POLICY BRIEFING

Health and Wellbeing Boards: system leaders or talking shops?

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Summary
This policy briefing summarises and comments on a Kings Fund survey of health and wellbeing boards which presents findings on issues such as:

- membership
- leadership and
- expectations.

The Kings Fund also identifies key themes and describes three scenarios which suggest how boards need to develop to meet forthcoming challenges.

Overview
As part of its ongoing work to support the development of health and wellbeing boards (HWBs), the Kings Fund undertook a survey of 45 shadow boards in October 2011. The survey shows trends in how boards are developing; for example, only four of the boards had more than 20 members, and around only a quarter included NHS provider trusts.

The report indicates that most HWBs in the sample got off to a ‘flying start’, with the majority of respondents optimistic that boards would have a positive impact on integrating health and social care and other priorities. However the context in which boards will have to operate is extremely challenging, with newly formed boards having to deal with major problems such as large funding gaps and major service reconfigurations.

The Kings Fund identifies a number of key themes that need to be addressed to enable HWBs to ‘deliver strong, credible and shared leadership across local organisational boundaries’.
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Sharing what works and ongoing support

Local authorities should look afresh at ways of working with local partners rather than uncritically building on existing arrangements. Local discretion to set up boards leads to a variety of different approaches and it is important that sector-led support allows boards to capture and share lessons. Joint Health and Wellbeing Strategies should not be a wish-list of uncosted proposals, rather based on rigorous prioritisation of need and demands. Working in this way is particularly daunting for new organisations and partnerships – CCGs and HWBs. Ongoing support to help boards develop skills and relationships is important.

Commissioning and integration

The Kings Fund identifies a tension between the role of HWBs in overseeing commissioning and promoting integration and points to its research that suggests that a ‘hard separation of commissioning and provider roles’ potentially impedes integrated care. The Kings Fund relates this to whether or not providers are involved in the work of boards. It stops short of advising that providers should be full members of boards, but does say that boards need to give more thought to what governance arrangements are needed to fulfil HWBs’ ‘primary purpose’ of integrating services.

National framework with local freedom

Local areas are concerned that national policy imperatives from the NHS Commissioning Board may override local priorities. The relationship between HWBs, CCGs and the NHS Board is a significant unknown. The Kings Fund recommends that more is done to define the roles and responsibilities of new bodies. It also recommends a stronger national framework for integrated care, with a single outcomes framework to promote joint accountability.

This report is an interesting addition to research into health and wellbeing boards and those involved may find it helpful to consider the Kings Fund’s three scenarios, described below, to consider where their board is positioned in this spectrum.

Boards will need to take a view on whether to include NHS providers as board members when they become fully operational; as yet it is clear that most favour commissioner-focused membership for many valid reasons, such as size of boards and range of potential providers. However boards will need to make sound arrangements for involving key partners, such as the voluntary and community sectors and major providers, in shaping and implementing change.
Briefing in full
Survey Findings

Size and composition of boards

Of the 48 boards surveyed the size of membership was as follows:

- 21 had up to 12 members
- 23 had between 13-20 members
- 4 had more than 20 members.

The survey found that unitary authorities were likely to have smaller boards, with shires and metropolitan boroughs more likely to have larger numbers due to the involvement of district councillors or more clinical commissioning groups (CCGs) within the HWB area. Some shire counties are operating with complex networks of partners. Six boards had established a smaller executive or officers’ group responsible for driving progress outside board meetings.

In terms of composition, boards tended to focus on the core membership set out in the Health and Social Care Act; all boards included councillors, public health, social care and CCGs and 86% involved patient and public involvement groups. Some included other representatives:

- 23% involved NHS providers
- 57% involved voluntary/third sector groups
- 68% involved district councils.

Involving stakeholders

The report suggests that the decision to include or exclude providers reveals differing views about the fundamental purpose of HWBs. Those that do not include providers see the main focus of the board as commissioning, with provider involvement seen as inappropriate, and potentially leading to conflict of interest. Many of these boards were identifying ways of engaging with providers outside formal meetings. Boards that include providers see them as important for the integration of health and social care, and also recognise their role as major employers.

The range and extent of the voluntary and community sector organisations was identified as one reason why 43% of boards did not have third sector representation.

The report indicates that research into organisations shows that effective companies have smaller boards – generally around eight to 12 members. However, public sector organisations are expected to include a wider range of interests so a balance needs to be achieved.
Most boards saw wider involvement of local stakeholders beyond formal meetings as an important way of ensuring that people actively contribute to shaping health, public health and social care. Some aimed to have a tight core membership supported by a wide network of stakeholders. A few were continuing to hold informal workshops or meetings with wider stakeholders, and a small number were alternating public meetings and board meetings. Four boards had organised meetings and events with CCG members. Most boards were considering how to position the HWB in relation to other partnership bodies such as children’s trusts or community safety partnerships; there were wide variations in this, but some areas were using the HWB as the overarching body.

**Frequency of meetings**

77% of boards were planning to meet every 6-8 weeks, and 10%, monthly. The report comments that it is difficult to see how such frequency can be maintained in the longer term, once priorities and plans are established.

**Chair and vice chair**

Leadership of shadow boards in the survey was as follows:

- 25 – portfolio holder for health, adult social care or children’s services
- 17 – council leader or deputy
- 2 – elected mayor
- 2 – shared between elected member and PCT or NHS trust chair
- 1 – Director of Public Health
- 1 – Local police commander.

24 boards surveyed had not yet chosen a vice chair, but there was a trend towards a vice chair from the NHS, usually the chair of a CCG. In two boards the vice chair was held by a patient/public involvement representative.

The report comments that the seniority of the chairs and moves to share leadership are good signs for the emergence of mature partnerships.

