Local Government Group

DH Department of Health

Health, adult social care and ageing

New partnerships, new opportunities

A resource to assist setting up and running health and wellbeing boards – **Executive summary**

Contents

Ministerial foreword

I would like to thank colleagues at the Local Government Group (LG Group), and in the local councils that contributed case studies, for this helpful and timely publication.

I continue to be struck by the passion and enthusiasm of local leaders for this work. They tell me about the potential of health and wellbeing boards to transform services, in particular for those who are most vulnerable, and improve health and wellbeing across local communities. I think we are seeing a new form of system leadership emerging, with councillors and their officers, clinicians and local communities sharing leadership responsibility. Together, they are aiming to achieve the best for local people, bringing together their resources and experience to shape services to meet local needs. This is about moving away from service silos, increasing democratic accountability, increasing engagement with the public, and seeing political leaders, clinical leaders and local partners working together in the best interests of the people they serve.

I am also impressed by the focus on building the right relationships and developing leadership that the case studies featured here have shown. The coming months are a real opportunity to accelerate the pace, strengthen the relationships and translate a shared understanding of local health and care needs into improved outcomes. This publication draws on past hard work and experience, both in the case study areas, and across the country through the LG Group's support to councils, including the Healthy Communities Programme. It provides an excellent link into the National Learning Network for health and wellbeing boards that has been set up by the Department of Health, the LG Group and early implementer areas.

The National Learning Network is bringing together local councils across the country to share learning about what works, collectively address challenges and support development of shared leadership. We know that the answers to how to make health and wellbeing boards effective will be found in local communities not in Whitehall. I look forward very much to working with colleagues in the months ahead as you find those answers – and to seeing the potential benefits for local communities become a reality.

Paul Burstow MP
Minister of State (Care Services)

Foreword

Local government has a long track record of setting up and sustaining effective partnerships to address the issues and challenges facing our local communities. From promoting safer and more sustainable environments to building prosperous places and inclusive, cohesive communities, local government has been at the forefront of driving partnership arrangements in their localities.

Health and wellbeing boards are set to usher in a new era of partnership working between local councils, GPs and other health professionals and local HealthWatch, representing the views of patients, communities and people who use services. They will be at the heart of the local health system, bringing greater democratic accountability and legitimacy to the NHS, promoting better integration across health and social care in the interests of patients and the public and ensuring that the needs of local populations and vulnerable groups are met.

Currently over 90 per cent of all eligible local authorities have opted to become early implementers for health and wellbeing boards. This is evidence of commitment to our new role. We are working with the Department of Health to ensure that the early implementers are supported to take on their new role, in particular through supporting leadership and elected member development and also the development of a National Learning Network for health and wellbeing boards.

Many local areas have previously established health partnerships which have made a major contribution to health improvement. It is clear, however, that many challenges still remain. Sir Michael Marmot's report points to the persistence of health inequalities. The current economic climate facing the public sector demands new ways of working and new solutions to intractable problems. Health and wellbeing boards provide the potential to deliver transformational change in health outcomes. But to realise their potential, boards need to be built on firm foundations of trusting relationships; a focus on outcomes, together with a shared vision and understanding about the priorities to be achieved and agreement about what success will look like.

This publication comes at a fitting time in the development of health and wellbeing boards. It identifies some of the key emerging challenges that boards are working through such as balancing an inclusive board that reflects diverse interests with the need for an optimum size and membership to ensure effectiveness, to practical issues such as timing and frequency of meetings to enable equal participation by all board members. The publication provides invaluable lessons from some of the early implementers, together with a range of resources for health and wellbeing boards to draw upon. It also helps to set the context for National Learning Network for health and wellbeing boards and learning sets in particular, by identifying some broad issues that should inform the focus for their work.

Councillor David Rogers OBE
Chairman, Local Government Group
Community Wellbeing Board

Next steps – the National Learning Network

Over the last seven months, the Department of Health (DH) and Local Government Group (LG Group) have worked with early implementer health and wellbeing boards and national stakeholders to scope how best we can support the early implementers to share learning across the country. As this publication demonstrates, leaders in local government and health are very positive about the potential of the new boards to improve health and wellbeing in their communities and are working at pace to get them established. From our conversations we know those leaders are keen to work together on how best to maximise the potential of the boards and the wider opportunities for joint working between local government and the NHS.

In response, we have developed a National Learning Network for health and wellbeing boards. The National Learning Network concept is guided by three principles: development work should be 'sector-led', success requires 'co-production' at both national and local levels, and the network should be designed around the needs of the individual localities who have the ultimate responsibility for establishing an effective health and wellbeing board. The DH and LG Group are working closely together to ensure that the Network is delivered in line with those principles.

A wide range of stakeholders have helped to develop an approach that supports different ways of learning and sharing, and complements, not duplicates, the development work which is already happening at local and regional levels. The Network will be made up of different elements:

- a virtual 'learning hub', hosted through the LG Group Communities of Practice, to enable information sharing, collaboration and networking across all sectors engaged in developing health and wellbeing boards
- national learning sets which will enable board members to work with their peers across the country on key themes of common interest
- leadership development for elected members, alongside clinical leaders and other local partners. This element will be delivered by the LG Group, and will build on previous development work with elected councillors
- guidance and tools for specific issues such as the Joint Strategic Needs Assessment (JSNA) and joint health and wellbeing strategy
- ensuring that the Learning Network for the boards aligns with development and transition support for clinical commissioning groups (CCGs), public health and HealthWatch.

All the elements of the Learning Network are designed to support boards with their biggest challenge – developing a shared leadership style which ensures that the contribution of the board is greater than the sum of the constituent parts.

Early implementers and stakeholders have been united in a desire for health and wellbeing boards really to make a difference and not just be 'talking shops'. In some places this means using the creation of the board to drive existing partnership work further. In others, it is an opportunity to do things differently, recognising that existing partnerships are not 'delivering the goods'. The network will provide an opportunity for boards to debate and stimulate fresh thinking with their peers, as well as supporting the development of highly effective boards in each locality.

In order to do this we want to create an environment and a process which enables individual boards to:

- be clear about their shared purpose and priorities
- develop a shared leadership approach which fosters mutuality in the board and amongst local partners
- regularly review their own progress against their agreed goals and the outcomes they want to achieve.

We have already developed some parts of the network, and we are working together to complete the other elements. We intend to be flexible in our approach, responding to the network's feedback and ideas.

Many of the people who read this publication are already participating in the Network. If you want to get involved, you can do so in a number of ways:

If you are a member of a board, or supporting development of a board, you can:

- join and contribute to the online Community of Practice at http://tinyurl.com/6jlmmtg
- get involved in a learning set (to find out more email Lola Olawole – lola.olawole@dh.gsi.gov.uk
- develop and test the leadership offer for elected members and clinical leaders (again, please contact Lola Olawole).

