeing of the community. In two cases, the role was shared between an elected member and local primary care trust (PCT) or NHS trust chair. Only one board was led by the director of public health.

Twenty-four of the boards we interviewed had not yet assigned a vice-chair as they were in the very early stages of development, but there is a trend towards the local NHS – usually the chair of the clinical commissioning group – being appointed to this role. In two cases, the chair of the Local Involvement Network (LINk) or HealthWatch had been appointed vice-chair. These models of shared leadership between the local authority and the local NHS – especially the clinical commissioning groups – augur well for the emergence of mature local partnerships through the new boards.

Early issues and challenges

All the shadow boards surveyed faced similar challenges in establishing an entirely new partnership body with a high degree of flexibility and discretion. In the absence of prescriptive guidance from central government, local authorities needed to find other ways of identifying good practice and to check their progress against some kind of external benchmark. They wanted to learn from other local authorities and share knowledge – for example, through the early implementers network. Other methods mentioned by respondents included forming regional partnerships and meeting with neighbouring local authorities.

A number of respondents mentioned employing or seeking to use external organisations and facilitators to support the formation of their boards. These varied widely; each London borough had been allocated £15,000 for board development work, and London councils and London NHS together had commissioned programmes to support the development of their boards. In other areas, boards had approached other organisations for support, including The King's Fund, the Local Government Association, the Association for Public Service Excellence (APSE), and local universities. Obtaining this support was seen as vital to '*bridge the differences and lack of knowledge that [we] have about each other*' and balance the culture gap between the local authority and the NHS. This facilitation role often involved meeting with individual stakeholders and running workshops. There was only one instance where an internal health and wellbeing board co-ordinator had been recruited and, in that case, their tasks were very similar to those undertaken by external facilitators.

Access to support varies widely in different parts of the country, and the 'newness' of boards as a cross-organisational vehicle will create ongoing needs for leadership and organisational development that have yet to be systematically assessed. This will be a real test of the ability of sector-led improvement to meet these emerging development needs and avoid all 152 local authorities reinventing the wheel.

As well as these common challenges, there were additional issues facing different types of local authority. As we have seen, shire counties experience greater organisational complexity, having to find ways of engaging with several clinical commissioning groups as well as a second tier of district councils. Surrey, for example, has been working with more than 20 statutory bodies from the NHS and local government alone. Many shire counties have done well to limit their board membership to below 20, but ensuring engagement beyond the board will demand sustained attention. They also cover large geographical areas, with urban populations as well as dispersed rural communities. These are likely to generate different and distinctive patterns of need that will be hard to capture within a single joint strategic needs assessment and health and wellbeing strategy.

In contrast, metropolitan boroughs, unitary councils and London metropolitan districts have a much less complex organisational architecture, with fewer organisations. The expectation that clinical commissioning groups should be coterminous with health and wellbeing boards (that is, cover the same geographical boundaries) should strengthen partnership working. Clearly defined and shared geographical areas allow for more straightforward membership, reporting, and stakeholder involvement.

One area that had yet to be addressed was how the new boards would be resourced and serviced. Local authorities are expected to establish the boards as formal statutory committees, but are not receiving any additional resource to do this. Some of our respondents had been using council democratic teams as administrative capacity for the board, while others were using existing project management capacity. Some had identified the need to specify what contributions other organisations should make – especially clinical commissioning groups, as principal partners – to the costs of operating the boards.

Case study: Lambeth

Lambeth is a densely populated and diverse inner London borough, with high levels of deprivation. More than a third of its 274,000 population are from ethnic minorities and 150 languages are spoken. Over half of its workforce are in professional jobs but a high proportion of the population are economically inactive. Despite complex health and social care needs, recent years have seen good progress in terms of higher life expectancy, fewer teenage pregnancies, and smoking cessation. Relationships between the council and the NHS have improved substantially and both are keen to build on these achievements. The organisational landscape is straightforward, with one coterminous clinical commissioning group.

Following initial discussions between the council and the primary care trust (PCT), it was agreed to adopt a phased approach to developing the health and wellbeing board. The process involved identifying the outcomes that partners want to achieve through the board, rather than rushing to establish its governance, membership and way of working. There was clear agreement that the board offered Lambeth a new opportunity to achieve more for its residents, and that simply continuing with 'business as usual' based on its previous partnership board would be neither effective nor appropriate.

A series of workshops were held from spring 2011, attended by 25 participants from a wide range of statutory health, social care and local government organisations, including the Local Involvement Network. The engagement of GPs in particular, as well as local foundation and acute trusts and elected members from across the political spectrum, is a distinctive feature that has been particularly encouraging. New conversations were able to take place for the first time between organisations and clinical disciplines, notably GPs. The active and committed involvement of providers has been a distinctive feature of Lambeth's approach; it reflects the presence of King's Health Partners, an Academic Health Sciences Centre (AHSC) that brings together three major acute foundation trusts with an annual spend of £2 billion (compared with the combined NHS Lambeth and council spend of just over £1.6 billion).

The workshops focused on revising the joint strategic needs assessment, taking into account the current priorities and plans of existing organisations, and how the health and wellbeing board could add value. This has helped the organisations involved to understand each other's agendas and concerns. A mapping of existing spend showed that the total public resource that falls within the remit of the board is more than £1 billion, and that its core mission will be to consider its overall deployment and what outcomes will be achieved in terms of the joint strategic needs assessment and health and wellbeing strategy.

The board's role is seen as strategic, with no direct involvement in detailed commissioning. This understanding has helped to frame initial priorities; workstreams have been agreed on and work has begun on citizen involvement, public health, integrated care and early intervention.

Key features of Lambeth's early experience:

- An evolutionary approach, emphasising relationship-building and the development of agreed shared outcomes rather than formal board meetings.
- Positive engagement of GPs and a partnership approach.
- Direct involvement of acute providers, recognising their expertise in innovation and financial scale in relation to the health and care economy.
- A strong focus on citizen engagement and co-production, rooted in Lambeth's 'co-operative council' approach.

Case study: Surrey

This is a large and complex health and care system, covering a population of 1.1 million. There are more than 20 statutory organisations, including 11 district councils, and 12 nascent clinical commissioning groups. The county is served by five acute hospitals (based at five trusts, three of which have foundation status), two major community providers (one social enterprise), a county-wide mental health trust, and 12 GP commissioning consortia (10 of which are pathfinders). Its geographical location means that significant use is made of London hospitals. Although the population is relatively prosperous and healthy, there are substantial inequalities in terms of social class and ethnicity, and between different parts of the county. Particular issues of concern are lifestyle-related illness such as alcohol misuse, smoking rates and childhood obesity. The use of residential care is above the national average and reflects the ageing population.

