UNIVERSITY OF BIRMINGHAM

Institute of Local Government Studies
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Health and Wellbeing Boards: developing a successful partnership

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Introduction

This informal paper has been produced for anyone who is likely to be involved in a Health and Wellbeing Board, including HealthWatch representatives, GP commissioners, local authority leaders, portfolio holders and chief officers and providers of health and social care services. We present it as a discussion paper and would welcome your comments and ideas as these new bodies start to develop.

At the University of Birmingham, the Institute of Local Government Studies (www.inlogov.ac.uk) and the Health Services Management Centre (www.hsmc.bham.ac.uk) have a long standing interest in partnership working and are already supporting a number of local areas as they consider how best to approach the new opportunity these Boards present.

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Health and Wellbeing Boards: what is the context?

'The Government is clear that joint, integrated working is vital to developing a personalised health and care system that reflects people's health and care needs. Services also need to be developed in ways that fit around the people who use them, and their families, and that they can understand and shape. We have an opportunity to strengthen integrated working across the health and social care agenda, from the point of providing services, to people understanding how services need to be commissioned to best meet the health and wellbeing needs of local populations. We can also improve integrated working right along the care *pathway'. (DH 2010a, p6)*

As the professional and academic communities have had time to consider the wide ranging reforms proposed by the Coalition Government there has been increasing concern about the emphasis of the Bill on an 'open market' based on competition. One of the principle fears regarding this approach is that it will fragment service delivery rather than support integration, as integration could be seen as 'anti-competitive'. This would conflict with the expressed commitment of the Coalition Government to continue with the policy drive of the previous Labour government to achieve better integration at all levels of the health and social care system. The public health White Paper (DH 2010b) further extends

this vision of integration beyond services traditionally designated as concerned with health and social care, and places local authorities at the centre.

'Local government's new role in public health presents an opportunity to address this challenge. Public health will be better integrated with areas such as social care, transport, leisure, planning and housing, keeping people connected, active, independent and in their own homes. Neighbourhoods and houses can be better designed to support people's health, such as by creating Lifetime Homes, and by maintaining benefits such as the winter fuel allowance and free bus travel, which keep people active and reduce isolation'.

Health and Wellbeing Boards will act as the main strategic vehicle to achieve this integration, but despite their vital role they have received relatively few mentions in the heated debate about the predicted impact of the other changes set out in the Health and Social Care Bill 2011. Along with the reconfiguration of the health service, these champions of integration will be tasked with responding to a range of other major challenges and changes.

Less funding

The cuts to local government funding following the Comprehensive Spending Review (CSR) are the largest in a generation and are resulting in major internal reorganisation, as well as moves to share infrastructure costs across traditional boundaries. Councils are tightening the eligibility criteria for social care and a number of independent providers are concerned about the viability of their businesses. Many commentators believe that the cuts will have greatest impact on the most deprived areas where health inequalities present the greatest challenge (LGC 2010). The NHS has, in theory, been protected from reductions in funding but is still required to make £20 billion of savings to ensure that current funding can address rising demand caused by an ageing population, the costs of new procedures and technologies and increasing inflationary pressures. The connected 45% reduction in management costs will cause further disruption as PCTs manage the transition to GP consortia. These financial pressures will put a strain on relations between health and social care services as the deficit reduction plans of social care may increase the demand on health care services and equally rationing of health care may lead to people requiring long-term social care support (Glasby et al 2011).

Local freedoms

The Localism Bill purports to offer local authorities the freedom to do what is best for its local area, through a General Power of Competence (Raine & Staite 2011). GP Commissioning Consortia will have 'assumed responsibility' rather than 'earned autonomy' (DH 2010c p72) in their responsibility for 80% of the NHS budget and be at the frontline of a health services led 'in the consulting room and clinic' (DH 2010d p9). Health and Wellbeing Boards will be exercising these freedoms at a time when not only is money extremely tight but when Coalition partners are trying to establish themselves as the long term parties of government. It may prove difficult for ministers to resist intervening if local areas are not achieving the pace or direction of change desired, and to a degree this has already been witnessed by criticisms connected with local authorities reducing funding to

the voluntary sector due to their potential implications for the ‘Big Society’ vision (Cameron 2011)

Consumer (and Citizen?) power

Through ‘any willing provider’, individual budgets in health and personalisation in social care, the government are continuing with a model in which people receiving services have more autonomy to determine both the type of support they receive and the services that will provide that support. Depending on your viewpoint these changes can be seen as driving through reform on the basis of ‘consumer’ and / or ‘citizen’ power. This more individualistic approach will mean that the Health and Wellbeing Board, as the strategic commissioning body, will have a very different role to previous times when commissioners were able to determine what services would be provided by which agency. It will instead have an increasing focus on developing a local market place in which people choose, and this will mean a different set of skills and relationships. At the same time, Boards will be engaging with the local population, either via the local HealthWatch or directly, as both ‘citizens’ and ‘consumers’.