If you are not part of a board but keen to support their development and to stimulate thinking and good practice, you can:

- join and contribute to the online Community of Practice
- register your interest in the work of the learning sets (where they are looking to widen their current membership you will be invited to join)
- write directly to us (john.wilderspin@dh.gsi.gov.uk or sandie.dunne@local.gov.uk).

As the case studies in this publication demonstrate, local leaders are actively engaged in developing health and wellbeing boards, and tackling the challenges inherent in partnership working. The National Learning Network is designed to spread that existing learning and stimulate new thinking, so that boards are well placed to meet their own aspirations for the benefit of the people they serve. We look forward to working with you on that journey.

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It was written by Fiona Campbell and Christine Heron, and edited by Lorna Shaw and Tess Gool. The views expressed in this publication are those of the authors and do not necessarily reflect the views of the DH.

Dr Fiona Campbell was a founder board member of the Centre for Public Scrutiny, a commissioner on the board of the Healthcare Commission, is currently a member of the Independent Reconfiguration Panel and the National Institute for Health and Clinical Excellence (NICE) public health selection panel and is director of Policy and Practice. She was head of scrutiny at the Greater London Authority and co-ordinator of the Democratic Health Network. Fiona has been a non-executive director of a primary care trust, a county councillor and a director at the Equal Opportunities Commission.

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We are very grateful to the nine case study areas for their invaluable contribution. Our thanks also to everyone who provided us with information and material.

Purpose of the resource

This document is a summary of 'New partnerships, new opportunities: a resource to assist setting up and running health and wellbeing boards'. It is intended to provide an overview of the information in the full resource which can be found at: http://tinyurl.com/6jj8xtm

Accompanying this publication is a compendium of information on the case studies (see below) which describes the journeys of nine health and wellbeing boards (HWBs). It can be found at: http://tinyurl.com/6jj8xtm

'New partnerships, new opportunities' is aimed at all those involved in, or with an interest in, setting up and running effective HWBs. It provides the following information:

- discussion about the main opportunities, challenges and solutions involved in setting up boards and key messages based on these discussions
- questions to consider when preparing for HWBs
- case studies showing the journeys of nine boards from around the country
- a summary of national and regional resources available to support implementation.

The information, key issues and emerging messages in the resource came from a wide range of sources. References throughout the publication are to the sources below. They do not claim to be a completely comprehensive picture of how all areas are developing their HWBs. The intention was rather to take an in-depth look at how a number of areas are going about the task. However, we are confident that the examples we give do go some way towards capturing the range of approaches across the country.

Our sources are:

- nine case studies of areas where preparations for HWBs are generally well advanced. These are mainly drawn from an initial group of 25 councils that worked with the DH to help shape the early implementer network, but also represent a geographical spread, different size and types of council and political control, and a varied range of approaches to the task. They are:
  - Birmingham
  - Buckinghamshire
  - Calderdale
  - Cornwall
  - Croydon
  - Leicestershire
  - North Tyneside
  - Somerset
  - Wigan

- information from the regions about overall progress, sources of support and topics of interest
- national, regional and local events
- a survey of websites
- information from the HWB Early Implementer Community of Practice (CoP). http://tinyurl.com/6jlmmtg

SECTION A

HWB Boards – Potential for a new era in partnerships

New opportunities

Local areas already have partnerships for health, care and wellbeing, both within and outside their wider strategic partnerships. Some of these will be performing well, others will need improvement, but few will involve the sort of meetings that cause any excitement in their members. So, in light of the huge financial, quality and organisational challenges facing health and social care, why has the prospect of setting up new partnership arrangements caused such interest?

Many case study areas are keen to point out that HWBs should be regarded as **new arrangements with new opportunities** – as part of a dynamic movement for change with the aim of improving outcomes in health, care and wellbeing. Enthusiasm for boards is by no means confined to councils. The case study areas all found that clinical commissioning group (CCG) leads welcomed the broader opportunities offered by HWBs. There is a palpable sense of leaders in primary care and local councillors engaging with each other, often for the first time, learning about each other's work and realising the huge gains in health and wellbeing and reducing health inequalities that could be made by closer collaboration.

Pragmatically, at a time of wide-scale change, boards can be a vehicle for new local partners to come together to start to address a challenging agenda. Even though they are still developing, they can provide continuity of expertise and information that could otherwise be lost or fragmented as organisations restructure. New relationships may also mean fresh energy for tackling problems such as the increase in long-term conditions and dementia.

Most importantly, HWBs offer the opportunity for system-wide leadership to improve both health outcomes and health and care services. HWBs will have a duty to promote integrated working, and their core purpose is to drive improvements in health and wellbeing by promoting joint commissioning and integrated delivery (HMG 2011)1. Their agenda extends beyond health and adult social care to include children's health and wellbeing, and wider areas that impact on health such as housing, education and the environment.

Also, since commissioning plans (whether the statutory plans as in the case of CCGs or plans for commissioning as in the case of local councils) will be prepared by commissioners involving the HWB, drawing on the joint health and wellbeing strategy (JHWS) and joint strategic needs assessments (JSNAs), they will consider issues that are generally seen as

1 At the time of writing the Health and Social Care Bill is passing through Parliament so there is not yet a single, comprehensive source of information about national intentions for HWBs. A summary of key measures in the Bill is in Information Sheet 1 in Section E.

core NHS services – for instance cancer care, or hospital configuration – rather than those mainly at the council/NHS interface.

HWBs' role in carrying out the JSNA immediately increases its importance, enabling a direct route into strategic planning through the JHWS. There is a new requirement in the Health and Social Care Bill to involve local people in the development of the JSNA and JHWS, further raising their profile. Local areas are now considering how their JSNA can be enhanced to embrace more strongly the perspective of clinical commissioners and to cover areas identified as local priorities, such as community assets and services, equalities issues, or alignment with environmental assessment.

An effective board brings together senior leaders to build a commitment for transformational change. This will be reflected in the JHWS as an overarching strategic framework, but it must not stop there. It needs to be translated into coordinated action at all levels of the commissioning organisations and their partners. Many local case study areas have reviewed or are reviewing the joint commissioning arrangements that will be responsible for implementing the direction set by the board. Final arrangements will not be in place until there is clarity about the configuration of local CCGs, but interim partnerships generally involve commissioning consortia as well as PCTs and councils.

Local areas are also considering their relationships with providers – foundation trusts and those from other sectors – with community and patient groups, and, in two-tier areas, with district councils. Again, there are variations in the models that are emerging from the HWBs considered in this publication. Some boards have a membership focused on the roles identified in the draft legislation (HMG 2011) and are supported by a more inclusive sub-structure of forums or a network approach. Some boards also include providers as members, others include voluntary and community sector members, and some include both.