Relationships between the council and NHS partners had improved significantly in recent years. Building on this, stakeholders from across the county were brought together in three development workshops in spring 2011 to develop a shared vision for the new health and wellbeing board. The starting point was a strong focus on outcomes, seeking stakeholder views on three questions: what are the top three health and wellbeing priorities for local people?; what needs to be done to address them?; and what needs to be commissioned differently to achieve those outcomes?

Workshops involved at least 60 people drawn from across local government and the NHS, including the private and voluntary sectors and acute health providers. Achieving effective engagement on this scale is a particular challenge for shire counties like Surrey, where there is a second tier of local government in the form of district councils. The attendance of GP leads from the clinical commissioning groups reflected their commitment to the process.

Early themes included: ensuring clarity of purpose (avoiding the risks of the board adding a further complication to an already complex system); mapping existing spend and services across the county; understanding the overall picture (and differences within the county); and building strong relationships, both within the board and externally. Efforts were made to ensure that board arrangements dovetailed with other existing and valued partnerships (eg, the children's trust, safeguarding boards, etc).

Mapping work through the joint strategic needs assessment had shown that combined spending across the NHS, adult social care and children's services amounted to more than £2 billion. Thinking focused on what kind of arrangements would best ensure that this resource is used most effectively; the construct of 'The Taylor family' was proposed to think about how these resources could benefit local residents.

A clear consensus emerging from the workshops was that the purpose of the board is to promote transformational change, recognising the need for fundamental changes in what services are commissioned and how this is done, rather than simply tinkering with or repackaging existing arrangements.

By the time of the final workshop, the county council was able to articulate some clear models for the board. These included: one main board and 11 local boards based on district/borough boundaries (drawing on previous work of the local strategic partnerships); and a two-tier model with a single board and four sub-groups based on the PCT resource hubs or the clinical commissioning group cluster areas. These models reflected the need to ensure the engagement of both district councils and clinical commissioning groups, made difficult by the lack of coterminous geographical boundaries.

The shadow year (from April 2012 to April 2013) is seen as an opportunity for experimentation, and a shadow board has been set up and has already met twice. Chaired by the council's cabinet member for adult social care and health and co-chaired by a GP lead, it has approximately 27 members (17 of which are GP leads). There will be wider engagement activity with other key stakeholders who are not members of the board. The board is now developing its work programme, including timescales for the joint strategic needs assessment and health and wellbeing strategy for 2012/13.

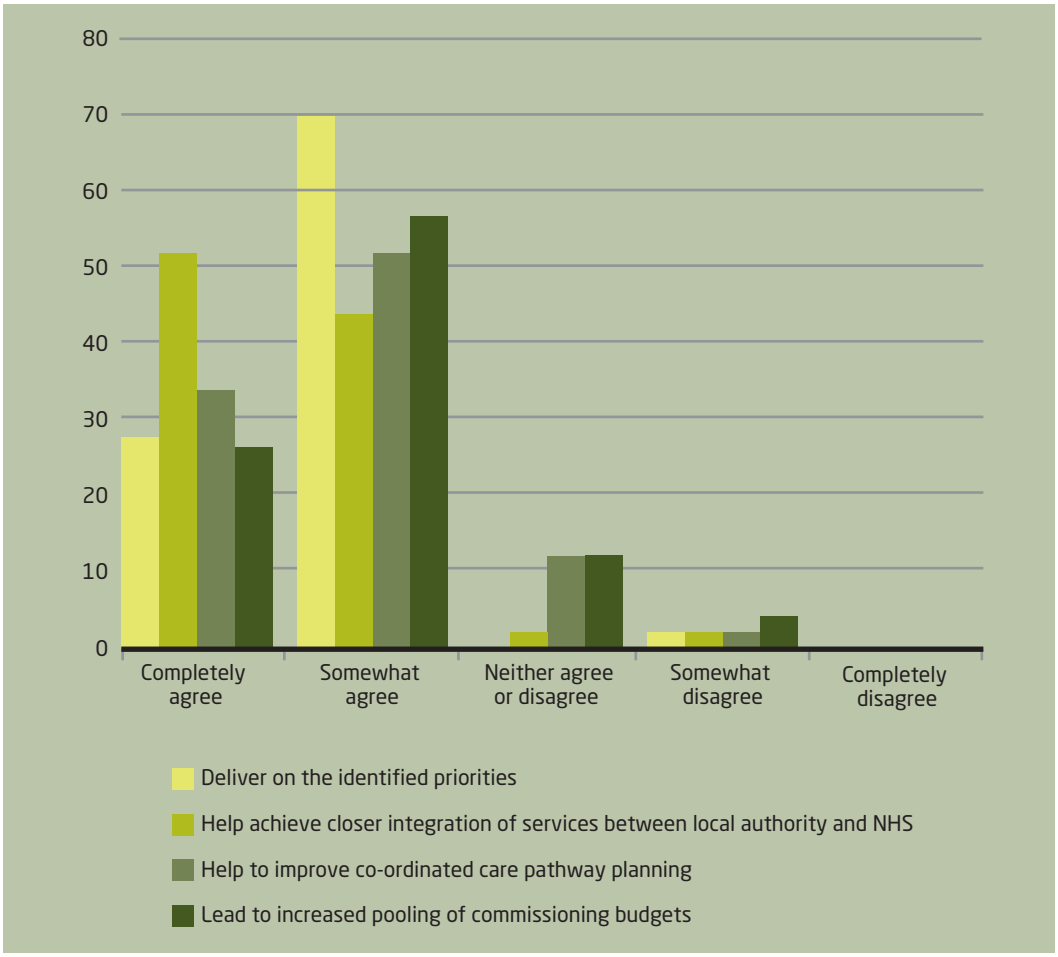
Key features of Surrey's early experience:

- achieving a single board in a complex system with multiple organisations and two tiers of local government will be challenging
- the local authority can take a lead role but must secure the consent of external partners
- the emerging role of the board is strategic, overseeing transformational change and adding value by bringing together multiple stakeholders
- more work needs to be done to engage the voluntary and third sector.

Prospects for success?

Respondents were generally very upbeat about their expectations of what the board would achieve against four objectives that reflect their core functions: delivering locally identified priorities, achieving closer integration, more pooled budgets, and improved planning of care pathways (*see* Figure 5 below).

Figure 5 How effective will the boards be?