Increasing inequalities

The investment and health reforms overseen by the Labour government led to considerable improvements in relation to waiting times and in overall life expectancy. Smoking rates have declined and overall patient satisfaction with the NHS has increased (Thorlby & Mayblin 2010) But health inequalities, one of the key areas targeted by Labour, have proved harder to tackle and people living in the poorest areas will, on average, die 7 years earlier than people living in rich areas and spend 17 more years living with poor health. The Marmot Review (2010) concluded that previous strategies had focused on lifestyle interventions rather than economic and psychosocial determinants and that NHS funding continues to be skewed to the acute sector rather than to primary care.

Health and Wellbeing Boards: what is their role?

The timescale for Health & Wellbeing Boards to assume statutory duties has been set as April 2013, and already 90% of local authority areas have signed up to be Early Implementer sites. That the majority of areas have signed up to participate ahead of the required timescale could be taken as a sign that this a model that health and social care leaders have been looking for, or a sign that the Boards are seen as a ‘low risk’ initiative to adopt because they are not that different from current local arrangements. The answer may be more pragmatic – if these arrangements have to be introduced and there will be a degree of flexibility local areas may believe that it is best just to get started. Being part of the ‘early’ wave will also provide the opportunity to influence central government thinking.

Figure 1: timetable for change

End of 2011/12	Shadow Board in place unless (early adopters)
2011/12	Public Health England set up in shadow form
2012	Local authorities get shadow allocation of public health funding
March 2013	PCTs abolished
April 2013	Health and Wellbeing Boards assume statutory duties

Powers and Duties

The Health and Social Care Bill sets out the powers and duties of Boards, in sections 176 to 183. In brief, they are to:

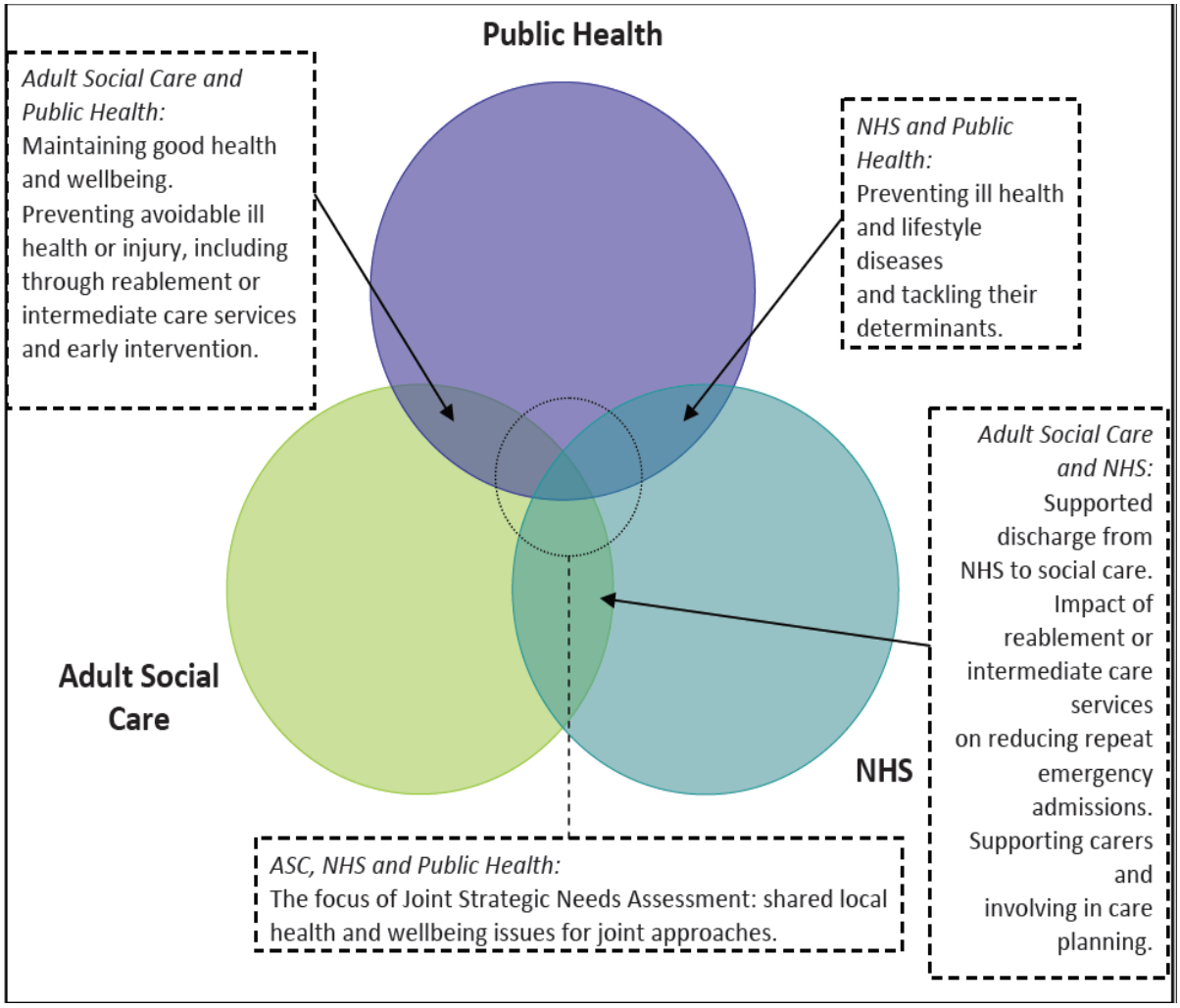
> Undertake a joint strategic needs assessment – under the provisions of s116 of the Local Government and Public Involvement in Health Act 2007.
> Develop a joint Health and Wellbeing Strategy between the Council, the GP Commissioners and the NHS Commissioning Board.
> Encourage integrated working between providers, including the use of pooled budgets and other financial arrangements under s75 of the NHS Act 2006.