Perhaps one of the most significant reasons for the hope that HWBs will represent a step-up from previous attempts to promote integrated working is the fact that they are high-profile groups with a statutory mandate. Boards can be seen as a further stage in addressing the local democratic deficit in the NHS, building on councils' executive role in health and social care. Councils are responsible for setting up a board in their area, and this will be a committee of the council. The seriousness with which councils are taking the role of HWBs is reflected in the fact that most boards considered as part of this study have either the leader of the council or a senior cabinet member as chair or deputy chair.

However, while councils have a clear leadership role, it would be inaccurate, and highly counterproductive, to view boards as **council-owned committees** – and councils themselves are very aware of this danger. HWBs involve an interplay of powers and responsibilities, and are best seen as a forum for **shared leadership** across the health, care and wellbeing system. The framework aims to put equal responsibilities on councils and CCGs to work towards the shared priorities of their JHWSs.

Both CCGs and councils must have regard to the local JSNA and JHWS in carrying out their functions, while HWBs must have regard to the Secretary of State for Health's mandate to the NHS Commissioning Board (NHSCB) in developing their JHWS. It is essential that clinical commissioning leads feel an investment in boards just as much as councils. This is reflected in a strong theme emerging from HWBs – the importance of shared vision and building consensus.

Health and wellbeing boards: developing relationships

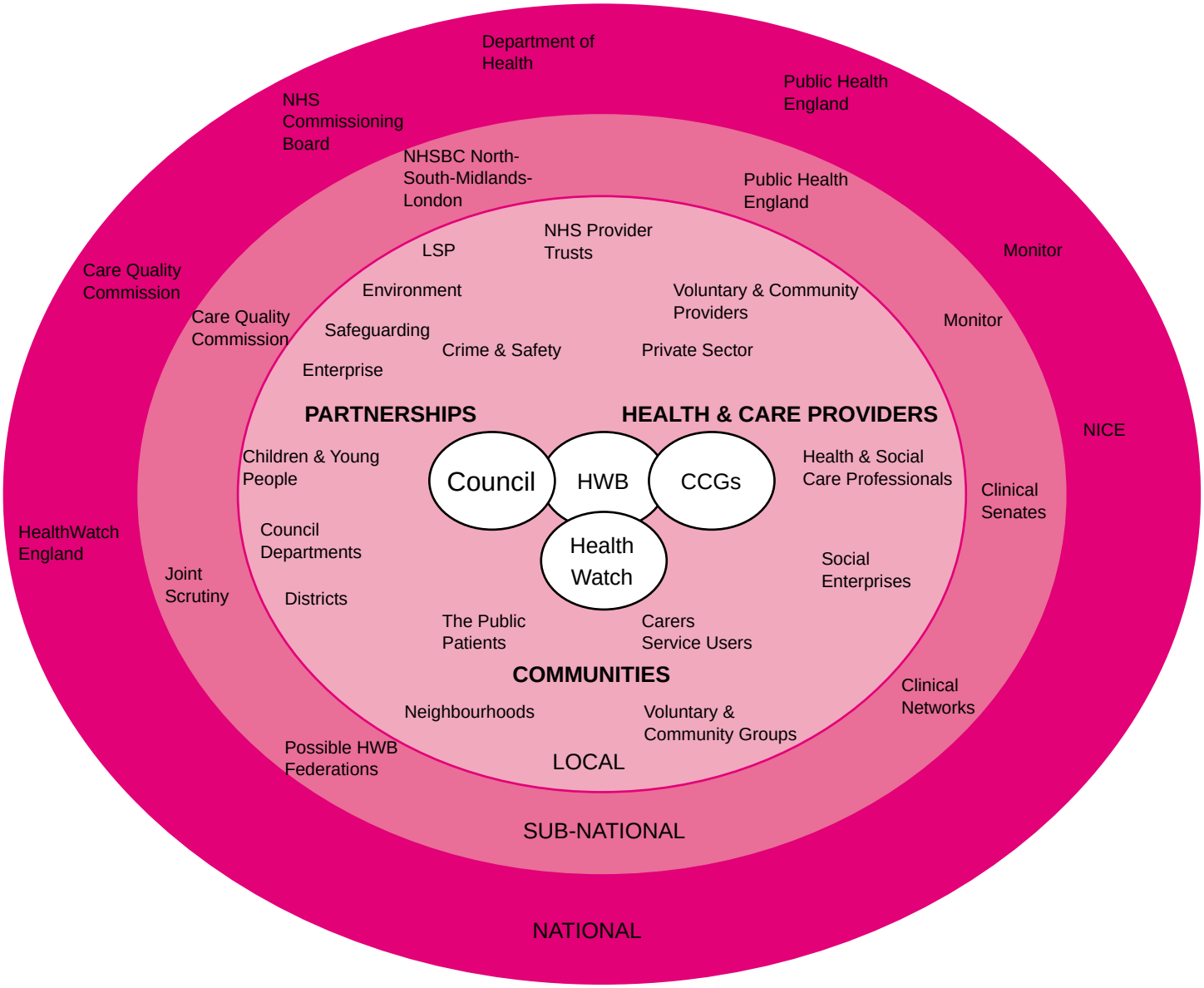

Figure 1: Diagram showing some of the national, sub-national and local bodies with which health and wellbeing boards will need to develop relationships

New challenges

Even the most optimistic advocate of HWBs would agree that they operate in a complex landscape of relationships requiring a considerable amount of skill and commitment to navigate successfully. As well as identifying the span of relationships, Figure 1 also shows their complexity (it is not intended to show lines of accountability, which would require a different diagram). A number of challenges have been identified by people interviewed for this publication:

Membership and governance

- Membership dilemmas – should boards consist of commissioners only or have wider membership from providers and/or voluntary and community groups?
- The need to develop the relationship between the board and council overview and scrutiny.
- The need to understand the constitutional issues of taking on new functions, and to make sure these do not affect relationships between partners; for example, the boards' role in contributing to the NHSCB's annual assessment of CCGs.
- Concerns about whether HealthWatch will be able to provide **strategic** input to boards, sometimes based on experience of working with some local involvement networks (LINks).
- Directors of adult social services, children's services and public health have formal membership of the board alongside councillors. This will require consideration of the relationship between officers and elected members.

Skills and preparation

- The skills needed for running a successful board are considerable – how can members be best prepared? Also, to what extent do cultural and organisational differences between councils and clinical commissioning groups need to be addressed?

Defining the board's role

- There is room for interpretation about the role of boards – for instance do they focus on strategic influence or engage more directly in commissioning (for example, with responsible for pooled budgets), or both?
- Wider partnerships – will local strategic partnerships (LSPs) continue locally and what will be the role of HWBs in relation to arrangements such as LSP thematic groups?
- Children's issues – how much of the children's agenda will the board cover, and will it receive sufficient priority?
- Safeguarding – can boards play a role in embedding and co-ordinating safeguarding of vulnerable adults and children across the whole of the public sector, ensuring that it is seen as 'everybody's responsibility'?