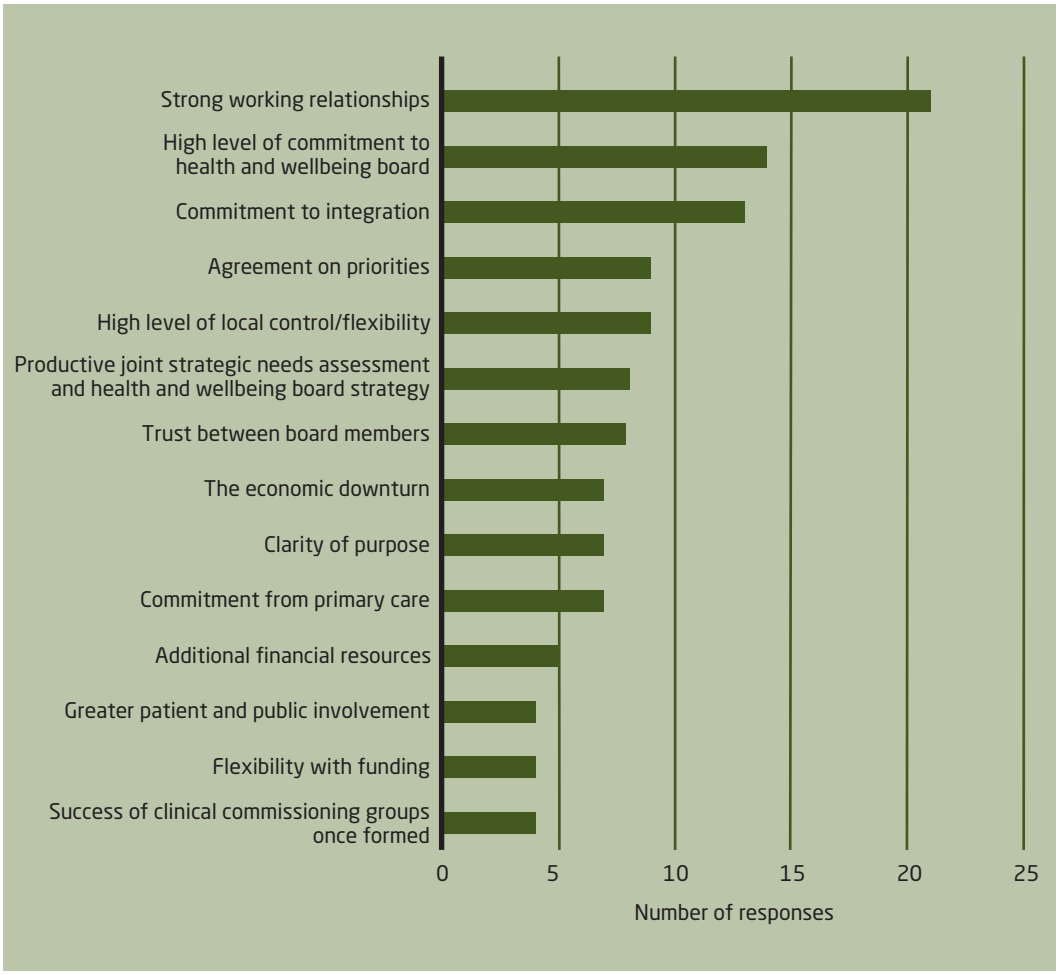


We asked respondents what would be different about the new boards compared with previous joint working arrangements. They cited:

- greater involvement/engagement of GPs in the health and wellbeing boards
- better governance and accountability because of the status of the board as a committee of the local authority
- greater ability to set the strategic direction for health and wellbeing in the area (including being viewed as the local strategic system leader for health)
- a wider, more preventive focus, considering both health *and* wellbeing (facilitated by the movement of public health into the local authority, and more effective use of joint strategic needs assessment to have a clearer picture of local needs)
- achieving greater partnership working between organisations, particularly across the breadth of the local authority and the local NHS (that is, greater integration)
- the importance of making the board a statutory requirement (unlike the local strategic partnerships) with greater influence – and some seeing it as having executive decision-making powers
- a strategic focus on commissioning, affecting both membership of the board and the nature of the local health and wellbeing strategy.

Respondents were asked an open question to name up to three factors that would be most significant in helping health and wellbeing boards achieve their objectives. The answers were then grouped into themes by the research team. The key themes identified are set out in Figure 6 below.

Figure 6 What factors will help boards to achieve their objectives?

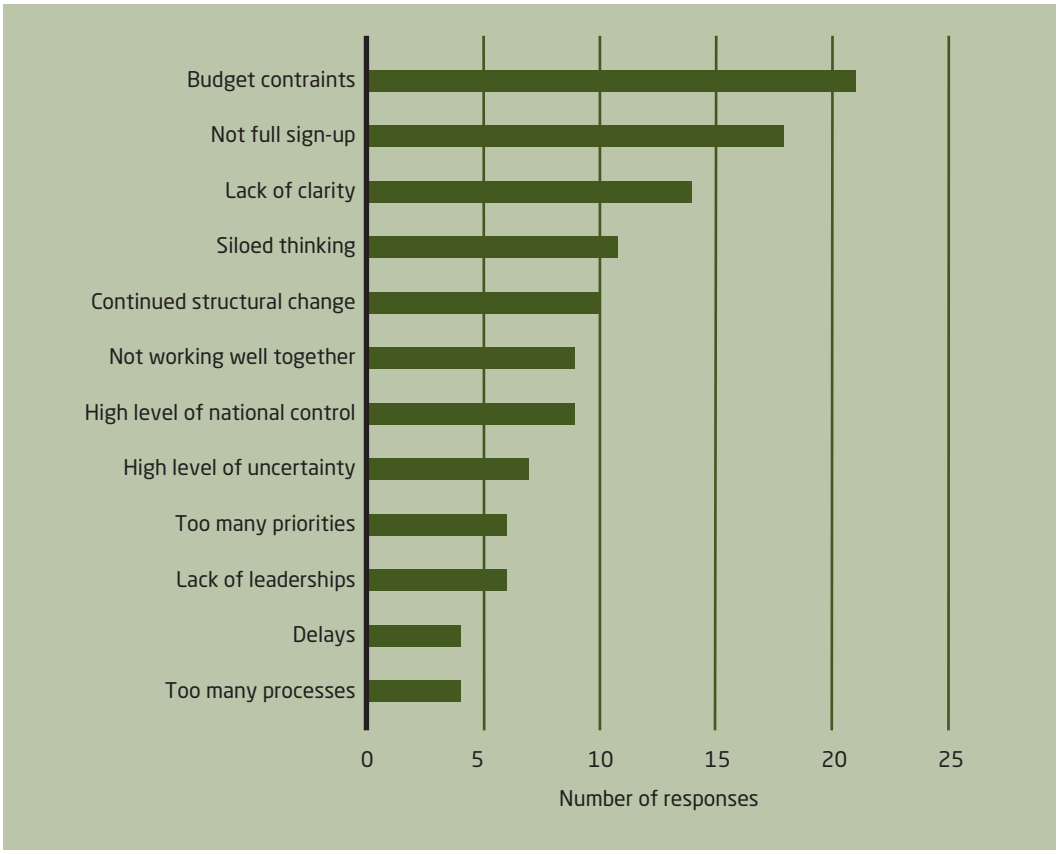


The most frequently mentioned factor was strong working relationships. This included having frank and full discussions between board members, a genuine willingness to work with one another, and a commitment to building on positive relationships that already exist across organisations. It was also felt that a high level of commitment to working on the board, and the ability to agree on priorities, were critical elements for success. These both link to the need for strong working relationships, and suggest that effective leadership and management qualities will be essential for the boards to work effectively. Commitment to integration was also seen as a key to success, particularly through closer alignment and sharing of resources.