And – in the case of Board members who are also commissioners – to:

> Have regard to the JSNA and the Health and Wellbeing Strategy when making commissioning decisions.

The white paper *Equity and Excellence: Liberating the NHS* (DH 2010d) spelled out a role for Health and Wellbeing Boards of 'holding the ring' between adult social care, public health and the wider NHS. Figure 2 shows how the three parts of the system, public health, adult social case and the wider NHS, connect and overlap.

Figure 2: The relationship between public health, adult social care and acute services (DH 2010f)



Membership of Health and Wellbeing Boards

The minimum membership consists of;

The Leader, or a member appointed by the Leader (as Chair)
Director of Adult Social Care
Director of Children's Services
Director of Public Health
A representative of the local HealthWatch (whose role will be to gather and represent views about local health and social care needs and the performance of services)
A representative of each of the GP commissioning consortia in the local area (one consortium can represent all of the consortia if the Board agrees)

A representative of the NHS Commissioning Board (who will contribute to the Joint Strategic Needs Assessment and the Health & Well-being Strategy and to discuss issues related to services commissioned by the NHS Commissioning Board)

The council may appoint anyone else it thinks appropriate. Once the Board is established, the local authority must consult with the Board before appointing any additional members.

Linked to decisions over membership will be issues of engagement with providers of health and social care. Boards will be commissioning from a diverse sector and achieving meaningful and fair provider representation will be complicated.

Geographic Locality

With local authorities acting as the lead agency for the Board, it is likely that the default position for deciding the locality for which the Board is responsible will be the local authority geographical boundary. However, this does not have to be the case, with the government's proposals containing the flexibility for having more than one Board within a local authority area and/or Boards being responsible for areas that overlap local authority boundaries. The latter scenario could be an option for localities in which the GP commissioning consortia include practices within more than one local authority but all the local authorities concerned would have to be in agreement.

Relationship to the Local Strategic Partnership

Local authorities and their partners will need to define the relationship between the Health and Wellbeing Board and other partnerships. Where local authorities retain a Local Strategic Partnership (LSP), it would make sense for the Health and Wellbeing Board to be a sub-group of the LSP. Many of the key health inequalities challenges which Health and Wellbeing Boards will be focusing on have their roots in the wider determinants of heath. Therefore they will need to connect with a wide range of partners on issues such as worklessness, housing and leisure services. The LSP will need to help the Health and Wellbeing Board to make those connections and provide opportunities to influence spending decisions and support better integration in those areas.