Focusing on priorities

- With such a wide-ranging agenda, how do boards focus their work? For instance, how do they ensure a proper balance across health, social care health improvement, social determinants, wellbeing and tackling health inequalities? Do boards have an agreed understanding of wellbeing?
- How do they maintain focus on agreed local priorities when they may increasingly be seen as the first port of call for all new strategies and policies that cross council/ health boundaries?

Tackling problematic issues

- What can be done if partners are less willing to engage – for example if CCGs seek to pursue a predominantly medical approach or if there is political opposition to service reconfiguration?
- How do boards tackle the tough issues such as the economic climate and pressure points for partnerships such as NHS continuing healthcare and delayed discharge, and potentially controversial service decisions such as shifts in hospital provision?

In the next section we consider some of the ways in which early implementers have approached both the opportunities and challenges of HWBs.

SECTION B

Five key stages in developing a health and wellbeing board

Councils and their partners are at different stages in developing their boards. Some are undertaking their preparatory work, some have developed terms of reference, and some have already met several times as HWBs and have begun to form their agenda. Others are intending to meet before April 2012 when all areas will need to have set up board in shadow form. Because of this, we have approached the setting up of HWBs as five stages in a journey:

1. Preparing for the board.
2. Forming the board.
3. Work programmes, priorities and commissioning.
4. Developing JSNAs and JHWSs.
5. Review, performance and looking forward.

This section gives a summary of the approaches, challenges and solutions that are emerging as HWBs start their journey towards being legally established. Information comes from case study areas, regional information about progress, the Early Implementer Community of Practice (CoP), and national web-based research.

1 Preparing for the board

Many of those involved in the case study areas stressed the importance of setting up the board in an organised way through a development plan. This would involve considering the starting point of the council area, such as current partnerships, stakeholder involvement arrangements, political make-up, set-up of CCGs, progress so far on integrated commissioning and so on.

Coordination was also seen as important, with many areas favouring a senior team with a 'hands-on' role in setting up boards. Senior officers brought in-depth understanding of the health, care and wellbeing system, and the ability to command resources. Even though it was difficult for senior figures to find the amount of time required, this was seen as an investment for the future.

A key feature in all areas was establishing informal relationships between councillors and CCG leaders. This often started with introductory meetings and could evolve into sessions exploring each other's roles, responsibilities and views about priorities.

Engagement with stakeholders is another essential element in preparing for boards. This is emphasised by the government's response to the NHS Future Forum which signalled new duties to involve local people in the development of the JSNA and the JHWS (DH 2011a).

Stakeholders include providers from all sectors: community and voluntary groups; LINks, service users, patients, and carers; LSP partners; staff; and the wider council including districts, overview and scrutiny, and functions such as housing and regeneration. Some areas have developed an engagement plan, customised to the needs of different individuals or groups. A popular approach has been to hold large stakeholder events in which people are invited to help shape the board and identify local health, care and wellbeing priorities. Establishing good two-way communication is seen as an important opportunity to share messages about the potential of HWBs.

An organisational developmental (OD) programme

Wigan's board has been involved in an externally-facilitated OD programme involving:

- individual interviews between the facilitator and board members to establish hopes, concerns, challenges and priorities in joint working
- workshops, based on the above, to establish a common purpose and priorities
- interviews between the facilitator and 'critical friends' not on the board – for example LSP members and main providers – to gain their views
- a final workshop to create a framework for how the board will do business in terms of shared values, relationships and operational processes.

With new partners and new responsibilities, HWBs in the case study areas are considering how to help board members to develop a shared vision and priorities and to address potential cultural differences between councils and CCGs. Some areas have chosen to carry out a development approach prior to the board meeting to do business. Others are running developmental activity alongside business meetings. The extent to which areas have agreed to discuss difficult issues such as pre-conceptions about partner organisations varies – some believe this is very helpful, others that it would be counterproductive.

The following types of developmental activity have been taking place:

- development programmes or individual workshops, often with external facilitators
- scenario planning, working through the roles of the respective members in different scenarios, such as budget-setting and service reconfiguration, for example
- joint visits to services, such as supported housing
- problem-solving sessions working together on operational issues, such as a system-wide approach to commissioning for cardio-vascular disease
- presentations and discussions about roles and responsibilities.

A county-wide commitment

In Cornwall, preparation for the new NHS and local government arrangements on health and public health, including the HWB, involved a great deal of collaborative work between the council and the NHS. This has culminated in a 'Cornwall Commitment' (to be formally agreed by the council and each NHS board by the end of October 2011) which sets out a vision for health and care transformation and improvement.

Successfully running a board will involve high levels of skill and knowledge. Boards are also considering the developmental needs of their individual members. This includes support for existing LINk and subsequently HealthWatch members to ensure they are prepared for their new role of representing the views of local people in high-level commissioning decisions.

Key messages to consider when preparing for a health and wellbeing board

- An initial development plan, with in-built flexibility, is useful for keeping on track when setting up a board.
- Consider identifying a senior lead or senior lead team to be 'hands-on' responsible for setting up and supporting the board, its external relationships and communication needs, until it is well established.
- Establish ongoing communication between CCG leads, councillors and senior officers, and where necessary maintain these with contact beyond the HWB.
- Develop a stakeholder engagement plan with a variety of mechanisms for involvement, for example, one-to-ones, group meetings, and large stakeholder events. The plan could include stakeholder mapping and identify the purpose of engaging different stakeholders – is it to inform, consult, involve, or work in partnership?
- Ongoing communication is also important, not just with external partners but with staff throughout organisations, to ensure messages about the new approach to health and wellbeing are shared.
- HWBs are new partnerships with new members and all boards will need developmental support. It is important to spend time in discussion with board members as individuals and as a group to work out a development programme right for the area.

2 Forming the board

Membership

While the Health and Social Care Bill sets out core members of HWBs, considerable debate is taking place about local membership. Early implementer boards considered as part of this study appear to be taking two main approaches:

1. Commissioner-focused – the board is mainly confined to the core roles identified in the bill: councillors, directors of adult social services, children's services and public health, and CCG leads. PCT representatives are included for transition purposes; LINks are mostly, but not always, involved in advance of HealthWatch.
2. Mixed-membership – a number of others are involved in addition to the core roles. This varies between boards, but will include some or all of the following: voluntary/community sector representation, NHS provider trusts, representatives of head teachers and miscellaneous members relevant to local areas, for example, the local university.