Interestingly, some respondents viewed the economic downturn as an opportunity rather than a constraint, in that resource pressures would encourage organisations to think of 'new ways of doing things' between themselves, in partnership as opposed to in silos. But some respondents suggested that additional resources would be needed to support and service the work of the boards if they are to deliver what is required of them.

Turning to the factors that hinder board effectiveness, the most frequently cited issue was budget constraints. The financial challenges facing the NHS and local government create a number of risks: that organisations will try to manage these pressures by retreating into silos instead of fully embracing the opportunity to align plans and resources; that they will not sufficiently prioritise investment in prevention and wellbeing services; or that they will not receive sufficient resources in the transfer of public health responsibilities to tackle health inequalities and the wider causes of ill health. This, in turn, will weaken their commitment to partnership working, thereby undermining 'sign-up' and commitment to the board (*see* Figure 7 below).

Figure 7 What factors will hinder boards in achieving their objectives?



Lack of clarity about the scope and purpose of the boards was also a significant concern, especially at the interface with other NHS organisations, in terms of how their respective roles and responsibilities would fit together.

The reorganisation of structures and changes in key personnel were seen as impeding the development of strong working relationships. Structural change was frequently mentioned as a factor that would hinder the effectiveness of the new boards. Many respondents feared that the continued changes at both local and national levels would create fatigue and confusion within their local system, and this would undermine relationship-building and the ability to reach local agreements.

Although the government's approach to the boards is relatively non-prescriptive, some respondents saw a high level of national control as a potential hindrance, and were concerned that national 'interference' would inhibit boards from working on what really matters to their local populations.

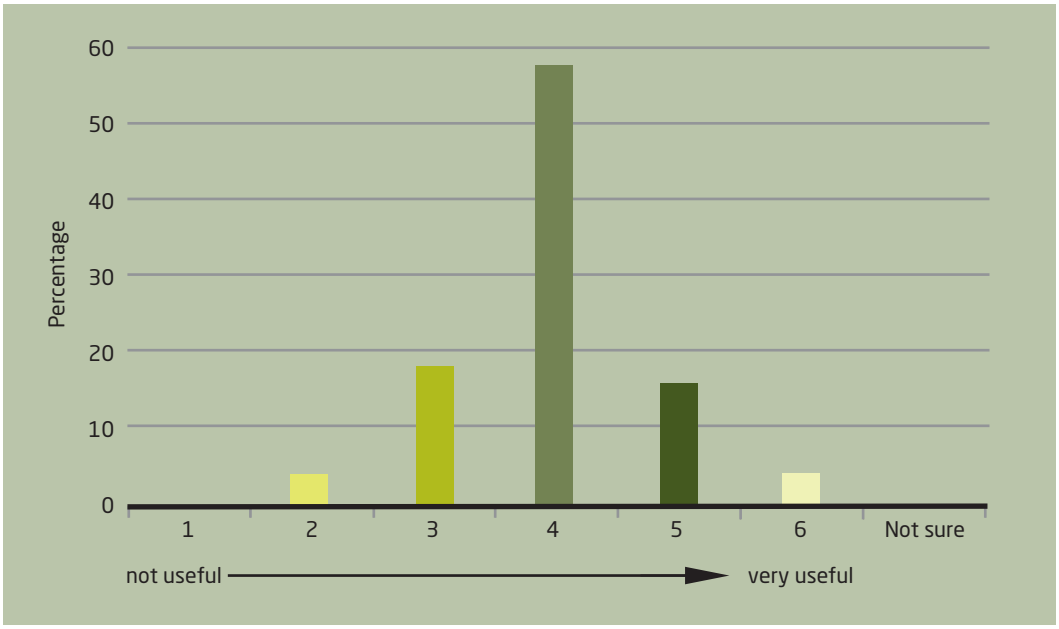
The joint strategic needs assessment and local health and wellbeing strategy

A core function of the new boards is to develop their joint strategic needs assessment and use this to agree a local health and wellbeing strategy. We asked respondents to assess the usefulness of their existing joint strategic needs assessment. Most (78 per cent) rated it on the higher end of the scale (*see* Figure 8 below), but intended to develop it further. Some described it as too much like a 'shopping list' and said that it needed to be more focused.

The main ideas for improving the joint strategic needs assessment were to make it more comprehensive by widening it to include other areas like housing, employment and culture. Many wanted to make it a more user-friendly, succinct and regularly updated web-based document that would be more helpful to commissioners, and so have greater influence on their decisions. One idea was to make the document relevant to the local population by mapping the needs of people at different levels (by postcode, in wards, in primary care, etc); another was to develop greater ownership of the joint strategic needs assessment through stronger public and patient involvement.

There is a clear desire to develop existing joint strategic needs assessments so that they bring together all relevant information about local population needs and become a stronger framework for integrating social care, public health and the local NHS in response to those needs. Draft guidance from the Department of Health on joint strategic needs assessments and health and wellbeing strategies should help the new boards take forward these ideas (Department of Health 2012b).

Figure 8 How useful is your current joint strategic needs assessment?



Another core function of the new boards is to produce a locally agreed health and wellbeing strategy that acts as the framework in which local services are commissioned. How important will these strategies actually be in influencing local commissioning decisions? Most respondents thought their strategy would be very influential in relation to the decisions of clinical commissioning groups, but not those of the NHS Commissioning Board, where respondents were either negative or unsure. This mirrors the concerns described earlier about the relationship between health and wellbeing boards and the NHS Commissioning Board. This is very significant, because the NHS Commissioning Board will be responsible for commissioning all local primary care, dentistry and pharmacy services as well as specialised services – comprising as much as £20 billion of the total NHS budget. If the new boards are to promote the strategic co-ordination of all local services relevant to health and wellbeing, they will need to influence all commissioning activity affecting their local population – including the NHS Commissioning Board.