Outcomes

Health & Well-Being Boards will be expected to achieve better outcomes for users and communities through integrating commissioning and provision. The government has made this potentially more complex than is necessary by choosing not to produce an overarching framework of outcomes but instead to introduce separate frameworks for adult social care, public health and the wider NHS. The three sets of objectives are set out in figure 3 (below). Some are the same, others overlap and some are service specific. The objectives vary in their scope. Some relate to individuals, some to groups and some to the

population as a whole. Some are expressed as positives whereas others seem to be based on a deficit model. It would be easier for Boards to make sense of this varied range of outcomes if they were grouped together within a common, integrated framework so achievement of one objective supported achievement of another.

Figure 3: Outcomes Frameworks (DH 2010e, DH 2010f , DH 2010g)

	Death	Wellbeing	Recovery	Experiences	Safety
NHS	Preventing people from dying prematurely	Enhancing quality of life for people with long term conditions	Helping people to recover from episodes of ill health or following injury	Ensuring that people have a positive experience of care	Treating and caring for people in a safe environment and protecting them from avoidable harm
Public Health	Preventing people from dying prematurely	Tackling the factors which affect health and wellbeing Helping people to live healthy lifestyles and make healthy choices	Reducing the number of people living with preventable ill health		Protect the population's health from major emergencies and remain resilient to harm
Social Care		Promoting personalisation and enhancing quality of life for people with care and support needs	Preventing deterioration, delaying dependency and supporting recovery	Ensuring a positive experience of care and support	Protecting from avoidable harm and caring in a safe environment

Health and Wellbeing Boards: developing resilience

Outside of the framework set out above there appears to be freedom for Boards to develop their own arrangements that respond to their local histories, needs and circumstances. There are a number of factors that will need to be considered in the development of these bodies if they are going to effectively rise to the challenges of increasing health inequalities and reducing financial capacity.

Coping with difference

As the key vehicle to drive health and social care partnership, Health & Well-being Boards will be inheriting a scenario of fragmented accountabilities, conflicting priorities and diverse cultures across health and social care. Organisational structures, work processes, inherent, and often tacit, values and beliefs are all key ingredients of organisational culture (Schein 1990) and they vary significantly between local authorities and PCTs and even more so between local authorities and GP commissioners. Meidinger (1987) describes culture as a 'set of shared understandings which make it possible for a group of people to act in concert with each other' and successful partnerships are able to create their own cultures and bridge the organisational divide. In recent years, partnerships have become increasingly aware that old ways of achieving improvement are no longer effective, that policy challenges facing national and local government require a new approach based on achieving priority outcomes through partnership working and transforming 'places' through innovation.

They will also be successors to previous local attempts at improving integration which will have varied in their scope and their perceived success (Staite 2008). Boards will be expected to create coherence with relatively limited tools at their disposal – essentially the encouragement of integration and the flexibility to agree joint arrangements such as *pooled budgets* and *lead commissioning* (Raine et al 2011, OPM 2008). There are real differences in perspectives between the different professional groups involved. The differences form icebergs – some are above the surface but most lie below, unacknowledged, poorly understood and a hazard to effective partnerships. These include differences in roles, language and experience as well as the differences between those who operate within the framework of local democracy and those whose political masters are in Whitehall. There are differences in professional and organisational cultures, values and beliefs, often unconscious or unarticulated. If GP commissioners think local authority colleagues are mere bureaucrats and local authority members and officers think GPs are self-interested mavericks, it will be impossible to create an effective Board. Le Grand (2003) highlighted the roles of 'motivation' in shaping the behavior of key players in public services and 'agency' (which he defines as the capacity to undertake action) in the design and implementation of public policy. Health and Wellbeing Board members will inevitably have a wide variety of individual motivations and potentially limited collective capacity to undertake action.

Taking a broader view

Although Health and Wellbeing Boards do not have responsibility for children's services, the inclusion of the director of children's services in the list of core members reflects the very real need for adults and children's services to be commissioned in a way which supports the delivery of holistic services, for example, for highly dependent families or for those in which a child or a parent has a disability or mental illness. This issue is highlighted in the (as yet unpublished) evaluation of the national Commissioning Support Programme undertaken by PwC.

Boards will have to look beyond traditional health and social care services to deliver the 'health and well being agenda' and enroll the support of both the wider local authority portfolio (such as leisure, housing and education) and other external partners such as local employers. The mechanisms for doing so will therefore have to be embedded within the revised structure of the Local Strategic Partnerships. The GP commissioning consortia structure is still to be finalised (although it is clear they will be 'statutory bodies') and the Boards can help to ensure that they are connected with the relevant work streams within the broader partnerships.