Across the country, and based on analysis of the range of sources of information drawn on by this study, it appears likely that more boards have taken the first option, but there are still a significant number of mixed-membership boards. Being commissioner-focused does not necessarily make a board 'lean' because it may involve a number of councillors and CCG representatives. Boards that have decided not to include provider representatives as members, generally because of conflict of interest issues, are looking at other ways of ensuring their involvement (see 'Governance and tackling difficult issues').

Information from the case studies and from some other boards across the country indicates that councillor membership is pitched at senior level – for example, elected mayor, council leader and cabinet leads – reflecting councils' commitment to the new arrangements. Some two-tier areas have included district council representation. Board chairs are almost always a councillor, but occasionally an independent person or a CCG representative. CCGs often provide the vice chair.

The watchword for boards is that they should not be 'talking shops'. The case study boards highlight that they will review membership and terms of reference before they take on their formal role.

The NHS Future Forum report has views on membership. For instance, it states that 'boards need to have a lean membership built around those with ultimate responsibility for leadership in the local health and wellbeing system' (2011).

Governance and tackling difficult issues

A strong aspiration from many people interviewed from case study areas is that boards should not be seen as 'just another council committee', and that they need to operate in a dynamic and flexible way to ensure that all partners keep motivated. Several boards are developing a value base that supports relationships, such as working on the basis of respect and honesty. The LG Group with the DH and other organisations are finalising a common set of operating principles that areas may find useful. Go to: http://tinyurl.com/6fdknn3

Operating principles that support relationships

Buckinghamshire's HWB has agreed a set of principles to underpin how it operates, to be incorporated in terms of reference:

- There is a shared commitment to make the board work in Buckinghamshire.
- Board members will have respect for each other's culture, and relationships will be based on trust.
- Members will be clear at the outset about what can and cannot be agreed.
- Members will be tolerant in relation to respective governance structures.
- Members will endeavour to ensure that organisational boundaries are not a hindrance.
- The board will be flexible in relation to the need to work at differing levels, from the very local to regional as appropriate.

There is a strong sense that developing consensus is vital, and having to vote on an issue should be the absolute last resort. While some areas have not introduced voting systems in the formative stage, others have a system in which the chair has the casting vote. Others may set restrictions on voting, such as excluding officers (directors of adult social services, public health, and children's services). This latter approach seems to be welcomed by officers as resolving potential tensions of voting alongside elected members and maintaining professional independence.

There is also a recognition from many of the people interviewed that some board functions have the potential to cause unease or disagreement in board members. Boards will be council committees with a role in contributing views on:

- the readiness of CCGs for authorisation and on their annual performance assessment – to the NHSCB
- whether CCG or council commissioning plans have due regard to the JHWS, with the ability to refer plans back to the CCG or cabinet, and with the additional ability to refer CCG plans to the NHSCB.

Boards will also be faced with difficult decisions about resources and service reconfigurations.

There are however approaches that can be taken to reduce the potential for disagreement. Councils may wish to adopt the role of **critical friend** in supporting CCGs as they prepare for authorisation, taking practical steps to help them build capacity such as establishing a robust JSNA which will be part of the evidence required. Boards could take an **even playing field** approach in which both council and health plans and assessments are considered equally, including commenting on any health and wellbeing-related council annual assessments and on HealthWatch annual assessment. The government's response to the Future Forum indicates that boards should be involved '**throughout the process** as CCGs develop their commissioning plans' (DH 2011a).

This is a very helpful approach, since if boards are involved in the developmental stage it is far less likely that problems will arise with the end product. Boards may also wish to consider ways of having **upfront discussions** about hard issues. Those that have done simulation exercises on potential difficult decisions may find this preparatory work beneficial.

In respect of constitutional issues, the Health and Social Care Bill has a clause that enables the disapplication of legislation that relates to council committees, such as legislation covering voting processes and terms of membership. The intention, subject to parliamentary passage, is for DH to work with the LG Group and early implementers to understand those parts which need to be retained and those that should be disapplied.

Relationships with partners

Figure 1 on page 15 shows some of the organisations with which boards will wish to establish relationships. In terms of local partnerships, most case study areas are reviewing their existing LSP arrangements and many have taken the temporary measure of locating the board in the LSP structure. Most case study areas have not yet come to a final conclusion about what their final arrangements will look like; for example, which thematic partnerships will continue to operate and how these will link with HWBs. Connections with community safety and economic partnerships are seen as particularly important for health and wellbeing issues. Defining the relationship between HWBs and children's partnerships is seen as a key task. Local areas are undertaking work to ensure they are clear about how much of the children's agenda the boards will cover. Will they cover health improvement, NHS healthcare, social care and wider issues such as child poverty?

Whether or not district councillors are represented on boards is a matter for local discussion, however it will be important to find ways of reflecting the vital role of districts in planning and delivering services such as housing, safety and leisure in the work of boards.

Developing health and wellbeing board ideas through scrutiny – a networked approach

Somerset County Council's cabinet asked the council's scrutiny committee to investigate and make recommendations for setting up a HWB within the wider context of health reform. One of the concerns was how HWBs could reflect the work of district councils as well as county-wide issues. There is currently one consortium in Somerset with nine federations that align with district council boundaries. The scrutiny committee felt that the way forward was for the board to be supported by networks or 'feelers in the community' that reflect both the GP federations and district councils. This would also allow better links between GPs, councils and other organisations within each district/federation area.

Case study areas were agreed that council overview and scrutiny will have a useful role in scrutinising the work of boards. A forthcoming publication from the Centre for Public Scrutiny on the role of scrutiny in local arrangements found that it can be 'the glue that binds together the local health infrastructure'.

Involving local stakeholders in the work of the board

- Councils have a long tradition of involving communities, the public and people who use services and carers. In recent years the NHS has made strides in this area, and emerging guidance about the NHSCB places considerable emphasis on involvement (DH 2011b). HWBs can build on the best of existing local mechanisms for involvement and extend these where necessary. Emerging approaches for involvement with HWBs include:
- representation on the board beyond LINks/ HealthWatch
- large, standing conferences or assemblies which would meet twice a year to inform the work of the board
- stakeholder involvement in the sub-groups that report to the board, including commissioning groups
- advisory or reference groups
- separate provider forums
- specific forums around topics, for instance carers or mental health, or around geographical areas such as districts or communities
- a network approach, in which the HWB is seen as a hub of a wide network of groups which have two-way interaction with the work of the board.

Some issues which HWBs may wish to bear in mind are calls from providers in the private and voluntary sectors to be as equally involved as NHS providers, and from the national voluntary sector to have voluntary and community sector membership of boards.

HWBs will also need to consider links beyond their local areas, particularly the relationship with the NHSCB. It will have representation on the HWB for some purposes, such as the preparation of the JHWS or at the invitation of the board. Detailed information on this role is not yet available, but the pace will accelerate as the NHSCB forms its more local arm.