Measuring success

Many boards had just begun to consider how they would assess their impact and success. More than half were planning to measure board performance against the delivery of stated objectives reflected in work programmes, joint strategic needs assessments, and the joint health and wellbeing strategy. Other respondents mentioned evaluating board performance internally or externally by asking local clinical commissioning groups or the public to be involved in the process; and also monitoring attendance at meetings. The local authority's oversight and scrutiny committee was also seen as having a role in regularly reviewing the actions and performance of the board.

Clarity around the need to use process measures to assess board performance contrasted with uncertainty over respondents' aspirations to measure their success in delivering improved outcomes. A quarter of respondents planned to evaluate their performance against specific outcomes, although these were yet to be fully defined. Examples of measures being considered were health inequalities, emergency admissions to hospital, accident and emergency (A&E) waiting times, admissions of over-75s, and patient/user satisfaction.

Others planned to use the forthcoming NHS, public health and social care outcomes frameworks to develop their own set of outcome indicators aligned across the three frameworks. A small number intended to use improvements in the integration of services as a measure of their effectiveness.

Several respondents saw the development of successful relationships between the partners on the board as a tangible way of establishing whether the board was working effectively. The 'personal dynamics' of the board not only referred to reaching agreements but reaching a level of familiarity where members felt secure enough to openly disagree. As one respondent said: '*In the past [we've had] no public disagreements. I would like one member to feel able to openly disagree with another in a meeting.*'

More than a third of boards had not yet discussed how they planned to assess their success or impact. As one respondent explained, they did '*...not want to nail [our] colours to the mast too quickly. [It] will be linked to what a health and wellbeing board will need to do.*'

Where next for health and wellbeing boards?

Most local authorities in our sample have got off to a flying start in developing the new arrangements by moving quickly to establish shadow boards ahead of the required date of April 2012. New relationships are being forged with clinical commissioning groups

and there is a high level of engagement with public health colleagues. The fact that most boards are being chaired by senior elected members – in some cases, the leader of the council and elected mayor – signifies the importance that local authorities are assigning to the new bodies. Most boards are very optimistic about their prospects for success in promoting integration, increasing joint commissioning, and delivering locally agreed priorities. We found many examples of innovation and creative thinking.

Innovation – local examples

Many places were pursuing unusual and imaginative ideas.

- One board from a metropolitan district appointed an independent chair. This person had a background in health and social care but was not employed by the local authority or local NHS. Their board meetings were taking place in a neutral setting to help members focus on the needs of the local population, rather than the organisations they represented.
- One board in a unitary authority appointed the superintendent commander of police as the chair. This person was very much involved with the community and was keen on taking part in integrating health and social care within the locality.
- Many of the leads interviewed mentioned that their joint strategic needs assessment in the future would have much more of a focus on forecasting and market analysis, not simply epidemiological accounts of the population.
- One London board was planning a 'Dragons' Den'-style event to identify and champion local innovations in tackling health inequalities.
- One shire county was pursuing a novel method of engaging communities in developing their joint strategic needs assessment by sending out questionnaires to the communities in the different districts and other stakeholders, asking them what health and wellbeing needs should be addressed. The results would be fed into seven workshops and an electronic voting system used to identify the top 10 priorities.

Working in a context of unprecedented challenges

There has rarely been such strong support for closer relationships between NHS and local government and the integration of services. Expectations of what health and wellbeing boards can achieve are high, but the challenging circumstances in which they begin their work are unprecedented. This raises some fundamental questions about what the new boards can realistically achieve.

Over the next decade and beyond, the NHS, social care and related services face the enormous challenge of responding to the needs of increasing numbers of people with long-term conditions and an ageing population; this at a time when the NHS leaves behind the substantial real-term funding increases of the past to face a productivity gap of £20 billion, and local government faces an overall reduction of 26 per cent over the next four years. Both trends require a radical shift from a model of care based predominantly on acute hospitals towards a more preventive approach that promotes self-care and is much more personalised and co-ordinated around the needs of the individual. Health and wellbeing boards must play a central role in this shift, otherwise their impact will be as patchy as previous partnership arrangements.

In many places, this will require changes in hospital provision, involving the unpopular rationalisation or even closure of some services in order to concentrate specialist resources in fewer sites. A recent review by The King's Fund of how to improve health care in London sets out an important role for local authorities helping to lead changes through

health and wellbeing boards (Appleby *et al* 2011). But even where there is a compelling case for change on the grounds of clinical safety or outcomes, the local authority will come under pressure to reflect local opinion and preserve valued local services. In these circumstances, the local health and wellbeing boards will be in the eye of the storm, and the current wave of generalised goodwill on which they have been riding will quickly dissipate. At this point, the political leadership of the board will be tested to the limit. If boards can rise to the challenge and lead public opinion instead of merely following it, there is every prospect they will break new ground in transforming services and the lives of people who use those services – and avoid becoming just another talking shop in the long history of partnership working.

One of the core functions of the boards – producing a joint health and wellbeing strategy that will act as a framework within which all local services are commissioned – will also be a formidable test. If these new strategies are to be genuinely useful and have a real impact on commissioning decisions, they will need to be more than a wish list of uncosted proposals. Instead, boards will need to apply rigorous prioritisation in assessing competing needs and demands, and aim to reach agreement on the key priorities. This would be daunting enough for the most mature, well-established partnerships with proven governance arrangements. But the new boards will be in their infancy, and one of the principal partners – clinical commissioning groups – will be entirely new, grappling with their own development needs.

Boards are also emerging into a new world that is more complex organisationally than current or past arrangements, with responsibilities distributed across a multiplicity of clinical commissioning groups, commissioning support organisations, the NHS Commissioning Board, clinical senates and clinical networks. Public health functions are to be split between local government and Public Health England. As we have seen, there is considerable uncertainty about the respective roles and responsibilities of different bodies, especially during the transition from old to new arrangements, with the resulting risk of organisational instability. Health and wellbeing boards will be grappling with emerging fault lines emerging from these different parts of the new system as well as traditional divisions that remain untouched by the reforms – for example, the means-testing of social care, compared with NHS care that is free at the point of use.

These challenges will be played out in different ways in different places. Here, we present three possible scenarios that could emerge. They are not mutually exclusive though; elements from each could be combined into any number of permutations.

Scenario 1 Towards system leadership

The local authority decides early on to initiate contact with local GP leaders and other stakeholders and holds workshops to discuss how they can develop new partnership arrangements. They agree to completely revise the existing joint strategic needs assessment.