Incorporating different roles and accountabilities

The HealthWatch member will have a key role in representing patients', users' and community views but direct engagement will still need to be carried out by both commissioners and providers. This requirement should be seen as a strength within the reforms, as research suggests both that involvement leads to service improvements and users / patients generally welcome such opportunities (Crawford 2002). The challenge will be dedicating sufficient energy and funding to such activities in such difficult and cash limited times. Another potential complication is that the HealthWatch representative will be funded by the local authority, which can create challenges if that person is critical of services or how the Board is operating – 'biting the hand that feeds'. The NHS Commissioning Board representative may or not be local but they will be an 'outsider' and possibly only occasionally in attendance. Health care providers will be in direct competition with each other within a 'real' market, and attendance at the main commissioning forum within an area is likely to be seen as a considerable business advantage.

For the local authority members of the Board there will also be a need to take account of the political nature of their role - for example, there may have been manifesto pledges not to outsource services and this may well conflict with a need to develop markets, to reduce unit costs and to improve outcomes. The relationship between the chair of the Board and the wider political leadership of the council will be crucial in resolving these conflicts. Boards will be trying to shape a market in which people who receive services will have increasing autonomy over how their allocated funding is spent, and they will have to be sensitive to local 'consumer' views and trends otherwise service redesign could be undone by people sticking with what they know. Integrated care pathways offer potential solutions to tackling inefficient and ineffective historical practices, but the providers concerned may be in direct competition with each other. Boards will have to manage these tensions and convince all concerned that it is in everybody's interest to put aside such differences and focus on delivering better outcomes for the end recipients.

Adapting their approach

Health and Wellbeing Boards will have some statutory duties; to develop a joint strategic needs assessment (JSNA) and a health and wellbeing strategy but they have no statutory powers. This suggests their role is a 'soft' one, as broker, enabler and catalyst for change (Miller et al 2010). The process of completing the JSNA and developing their strategy will, if done well, necessitate wide engagement with users, carers and other stakeholder

groups, both via their local HealthWatch and directly. It will also require the Boards to have a good grasp of how the whole health and social care system and the connected economy currently operate. The choice of priorities will need to be based on evidence both of need and what works. They will also require an understanding of local community assets and how these can be fostered to develop greater social capital within and between different groups (IDEA 2010). Boards will need the knowledge and skills to understand conflicting evidence and to balance conflicting demand.

There are also some 'hard' elements to the Board's role. The commissioners on the Board - the GPs and the local authority - will have to make hard decisions about their priorities and funding will be cut or withdrawn altogether from some providers. This will have an impact on other members of the Board, most notably the providers. The commissioning decisions will also be implemented through contracting processes which will include performance management of providers. If providers do not perform well, the Board may have to switch from 'soft' mode to 'hard' - with serious consequences for partnership relationships between commissioners and providers on the Board. However, if they are not able to make that difficult switch, any serious problems will remain unresolved.

Health and Wellbeing Boards: first steps

It is clear that Health and Wellbeing Boards have considerable challenges ahead of them, but as with all new arrangements (and particularly ones with the promise of local autonomy) there is also potential for new approaches. The following are presented as our view of the initial steps that Boards should consider as they start to form and move towards taking up their full responsibilities in 2013.

Step 1: **Agree initial membership and simple terms of reference** through which partners can define roles and articulate their shared objectives.

Step 2: **Build strong relationships** of trust and develop a shared understanding of each other's objectives.

Step 3: **Focus on outcomes** to provide strategic vision and safeguard against the temptation to become focused on the processes of partnership rather than what it delivers.

Step 4: **Develop success measures**, both for health and social care outcomes and for the effectiveness of the Board.

Step 5: **Invest in engagement** with the various stakeholders within the local system, as this will provide legitimacy, intelligence and support for the difficult decisions that Boards will have to make

Step 6: **Make sense of the changes** through developing a common narrative about the journey that the local area is on and the role of the Board in supporting that journey.

Step 7: **Ensure clarity in the information** required to inform the Board's decision making, for example, about need, the views of users and communities, emerging technologies and about new types of provider organisations.

Step 8: **Establish an effective strategic planning process**, through their JSNA and the health and wellbeing strategy, which fits in with the local authority and NHS budget setting cycles, so they can get decisions at the right time and also influence decisions made by other parts of the local authority which will have an impact on health and social care.

Step 9: **Build on the current and potential strengths** of the local communities

Step 10: **Learn to live with complexity and paradox** as well as to **manage conflict and avoid blame**.

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