Stakeholders involved in setting up HWBs have pointed out the need for ongoing two-way communication. This will be important to enable boards to raise their profile, including building trust so that they are accepted in taking a lead on difficult issues such as service reconfiguration.

Comprehensive stakeholder involvement and communication will require sufficient resources. HWBs may wish to consider the most effective use of joint resources, including the role of HealthWatch, as a group. For example, in some areas councils and the NHS are co-ordinating their involvement activity to reduce duplication and maximise use of resources.

Key messages to consider when forming a health and wellbeing board

- When deciding on membership, consider what is needed to ensure a fair and balanced board which is of a size that facilitates decision-making.
- It will be helpful for boards to consider legal and constitutional issues as a group.
- HWBs will wish to discuss as a group what measures they can take to ensure that there is a feeling of shared ownership.
- Boards will wish to consider what role can be taken in supporting CCGs in the forthcoming authorisation process.
- It is important that the HWB is recognised as having a distinct identity, new functions and fresh potential.
- Local areas need to develop clear accountability and operational links between boards and other partnership groups or bodies.
- Consider developing an engagement strategy covering all the main stakeholders for the board and the different ways in which they can be involved.
- Consider developing a communication plan to share messages about the board and developing health and wellbeing with all stakeholders.
- Consider setting up a web presence with detailed information about the work of the board.
- Consider discussing joint resources for engagement and communication as a board.
- Board members will need to consider all emerging information about HWBs' relationships with national bodies.

3 Work programmes, priorities and commissioning

Since HWBs are at an early stage of development, many will not yet have considered in detail how they will plan their work or what their exact role will be in relation to commissioning. However a number of case study areas have begun to develop general principles for prioritising their work and developing their commissioning role.

In terms of work programmes, two approaches seem to be emerging. Some are mainly focusing their work on oversight of the pillars of health and wellbeing reform such as the transfer of public health to councils, establishing CCGs, establishing HealthWatch, and developing JSNA and JHWSs. Others have these topics on their agendas but are also considering other business with a view to making 'quick wins'. Examples of agenda items include: service development plans such as reablement, proposals to develop an integrated health and social care workforce strategy and urgent items relating to local NHS providers.

Boards are aware that there will be many demands on their time and that they are not yet always clear about what are the most suitable items for their agendas. Some will use the coming months to test out which issues are most appropriate, whereas others intend to stick to a work plan. Most boards in the case study areas are undertaking prioritisation exercises with a view to shaping their work in the short term, but also feeding into the more extensive work they are doing to develop JSNA and JHWSs.

Thinking about joint and integrated commissioning

Birmingham has a pooled budget for learning disabilities and mental health which is the largest in Europe (£319m per annum), so considerable further discussion will be necessary to ensure this is managed appropriately in the new health and social care landscape. Discussions on joint and integrated commissioning will continue in workshop mode after the board is set up. Questions the partners will be asking themselves include whether the existing integrated commissioning board should carry on as a separate entity (with new clinical members, for example) or be related to the HWB structures. There is consensus that it needs to be 'wired in' in some way to the HWB, as it is crucially reliant on the JSNA to inform planning. It is generally agreed that the strategic role of the HWB will be to promote joint commissioning, for example by legitimising the mapping of responsibilities for its different aspects between partners across the city.

Case study areas have emphasised the importance of developing a shared understanding about what is meant by 'commissioning', as this can be understood very differently in and across the NHS and local government. One of the key debates about the role of HWBs is the extent to which they should be seen as commissioning bodies or as setting the strategic framework to shape commissioning.

Early information suggests some boards, in the formative stage at least, intend to focus on high level strategy, while others will also wish to take a more hands-on role, such as eventually taking responsibility for devolved budgets. Some boards have considered the circumstances in which they might assume oversight of commissioning. For example, this could be the case if a local commissioner asks the board to oversee any pooled or aligned budgets on their behalf or oversight of existing section 75 arrangements. Some areas are considering the sub-structures which will be needed to carry out the detailed work of developing joint commissioning.

Example of commissioning subgroups

In Leicestershire, a number of subgroups will support the work of the board, bringing together a range of stakeholders to inform commissioning decisions and support service delivery. Subject to board agreement these would include:

- the Staying Healthy Partnership (public health issues such as tobacco control and obesity)
- integrated commissioning (reablement, complex care for adults and older people, learning disabilities, dementia and mental health)
- JSNA steering group
- substance misuse board
- prevention and early intervention board.

Key messages to consider in planning work programmes, priorities and commissioning

- As the board's agenda develops, consider establishing a balance between quick wins and longer-term transformation.
- Keep oversight of the board's agenda to make sure it remains focused.
- Think about how to balance a businesslike approach to meetings with an inclusive format.
- An early priority-setting exercise can be used as a form of wider stakeholder engagement, giving legitimacy to the work of the board.
- Priority-setting can provide an opportunity to consolidate a shared set of values that reflect the priorities of individual board members and wider stakeholders.
- Prioritisation provides an early opportunity for a focus on outcomes rather than process.
- Developing board priorities can enable rationalisation and clarification of existing strategy documents.
- It is important to develop a common understanding among HWB members and CCGs about what is meant by 'commissioning' and what the commissioning roles of each of the relevant bodies will be – CCGs, councils, HWB, the NHSCB and Public Health England.
- It will be important for HWBs to agree a process with CCGs for early and ongoing communication and consultation on the development of CCGs' commissioning plans, and for boards to agree how they contribute to councils' commissioning plans (subject to legislation).
- Consider the role HWBs can have in ensuring stability in existing joint work through the transition to new responsibilities and beyond.
- Consider in advance how potentially difficult decisions can be best made.

4 Developing joint strategic needs assessments and joint health and wellbeing strategies

The proposed NHS reforms will place a new shared statutory obligation on CCGs and councils to work together to produce JSNAs and JHWSs through the HWB and to commission with regard to them and in collaboration with each other. The proposed legislation stipulates that local HealthWatch and people who live and work in the council's area should be involved in the development of JSNAs and JHWSs.

Tackling health inequalities

North Tyneside's HWB is developing its JSNA and health improvement priorities. The JHWS will include plans to tackle health inequalities based on the priority areas identified in the Marmot report. North Tyneside has a history of using cultural services (arts, leisure, sport) to improve health and wellbeing. The board has agreed that this is an important area of work which should be brought more closely into the JSNA and the JHWS through activity such as asset mapping and cost benefit analysis.

HWBs considered as part of this study have recognised the need to assess whether existing JSNAs are fit for purpose to support the development of their JHWSs, and a range of activity is taking place:

- holding or planning to hold stakeholder events on the topic of developing JSNAs to involve a range of local people and organisations
- extending the JSNA so that it represents the wider determinants of health including the early years environment, housing, economic development, crime, spatial planning, and environmental assessments
- extending the JSNA so that it includes a clinical perspective
- an asset-based approach which includes strengths as well as needs
- a 'life course' approach looking at needs and health determinants at stages of life
- undertaking peer review of the JSNA
- including more information on topics identified as local priorities, such as alcohol and substance misuse.