The local authority and Local Involvement Network (LINk) develop a public engagement strategy to test out emerging themes and issues. This reveals wide agreement about some priorities but sharp disagreements about others (eg, changes to A&E facilities needed for clinical safety as well financial reasons). The board agrees to set up an independent commission to make recommendations about the future shape of health and care services, with a particular focus on hospitals. Its terms of reference are agreed with the NHS Commissioning Board.

In the meantime, the shadow board agrees some selective but ambitious priorities, including tackling a fast-rising elderly population, escalating levels of Type 2 diabetes, and child and adolescent mental health. This begins to have some impact on local

commissioning decisions and there is eventual agreement to completely redesign services for older people through a single local care record and to form integrated locality teams.

Pressures on health and care budgets continue to grow. The board commissions a short-life task and finish group to review what can be done to manage these pressures.

In this scenario, the board's influence and credibility with local stakeholders is growing, and despite relentless financial pressures, it is beginning to offer leadership across the whole system, promoting greater integration and addressing the need for major service change.

Scenario 2 Strategic co-ordination

The local authority covers a mixed urban and rural population. There are several clinical commissioning groups whose practice boundaries overlap with adjacent local authorities. It has two acute NHS trusts who derive a substantial part of their income from out-of-area referrals. There are substantial differences in the need profiles of different parts of the county, which makes it difficult to produce a single health and wellbeing strategy.

The clinical commissioning groups are only at an early stage of deciding their commissioning priorities. These are likely to involve changes to hospital services (as part of a wider sub-regional reconfiguration) that will be unpopular with some local people. The local authority is channelling public concern through its overview and scrutiny committee, and is likely to 'agree to disagree' on this particular aspect of NHS commissioning intentions.

The board agrees to adopt some high-level priorities drawn from the existing, separate plans, one of which is better information and advice. A notable early quick win is that all local public service access points, from libraries to GP surgeries, agree to display basic signposting information to divert hospital attendances and promote self-care.

In this scenario, recognition of the multiplicity of different bodies and their different starting points sees the board take a strategic focus on the overall priorities that are shared by all partners, but these may not necessarily address the challenges facing the system as a whole.

Scenario 3 Passive engagement

Past relationships between the local authority and NHS have generally been good. The controlling political party has a small majority and adopts a consensual style of leadership.

Because of the tradition of good working relationships, the health and wellbeing board is largely a continuation of the previous health and social care partnership, with the addition of GP representation from the two clinical commissioning groups. Use of hospital and nursing home places is well above the national average due to a rapidly ageing local population. The local acute trust faces a growing financial deficit, with concerns also being expressed about quality of care.

The clinical commissioning group was late to be authorised and struggled to develop commissioning plans that were acceptable to the NHS Commissioning Board. Its engagement with the board has therefore been limited. As a result, board meetings are dominated by sharing of existing plans and strategies, which are usually 'rubber-

stamped'; most members continue to value the opportunities for networking and to maintain past relationships. They tend to attribute local problems to national policies and inadequate government funding.

The financial position of the acute trust continues to deteriorate, and concerns expressed by Monitor and the Care Quality Commission (CQC) lead to the NHS Commissioning Board initiating discussions with a neighbouring trust about a merger.

In this scenario, the board is largely irrelevant in an unfolding crisis of financial and service failure, with little influence or impact on the major decisions that will need to be made.

Next steps

The literature and evidence on partnership working illustrate the profound challenges in achieving effective collaboration and the fact that potential benefits have been hard to realise. The outcomes achieved by health and wellbeing boards will depend on a range of factors, including national policy and local circumstances, and there are likely to be wide variations from one place to another. Our findings and analysis indicate some common themes and issues emerging from the early implementers that need to be addressed by the boards themselves, their partners, and the Department of Health in the window of opportunity that is the shadow year.

Most local authorities are still developing their way of working, trying to set up boards that are fit for purpose without being too large or unwieldy. It will be hard to get this balance right where there are two tiers of local government and multiple clinical commissioning groups, and many are still thinking through how the new board will dovetail with other valued local structures such as children's trusts and safeguarding boards. They need to address risks that the board will be seen simply as an additional layer of meetings that adds cost rather than value to local partnership arrangements. The shadow year offers time for experimentation, and it is vital that there is rapid capture and dissemination of what works using different approaches.

The primary purpose of health and wellbeing boards is to promote integrated care, and it is widely agreed that this should become a major policy priority. In our recent report produced with the Nuffield Trust for the Department of Health and the NHS Future Forum, we pointed out that commissioners alone are unlikely to drive the development of integrated care at the scale and pace required (Goodwin *et al* 2012*).* Given the evidence on the difficulties faced by commissioners in enabling integrated care (Curry and Ham, 2010), it is likely that many integrated care partnerships will be led by providers rather than commissioners in the first few years (Goodwin *et al* 2012). Yet most boards do not include provider representatives, and while some boards have applied imaginative thinking in distinguishing board membership from wider stakeholder engagement, it remains to be seen whether this will be sufficient and can be replicated elsewhere. If health and wellbeing boards are to be a genuinely new and effective vehicle for integration, it is vital that all local authorities look afresh at ways of working with local partners. They must avoid the easy route of uncritically carrying forward previous partnership arrangements, with a hard separation of commissioner and provider roles.

This also raises a wider question as to whether the role of health and wellbeing boards needs to be more sharply defined so that there is greater clarity about what they are trying to achieve. The purpose of the boards is to set the strategic framework for commissioning – through the joint strategic needs assessment and health and wellbeing strategy – and not to directly commission services. However, the Health Select Committee has recently argued that the boards are '*…an obvious starting point for a radically strengthened*

commitment to integrated health and social care commissioning', and should have the powers to develop integrated commissioning budgets and approve commissioning plans (House of Commons Health Committee 2012).

There is a danger that stronger emphasis on overseeing commissioning will hinder efforts to promote integrated care. As we have noted, most boards do not include provider representation on the grounds of potential conflicts of interest. In contrast, clinical commissioning groups are addressing potential conflicts of interest between the commissioning and providing roles of GPs through the development of detailed governance arrangements that emphasise the importance of operating transparently, with specific measures to safeguard against any conflicts of interest that may arise (Department of Health 2011a). Health and wellbeing boards could take a similar approach to manage any conflicts of interest with providers – but if they are adopting a strategic role, these are unlikely to arise. Boards need to give more thought to what governance arrangements are required in order to fulfill their primary purpose of integrating services.