**Supporting formation and resourcing**

A number of boards surveyed had used external organisations to help them get established. These included the Kings Fund, the LGA and local universities. London councils and London NHS had worked together to provide support. Only one internal HWB coordinator had been appointed. Some councils were using existing democratic teams or project management capacity to provide administrative support. Some intended to identify what contribution other partners, particularly CCGs, should provide to the cost of operating boards.

The report comments that, as important new cross-organisational vehicles, there will be an ongoing need for leadership and organisational development. Achieving this,
and avoiding each of the 152 HWBs reinventing the wheel, will be a test of sector-led improvement capacity.

**Views from the boards**

When asked about HWBs’ potential, respondents were very positive. A large majority agreed ‘completely’ or ‘somewhat’ that boards would deliver on achieving:

- local priorities
- integration of services between councils and the NHS
- better coordinated care pathway planning
- increased pooling of commissioning budgets.

Boards were seen as different from previous joint working arrangements because of greater engagement of GPs; higher status through being a statutory committee of the local authority; and greater focus on strategic direction, commissioning, and prevention, facilitated by the transfer of public health to local authorities.

The most important factors that would help boards to achieve their objectives were strong working relationships, high level commitment to health and wellbeing and integration, agreement on priorities and local flexibility/control.

The most important hindering factors were budget constraints, lack of top level sign-up, lack of clarity about scope and purpose of boards, continued structural change, national control and silo thinking.

**Measuring success**

Boards were starting to consider how they would assess their impact and success.

- More than half were planning to measure performance against delivery of objectives in the joint health and wellbeing strategy and the board’s work programme.
- A quarter planned to develop measurable outcomes.
- Others planned to use the national outcome frameworks and develop their own indicator set from the three frameworks.
- A third had not yet decided how they would measure success.

**Possible HWB scenarios**

The report identifies the range and diversity of factors that will impact upon how boards operate and presents three scenarios which demonstrate this. The factors are not mutually exclusive and will be played out in different ways in different places.
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The Kings Fund suggests that boards should strive to become system leaders as in scenario one.

Scenario 1 Towards system leadership – a board’s influence and credibility grows as it begins to offer leadership across the system.

- Early engagement between local authority and CCGs and a completely revised Joint Strategic Needs Assessment.
- The local authority and local involvement network (LiNK) have undertaken a public engagement exercise which reveals disagreement with some proposed changes to NHS provision.
- In light of this, the board sets up an independent commission to make recommendations on the future shape of provision, with terms of reference agreed with the NHS Commissioning Board.
- The board agrees priorities e.g. tackling the needs of the fast rising older population and agrees to redesign older people’s services through a single local care record and integrated local teams.
- In light of escalating budget pressures, a joint task and finish group is appointed to review what can be done together to manage budgets.

Scenario 2 Strategic coordination – the board takes on a strategic focus on priorities shared by all partners, but does not address challenges facing the system as a whole.

- A complex local authority area with mixed urban and rural populations with substantially different needs, and several CCGs crossing the council’s boundaries; acute trusts derive much of their income from out-of-area referrals.
- The CCGs are considering changes to hospital services which will be unpopular with some local people.
- The local authority is channelling public concern through its scrutiny committee and is likely to ‘agree to disagree’ on the proposals.
- The HWB agrees some high level priorities drawn from existing separate plans and makes some quick wins, such as coordinating information and advice.

Scenario 3 Passive engagement – the board is largely irrelevant in an unfolding crisis of financial and service failure with little impact or influence on major decisions.

- Past relationships between local authority and NHS have generally been good.
- One political party is in control with a small majority, adopting a consensual style of leadership.
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- The HWB is largely a continuation of previous arrangements with the addition of CCGs.
- Hospital and nursing home placements are well above national average. The local acute trust faces a growing financial deficit and concerns about quality of care. The CCG was late to be authorised and has struggled to develop commissioning plans that would be acceptable to the NHS Commissioning Board; engagement with the board has been limited.
- Board meetings are dominated by sharing existing plans which are usually rubber stamped.
- Most board members value the opportunity for networking provided by the board; they tend to attribute local problems to national policies and lack of funding.
- The position of the acute trust continues to deteriorate and the NHS Commissioning Board initiates discussions with another trust about a merger.

Comment

LGiU Associate Fiona Campbell and I undertook the first large-scale study of HWBs during summer 2011. People we spoke to were determined their board should not become a talking shop or hung up on process, and where advanced partnership arrangements such as integrated services were already in place, they were keen that these should be maintained and built upon.

The Kings Fund survey reiterates these themes. Although it was carried out last year, issues raised at the National HWB Conference in April 2012 show that many are of ongoing concern, for example:

- should providers have a place on the HWB
- how will HWBs influence major reconfiguration when there are national directives (e.g. to CCGs) regarding strategic leadership
- how will boards work in a two-tier system
- should adult and children’s be commissioned separately or together – should commissioning be aligned
- how do we stop HWBs being pulled into issues of acute reconfiguration and going into ‘scrutiny’ mode?

An important issue which is not yet being addressed head-on is the relationship between the council and the HWB as a council committee. This is will be particularly important in relation to NHS provider reconfigurations which so often prove politically challenging. The Kings Fund describes the situation regarding contested reconfiguration as follows:
‘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 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.’

The key words here are ‘a compelling case for change on the grounds of clinical safety or outcomes’. Although situations are rarely completely clear-cut and political pressures are very real, it is clearly important that HWBs will need to develop skills in assessing the evidence-base of a proposal and transmitting accurate messages to the public.

Link

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Related briefing

LGiU Policy Briefing: Health and wellbeing boards – a new resource for local government

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