Considering the wider determinants of health and involving stakeholders

Calderdale is developing its JSNA to cover the wider determinants of health. A draft scope and shape for the JHWS have been developed based on the framework from the Marmot review. Calderdale Assembly – which involves a large range of partners, including providers from all sectors and service user, carer and community organisations – will meet in November 2011 to focus on the development of the JHWS based on evidence from a broad-based assessment of need, including the JSNA.

There is a general consensus that the potential for JSNAs to be at the centre of commissioning and de-commissioning decisions in difficult economic circumstances has not yet been fully realised. Realising this potential is vital to developing a JHWS which builds on the needs and assets identified through the JSNA and which informs a collaborative approach to commissioning.

The DH is developing statutory guidance and resources for JSNAs, working with the National Learning Network for health and wellbeing boards and stakeholders, due to be published in autumn 2011. A learning set on JSNAs and JHWSs will be established as part of the National Learning Network.

Key messages to consider in joint strategic needs assessments and joint health and wellbeing strategies

- The JSNA and JHWS are intended to be absolutely central to the HWB's work in shaping and influencing the pattern of local commissioning and services. The JSNA and JHWS need therefore to be fit for purpose for all those who are required to develop them and use them.
- Developing the JSNA, and the JHWS that flows from it, provides opportunities for stakeholder and community involvement and for a local debate about a holistic approach to the wider determinants of health, wellbeing and health inequalities.
- HWBs are increasingly taking an 'asset-based' approach to their JSNA; as well as mapping the deficits which create needs, they are also looking at the resources within communities that may help to address needs. This is an approach given added imperative by the economic situation.
- Working in an inclusive way to develop the JSNA and JHWS through a series of stages will help build mutual understanding, create ownership and should lead to products that are useful to all stakeholders.
- The 'life course' framework allows board members to consider the immediate and long-term health consequences at each stage of life. It can act as a means to show people doing different kinds of work how their contribution fits into the bigger picture.

5 Review, performance and looking forward

Nearly all boards are at an early stage in deciding how they will measure performance, but it is likely that they will need to consider performance assessment or review in a number of interlinked areas:

- assessing progress against the outcomes and objectives in the JHWS
- assessing the board's own performance in contributing to the above
- reviewing the board to ensure that it is fit for purpose for becoming a full statutory board
- evaluating the extent to which CCG and council commissioning plans pay due regard to the JHWS
- contributing views to the annual performance assessment of CCGs, and, should areas wish, of council health or wellbeing related plans.

In a sense, as far as evaluation is concerned, the distinction between the work of commissioners and the work of HWBs is an artificial one, since the work is so interrelated. It would make sense, therefore, for a monitoring and evaluation system for joint and integrated work to be agreed between all the parties contributing to it.

Linking local priorities with national frameworks

Leicestershire is developing an outcomes framework/dashboard for the HWB to monitor outcomes in support of the board's strategic priorities, including local as well as national indicators. The public health directorate is currently mapping the NHS, social care and public health outcomes frameworks which will then be linked to the JSNA and the JHWS.

Providing leadership in developing such a system will be part of the HWB's overarching role. One of boards' key challenges will be to gain agreement on what counts as success for the system as a whole, and how this will be measured in terms of baselines, milestones and outcomes. The consultation document on the public health outcomes framework shows the centrality of the HWB in 'holding the ring' in ensuring that the three sets of outcomes (public health, adult social care and NHS) are aligned and coincide at appropriate points (DH 2010b). HWBs may also want to include child health and safeguarding in their own models.

Some boards in the case study areas have already begun the process of ensuring that their priorities for action are supported by outcome statements and indicators or 'dashboards' against which the board can track progress. These are likely to include indicators from the national outcomes frameworks (DH 2010a, 2010b, 2010c) and local indicators identified through the JHWS process.

Priorities and outcomes

Croydon's HWB has agreed a set of four high-level priorities:

1. improved health and wellbeing
2. greater independence
3. integrated, safe, high quality services
4. a positive experience of care.

Each of these is associated with a set of outcome statements, as in the proposed national outcomes frameworks. This set of priorities and outcomes has been the subject of consultation with partners, providers and the public. The board is proposing to undertake further work on an equalities impact assessment of the priorities and outcomes before using them to inform the development of a JHWS.

A number of tools for assessing partnerships by looking at outcomes have been developed and are referenced in the full version of this resource. As boards move towards taking on their full remit and functions, the development work of the National Learning Network for health and wellbeing boards will result in a clearer understanding of best practice and what boards need to do to be effective. http://tinyurl.com/6bcabsp

Among the people interviewed, many indicated that their board will undertake a review of membership, terms of reference and other issues prior to taking on the formal role. It will be helpful if this is done within the context of wide stakeholder engagement.

Key messages to consider in review, performance assessment and looking forward

- When assessing their leadership and partnership development, HWBs will need to do this in terms of outcomes rather than processes or structures alone.
- Developing methods and tools for evaluating their work provides an opportunity for boards to revisit their vision and values and reach a consensus on what counts as success for them.
- Boards will need to consider the areas of shared outcomes in the national outcome frameworks in detail, but will probably also need to keep an overview of all the outcomes.
- HWBs will need to develop milestones and criteria for evaluating their progress towards full statutory boards in April 2013.
- When undertaking a review of the board before taking on the formal role, consider this in the context of stakeholder engagement.

SECTION C

Summary of case studies

Council	Stage	Who is involved	Support/sub-structures	Meetings	Priorities/topics discussed
Buckinghamshire County	Board set up in May	Chair – cabinet member health & wellbeing 1 x cllr 3 x council directors (incl DPH) Chair LINk/ HealthWatch 6 x CCG reps (2 each from 3 CCG) 1 x district councillor 1 x PCT (until 2013)	No sub-committees yet. LSP structures remain in place pro tem. Policy support from council policy team. Admin support from democratic services.	Monthly, since May.	Discussion of JSNA development. Plans for a JHWS by end of year. Discussion planned on priority-setting. Simulation exercise on physical activity run to prefigure roles and ways of working.
Birmingham City	5 facilitated preparatory workshops held. 1st meeting of the board in Sept.	Chair will be cabinet member. Final board membership to be agreed. Likely to include: 4 x cllrs (incl. 1 x opposition) 5 x council directors CCG reps PCT reps (NED and officers)	Sub-structures not yet agreed. Discussions continue in workshop form	Monthly from September	HWB outcomes drafted. Next steps include production of JHWS, proposals for joint and integrated commissioning, review of children's services commissioning, promotion of integrated safeguarding.