There also needs to be further consideration of how the role of the new boards will be affected by the work of the NHS Commissioning Board. It will be a significant commissioner of local services, yet respondents expressed little optimism that the health and wellbeing boards will have any influence on its decisions. This reflects wider uncertainty about the respective roles of the health and wellbeing boards, clinical commissioning groups and the NHS Commissioning Board, and how they will work together. In a more complex organisational landscape, these roles and responsibilities need to be much more clearly set out to avoid conflict and ensure that the primary purpose of the health and wellbeing boards is well understood. Anxieties about the role of the NHS Commissioning Board are fuelled by a deeper suspicion among respondents that, despite the rhetoric of localism, national policy imperatives could over-ride the local priorities agreed through health and wellbeing boards. This could lead to loss of interest in, and commitment to, the local board.

In their strategic roles, health and wellbeing boards will be grappling with the tensions between national priorities arising from the mandate to the NHS Commissioning Board from the Secretary of State for Health, and a more permissive regime in which 152 separate local authorities independently determine their own spending and commissioning priorities. As well as these structural differences, many respondents emphasised different cultures and ways of working within different parts of the NHS and local authorities. To operate as a unified structure, working to an agreed set of priorities, local boards will need to find ways of overcoming these differences. As we have seen, the creation of local health and wellbeing boards will do nothing in itself to change these fundamental differences, and the implications of this do not appear to have been fully appreciated in the planning stage. We have argued that there needs to be a stronger national framework for integrated care – including a clear, ambitious and measurable goal to improve people's experience of services – that will create a policy and regulatory environment in which health and wellbeing boards can achieve their objectives locally. This should include action to develop a single outcomes framework to promote joint accountability (Goodwin *et al* 2012).

The biggest challenge for the new boards is whether they will succeed in delivering strong, credible and mature leadership. As the report from The King's Fund Commission on Leadership and Management in the NHS points out:

> *The NHS needs leadership and management, not just 'from the board to the ward' – essential and central though that is – but across NHS boundaries into social care, local government, the voluntary sector and the wide variety of other agencies with which it interacts and without whose co-operation it will not achieve its primary objectives. This requires not heroic leadership but leadership that is shared, distributed*

> *and adaptive. Leaders must focus on systems of care and not just institutions and on engaging staff and followers in delivering results. Leadership development should focus on organisations and systems, not simply individuals, and should give much more attention to shared leadership between managers and clinicians.*
>
> (The King's Fund 2011, p 28)

It is very early to predict how health and wellbeing boards will operate in practice, what impact they will have, and whether they will achieve the consistent and geographically uniform success that has eluded previous initiatives over the past 40 years and more. The interviews on which this report is based took place in autumn 2011, and there is still more than a year to go before the boards become fully operational. Our findings reflect a largely positive view of progress so far, but our analysis suggests that if boards are to grow into mature partnerships delivering local leadership and service change – our 'system leadership' scenario – much more work is needed at national and local levels, especially to develop a stronger framework for integrated care.

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Appendix 1: Methodology

Several methods were used to collect data for this study:

- case studies based on two local authority areas (Surrey and Lambeth) where The King's Fund had facilitated local workshops
- a structured telephone survey conducted with self-identified lead officers for health and wellbeing boards in 50 local authority areas
- a follow-up questionnaire sent to all telephone interviewees
- a literature review to establish current knowledge of implementation of the boards and former initiatives intended to promote local joint working.

Case studies

As well as designing and facilitating workshops, fifteen semi-structured interviews were conducted across both authorities with contacts including cabinet members, clinical commissioning group leads, Local Involvement Network (LINk) leads, and Primary Care Trust (PCT) and local authority chief executives. Interviewees were asked a series of questions covering their past partnership arrangements, engagement with stakeholders, current progress in establishing the health and wellbeing board, factors helping and hindering development, and early priorities.

Telephone survey

- A pragmatic sampling strategy was conducted for the telephone survey. All 152 upper-tier local authority areas were identified, grouped by region and authority structure. Deprivation scores were calculated using the 2010 English Indices of Deprivation. In order to achieve a representative mixture of types of council, region and deprivation, 50 authorities were initially identified and invitations were sent to the directors of adult social services asking them to identify the appropriate health and wellbeing lead. Other councils from the remaining list were then approached to take part in the survey based on their region, structure and deprivation scores until a sample of 50 was reached (30.4 per cent response rate).

Between September and October 2011, 30-minute confidential telephone interviews were conducted with 50 self-identified lead officers for health and wellbeing boards. Respondents were asked a series of structured questions and asked to complete a brief post-survey questionnaire.

Table A1 Sample characteristics

Regions	Number
London	12
North East	3
North West	5
West Midlands	6
East	1
East Midlands	3
South East	4
South West	4
Yorkshire and the Humber	12
Total	**50**

Structure	Number
Unitary authorities	17
Metropolitan districts	14
London boroughs	11
Shire counties	8
Total	**50**

Respondent characteristics	Number
Director of social care (adult, children, combined role)	20
Assistant director/third tier	11
Directors of public health	7
Local authority chief executive or assistant	3
Other	9
Total	**50**

Follow-up questionnaire

A short questionnaire was sent to all 50 participants in the telephone survey. Respondents were asked to provide additional information on council and adult and social care budgets in 2011/12 and to restate the categories of board membership. Forty-one (82 per cent) of the local authorities sampled completed the follow-up questionnaire.

Appendix 2: Interview responses

What is your local authority type?

Local authority type	Number
Metropolitan district	14
Shire county	8
Unitary authority	17
London borough	11
Total	**50**

Did you have a health and wellbeing board or partnership in place prior to reforms (Y/N)?

Local authority type	Yes	No
Unitary authority	15	2
Metropolitan district	12	2
Shire county	5	3
London borough	10	1
Total	**42**	**8**

Do you have a joint Director of Public Health (Y/N)?

Yes	41
No	9
Total	**50**

How long have they been in post (less than 3 months, 3–6 months, 6–12 months, more than a year)?

Length of time in post	Number
Less than 3 months	1
3-6 months	0
6-12 months	3
More than a year	37
Total	**41**

How would you rate the current working relationship between the local authority and NHS (rating scale 1 (poor) –6 (good))?

Rating	1	2	3	4	5	6	Not sure	Total
Unitary authority	0	0	1	9	6	0	1	17
Metropolitan district	0	0	2	6	5	1	0	14
London borough	0	0	2	2	4	2	1	11
Shire county	0	0	1	4	3	0	0	8
Total	**0**	**0**	**6**	**21**	**18**	**3**	**2**	**50**

How many members does it have in total?

Number of members	Shire county	London borough	Metropolitan district	Unitary authority	Total
>12	2	4	4	11	21
13–20	5	5	8	5	23
20 +	1	2	1	0	4
Total	**8**	**11**	**13**	**16**	**48**

Can you tell me if the following are on the board?

Groups on the board	Yes	No	Total
Clinical commissioning groups	49	0	49
Social care teams	48	1	49
Voluntary/third sector groups	28	21	49
Public health professionals	48	1	49
Hospital trusts and secondary providers	12	37	49
Public and patient involvement groups	45	4	49
District councils	6	2	8

Level of engagement on a scale of 1 to 6 (1 = poor, 6 = good).

Groups	1	2	3	4	5	6	n/a	Total
Clinical commissioning groups	0	2	4	12	16	14	0	48
Social care	0	0	1	2	14	30	1	48
Voluntary/third sector groups	0	0	4	10	11	6	17	48
Public health	0	0	0	3	12	33	0	48
Hospital trusts and secondary providers	0	3	3	3	5	3	31	48
Public and patient involvement groups	0	1	8	7	19	10	3	48
District councils	0	0	1	1	2	1	3	8

Who will be chair/co-chair and vice-chair?

Local authority structure	Chair	Vice-chair
London borough	Councillor	Chair of clinical commissioning groups
London borough	Councillor	Councillor
London borough	Councillor	Not yet decided (NYD)
London borough	Councillor	Councillor
London borough	Councillor	NYD
London borough	Councillor	NYD
London borough	Leader of council	Chair of clinical commissioning group
London borough	Leader of council/Chair of NHS trust	NYD
London borough	Leader of council	Chair of clinical commissioning group/ Chair of HealthWatch
London borough	Leader of Council	Councillor
London borough	Mayor	NYD
Metropolitan district	Councillor	Leader of Council
Metropolitan district	Councillor	NYD
Metropolitan district	Councillor	Councillor

Local authority structure	Chair	Vice-chair
Metropolitan district	Councillor	Chair of PCT board
Metropolitan district	Deputy leader of council	NYD
Metropolitan district	Independent	Chair of clinical commissioning group
Metropolitan district	Leader of council	Councillor
Metropolitan district	Leader of council	Deputy leader of council
Metropolitan district	Leader of council	NYD
Metropolitan district	Leader of council	Clinical commissioning group representative
Metropolitan district	Leader of council	NYD
Metropolitan district	Leader of council	NYD
Metropolitan district	Leader of council	NYD
Shire county	Chair of NHS trust	Leader of council
Shire county	Chair of PCT/Councillor	NYD
Shire county	Councillor	Vice chancellor of university/ Chair of clinical commissioning group
Shire county	Councillor	NYD
Shire county	Councillor	Councillor
Shire county	Councillor	NYD
Shire county	Councillor	Lead of clinical commissioning group
Shire county	Leader of council	NYD
Unitary authority	Chief executive	NYD
Unitary authority	Councillor	NYD
Unitary authority	Councillor	Chair of clinical commissioning group
Unitary authority	Councillor	Chief executive for NHS cluster
Unitary authority	Councillor	Councillor
Unitary authority	Councillor	Councillor
Unitary authority	Councillor	Director of public health
Unitary authority	Councillor	NYD
Unitary authority	Councillor	Councillor
Unitary authority	Deputy leader of council	NYD
Unitary authority	Deputy leader of council	NYD
Unitary authority	Director of public health	Councillor
Unitary authority	Executive member of council	NYD
Unitary authority	Leader of council	NYD
Unitary authority	Leader of council	NYD
Unitary authority	Mayor	Chair of LINk
Unitary authority	Superintendent commander of police	NYD

Have any new appointments been made in relation to the shadow boards (Y/N)? If yes, please explain.

From 48 responses:

Yes: 6 (12.5%)

No: 42 (87.5%)

Has the board met (Y/N)?

From 50 responses:

Yes: 40 (80%)

No: 10 (20%)

How often do you plan to meet?

Frequency of meetings	Number
Monthly	4
Every 6-8 weeks	31
Quarterly	5
Total	**40**

Health and wellbeing boards are required to develop a joint health and wellbeing strategy detailing their plans to address the health and wellbeing needs of the community and reduce health inequalities.

Please rate on a scale from 1 to 6, with 1 being the worst and 6 the best, how important you think your local health and wellbeing strategy will be in:

a. influencing the commissioning decisions of clinical commissioning groups

b. influencing the commissioning decisions of the NHS Commissioning Board.

Level of influence	Clinical commissioning groups	NHS Commissioning Board
1	0	1
2	1	12
3	7	9
4	7	8
5	21	0
6	9	1
Not sure	5	19
Totals	**50**	**50**

How would you rate the current usefulness of the joint strategic needs assessment on a scale of 1 to 6, with 1 being the worst and 6 the best?

Usefulness of joint strategic needs assessment	Number
1	0
2	2
3	9
4	29
5	8
6	2
Not sure	0
Total	**50**

Do you COMPLETELY AGREE, SOMEWHAT AGREE, NEITHER AGREE NOR DISAGREE, SOMEWHAT DISAGREE OR COMPLETELY DISAGREE with the following statements?

a. The health and wellbeing board will deliver on the priorities we've identified.

b. The health and wellbeing board will lead to increased pooling of commissioning budgets.

c. The health and wellbeing board will help achieve closer integration of services between local authority and NHS.

d. The health and wellbeing board will help to improve co-ordinated care pathway planning.

	Completely agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Completely disagree	Total
The health and wellbeing board will deliver on the priorities we've identified	14	35	0	1	0	50
The health and wellbeing board will lead to increased pooling of commissioning budgets	13	29	6	2	0	50
The health and wellbeing board will help achieve closer integration of services between local authority and NHS	26	22	1	1	0	50
The health and wellbeing board will help to improve co-ordinated care pathway planning	17	26	6	1	0	50

About the authors

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A graduate of LSE, his professional background is social work, and over the past 35 years he has worked in a variety of roles, including as a director of social services and health authority chief executive (the first combined post in England) and in senior roles in the Department of Health. Richard is a columnist for the Local Government Chronicle, a non-executive director of Housing21 and co-chair of the associates' network of the Association of Directors of Adult Social Services. He is also a Fellow of the RSA.

Amy Galea joined The King's Fund in August 2011 as a Researcher. Her main interest is exploring ways in which the integration of care can occur at a local level in order to make sure the needs of the most vulnerable in society are not overlooked.

She joined the Fund from the Clinical Effectiveness Unit at the Royal College of Surgeons of England, where she supported their national audit work by undertaking data analysis. Prior to this, she worked at the Centre for Radiation, Chemical and Environmental Hazards at the Health Protection Agency, where she carried out an extensive literature review for the *UK Recovery Handbook for Chemical Incidents*. Amy holds a Masters in public health from King's College London.

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ISBN 978-1-85717-635-3

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Registered charity: 1126980

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The King's Fund is a charity that seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