Council	Stage	Who is involved	Support/sub-structures	Meetings	Priorities/topics discussed
Calderdale Metropolitan Borough	Board set up with terms of reference.	Chair – council leader 5 x councillors including 2 cabinet leads 3 x council directors (incl. DPH) plus chief executive 3 x PCT 1 x CCG 1 x head teacher 1 x LINk	LSP board stood down & HWB may take central role. No subgroups yet. Works in partnership with Clinical Commissioning Executive (PCT board involving CCGs and council). Support team from council in place	Quarterly since April	Workplan priorities: oversee transition of public health; oversee and support development of HealthWatch; broaden JSNA and develop JHWS (by Dec 2011); performance management system; developing engagement strategy.
Cornwall County	First meeting held (August)	Chair – cabinet member health and wellbeing vice chair – PCT chief exec 2 x cllrs 3 x council directors (incl. DPH) 3 x CCG reps (1 each from 3 CCG) 2 x LINk 1 x Changing Lives lead NHSNCB – tbc Observers Scrutiny chair & vice chair Isles of Scilly HWB	JSNA steering group and public health outcomes group report to HWB. Support from strategy manager and strategy adviser and democratic services	Every 6 to 8 weeks minimum.	High level headlines for work plan to be prioritised at next meeting. Include: Identification of risks during transition; promoting joint commissioning and integration; overseeing progress of HealthWatch Existing groups and partnerships to be mapped and assessed for fitness for purpose and relation to HWB.

Council	Stage	Who is involved	Support/sub-structures	Meetings	Priorities/topics discussed
Croydon London Borough	2 meetings and 1 board development day held and 1 engagement event for stakeholders. Board meetings planned 6 times a year.	Chair – Leader of council 4 x cllrs (incl. 1 x opposition & 1 x minority group) 3 x council directors (incl. DPH) 2 x PCT pro tem 2 x CCG reps 2 x provider NHS trust reps 4 x voluntary sector reps 1 x LINk rep.	An executive group chaired by council director manages day-to-day work of HWB. JSNA steering group reports to HWB. All groups reporting to LSP health partnership now transferred to HWB.	Every two months; 3rd meeting in Sept will review frequency of meetings.	Priorities (each supported by outcome statements): improving health and wellbeing; promoting independence; integrated services; positive experience of care. HWB has discussed childhood obesity & related NICE guidance.
Leicestershire County	HWB set up with terms of reference and development programme.	Chair - council health lead 2 x cabinet leads 2 x district councillors 3 x council directors (incl. DPH) 2 x reps from both CCGs 2 x LINk PCT chief executive 1 x local medical committee	HWB is part of LSP structure. Subgroups subject to agreement – Staying healthy partnership. Integrated commissioning. JSNA steering group. Substance misuse board. Prevention and early intervention board. Small HWB steering group including CCG rep is in place.	Quarterly since April.	Workplan priorities: Developing JSNA and the JHWS by April 2012. Supporting HealthWatch development. Board also considers urgent items, for example, issues with providers. Draft strategic priorities for JHWS identified. Developing performance management dashboard.

Council	Stage	Who is involved	Support/sub-structures	Meetings	Priorities/topics discussed
North Tyneside Metropolitan Borough	HWB set up in December 2010 with an ongoing induction programme.	Chair - elected mayor 5 x councillors young mayor; young cabinet member 6 council – chief executive, 3 directors (incl. DPH), 2 other 2 x CCG 3 x PCT 3 x NHS provider trusts 1 x voluntary sector 3 x LINk	HWB is part of LSP structure. Substructures include: Adult safeguarding board. Adult commissioning groups: Long-term conditions. Alternatives to hospital. Learning disabilities. Mental health. Health improvement and prevention. Board has appointed a coordinator.	Quarterly since December.	The board considers a range of items in 3 sections: JSNA and commissioning. Health improvement and tackling health inequalities. NHS reform. Agenda items have included: Agreeing joint plan for reablement. Signing off a serious case review. Considering an integrated workforce development strategy. Draft plan for HealthWatch. Progress on public health transition plans.
Somerset County	Scrutiny task and finish group has reviewed and made recommendations for new arrangements inc. HWB not yet formed.	Board membership not yet agreed but task and finish group favours a network model with links to district councils and aligned GP federations. Elected members likely to be the only voting members. Providers likely to be involved in support structures but not board itself.	Not yet decided, but task and finish group favours involvement of service users and interest group in ad hoc pieces of work.	Not yet decided.	Likely to focus on small number of strategic priorities from JSNA.

Council	Stage	Who is involved	Support/sub-structures	Meetings	Priorities/topics discussed
Wigan Metropolitan Borough	The HWB agreed a comprehensive, externally facilitated programme of organisational development (OD) sessions between April and September to develop common purpose.	Chair - Cabinet lead healthier communities & adult services council leader deputy leader 2 x cabinet leads 3 x PCT directors 5 x GP consortia leads officers in support council/PCT chief executive (joint post) 4 x council or PCT directors incl. DPH.	The LSP thematic group for health has been stood down. Substructures not yet agreed.	After the OD programme board will probably meet every two months.	Oversight of existing section 75 agreement likely to be through the board. Shared priorities are being determined through the OD process. A draft development plan has been produced identifying key outcomes. Work is underway on enhancing the JSNA and starting the JHWS.

SECTION D

In the full resource, this section features the nine case studies.

A short version of the case studies has been published separately. Both versions of the case studies can also be found online at: http://tinyurl.com/6jj8xtm

SECTION E

Further information, support and advice

In the full resource, this section consists of six stand-alone information sheets providing background information which members of HWBs may find helpful in understanding the context of the current changes.

Information sheet 1: the national policy context and legislation.

Information sheet 2: national support for health and wellbeing boards.

Information sheet 3: regional support for health and wellbeing boards.

Information sheet 4: questions for health and wellbeing boards to consider tool.

Information sheet 5: health and wellbeing board relationship diagram.

Information sheet 6: glossary of common terms currently in use in the health and social care sectors.

References

Department of Health (2010a), NHS outcomes framework: http://tinyurl.com/3ajkgv4

Department of Health (2010b), Healthy Lives, Healthy People: transparency in outcomes, proposals for a public health outcomes framework: http://tinyurl.com/6d7ddee

Department of Health (2010c), Transparency in outcomes: a framework for adult social care: http://tinyurl.com/37vo29h

Department of Health (2011a) Government Response to the NHS Future Forum: http://tinyurl.com/63kw97h

Department of Health (2011b) Developing the NHS Commissioning Board: http://tinyurl.com/6frmffd

HMG (2011) Health and Social Care Bill 2011: http://tinyurl.com/5sscgpe

NHS Future Forum (2011) Patient involvement and public accountability: http://tinyurl.com/6fgecjc

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