# Conquering the Twin Peaks

## London's Health and Wellbeing Boards

March 2015

LONDON COUNCILS

# Contents

# Executive summary and key messages

In autumn 2014, London Councils commissioned Shared Intelligence to carry out in-depth research into the position of Health and Wellbeing Boards (HWBs) in London.

The research encompassed a number of elements, including: an online survey of boards, interviews with senior stakeholders across the London health and care system, focus groups with key members of boards (including Clinical Commissioning Group representatives, elected members, local authority officers and Healthwatch representatives) and in-depth case study work with six London HWBs.

Using this combination of methods enabled the researchers to build up a comprehensive picture of the position of HWBs in London, their direction of travel and their future ambitions.

This research coincided with the publication of the NHS Five Year Forward view which envisages radical change in the health service and its relationship with social care and public health and commits to greater collaboration between health and local government through HWBs.

This executive summary sets out the key findings of the research which are described in more detail in the full report.

## Key Findings

The vast majority of members of HWBs interviewed for this research described their board as being on a journey or "work in progress", with very few claiming that their board was fulfilling its full potential. Other stakeholders shared this conclusion.

The research identified a number of examples of where boards had added real value on specific issues. Examples include:

- Developing a joint alcohol strategy
- Establishing a Black Health and Wellbeing Commission
- Instigating a review of access to primary care
- Improving services to tackle dementia
- Taking action to reduce the burden on A&E services.

Boards were also identified as having an important role to play in creating the conditions in which discussions can take place between the council, Clinical Commissioning Group (CCGs) and providers on the future shape of the health and care system in their area. This research has found little evidence of HWBs yet providing genuine systems leadership across the piece, although the vast majority of respondents reported that their board aspires to do so and that many are taking steps to enable them to do so.

Research carried out as part of this study suggests that an effective HWB would:

- Create the conditions in which there is genuine collaboration between key players in the local health and wellbeing system
- Ensure the existence of effective systems leadership
- Ensure effective engagement with the public and other stakeholders.

As a result of this there would be:

- Focussed, prioritised action which impacts on the wider determinants of health
- A shared vision for the future of health and care in place, which has traction with the strategies and business planning processes of the key local organisations
- A work programme to deliver and monitor this.

HWB chairs were found to have the single biggest influence over a board's focus and tone. Another key determinant of boards' effectiveness was found to be the relationship between the council and CCG, and between the chair (in most cases a senior councillor) and vice chair (often from the CCG).

Other factors which were found to enable boards to operate effectively include:

- A shared purpose and tight focus
- A small number of priorities and the discipline to stick with them
- An explicit role in creating groups and forums for other related conversations and activities
- Effective sub-structures and time to meet in informal settings
- An ability to influence all the key players and a shared strategy which secures action by relevant organisations.

The research also identified a number of factors

which can impede a board's effectiveness. They include national and local pressures to address issues which are not a priority locally and a tendency to focus on the board as a meeting – the board as council committee – rather than as an institution with a wider reach. Other attributes of less effective boards include: a failure to engage with, or seem meaningful to, providers; and being by-passed, with key discussions taking place in other forums outside the board's ambit.

A key challenge facing all boards was described by one interviewee as the "twin peaks" – the need to take action to both tackle the wider determinants of health and to play a systems leadership role, particularly in relation to the integration of health and social care.

When HWBs were first established there were very high expectations about what they could deliver. At the time a number of stakeholders argued that how they performed should be seen as a litmus test of localism. In this context it is significant that an important conclusion of this research is that the vast majority of factors which determine the effectiveness of a board can be influenced locally. Boards can, for example decide how tightly to prioritise and how tightly to stick to their priorities. They can determine the settings in which they meet and the length and nature of their agendas. They can also determine how to tackle the twin peaks – the balance of their attention devoted to the wider determinants of health as opposed to the future of health and care.

It is, however, important to acknowledge that there are responsibilities that sit in other parts of the wider system to ensure that boards are relevant and effective, in particular:

- Of the Department of Health and NHS England, in the demands it makes of HWBs
- Of other players in the system to draw HWBs into their work.

# 1. Introduction

"Our board is on a journey". This is how virtually everybody interviewed as part of this research has described London's health and wellbeing boards (HWBs). Many interviewees pointed to examples of where their board has added value or described how it has created the conditions for honest conversations and decision-making across the local health and care system. The vast majority saw considerable potential in effective boards but do not consider that their board is fully exploiting that potential yet.

There are important differences of perspective between the different categories of board member. Board chairs, almost always senior councillors, are most inclined to point to a board's role in creating the context for collaboration and integration. Representatives of clinical commissioning groups (CCGs) are more likely to express frustration at boards' lack of decision-making powers and the constraints associated with their role as council committees. What is clear, however, is that the attitude of the board chair and senior CCG representative and their relationship has a profound impact on the tone, focus and overall effectiveness of HWBs.

This report sets out the key factors determining the effectiveness (or not) of HWBs in London. These include factors such as: how boards operate (their size and mode of meeting); the robustness of their prioritisation process; how they engage with important local stakeholders (particularly providers); and the pressure of issues being referred to boards locally and nationally. Significantly this research concluded that most of these factors are capable of being influenced locally by the boards and the organisations that sit on them. This is particularly important given the discussion nationally about the potential for giving boards additional powers and responsibilities.

London Councils commissioned Shared Intelligence to research the position of HWBs in London in autumn 2014, around 18 months after they were formally established. This report sets out the key findings and conclusions of that research. The report:

- Summarises the methodology
- Sets out the national and local context in which London's HWBs operate
- Provides a picture of London HWBs drawing on the results of an on-line survey
- Describes the journey that most London boards are on
- Sets out the factors identified as either enabling or impeding board effectiveness
- Concludes with a series of questions drafted in the light of this research which could help London's HWBs to go further, faster on their particular journey.

The report also includes:

- A pen portrait of three composite anonymised boards illustrating different points on the journey
- A picture of how the different stakeholder groups tend to perceive HWBs.

# 2. Our methodology

This report draws on five main sources of evidence:

- An on-line survey of London's HWBs
- A short study of six boards in London primarily comprising interviews with key members of the board, including the chair, the CCG representative, local providers, senior local authority officers and, the local Healthwatch
- Focus groups with senior CCG representatives, local authority officers (including directors of public health and officers supporting HWBs), and Healthwatch
- Interviews with key stakeholders including officials from NHS England and Public Health England, London borough chief executives, directors of adult social services, providers and a number of HWB chairs
- A sense-making workshop with colleagues from London Councils and other stakeholders to test out and refine the emerging conclusions and recommendations.

In order to establish an honest picture of HWBs in London, the interviews, focus groups and case study work were conducted on a non-attributable basis.

# 3. The context

Health and Wellbeing Boards (HWBs) were established by the Health and Social Care Act 2012.

Each top tier and unitary council (including London Boroughs), is required to have a board, established as a formal council committee. They are intended to:

- Have a strategic influence over commissioning decisions across health, public health and social care
- Involve councillors and patient representatives in commissioning decisions
- Bring together clinical commissioning groups and councils to develop a shared understanding of the health and wellbeing needs of the community
- On the basis of a joint strategic needs assessment and associated strategy, drive local commissioning and create a more effective and responsive local health and care system.

A board's membership must include: a councillor, a representative of the local Healthwatch and the CCG; and the local authority directors for adult social services, children's services and public health.

The NHS Five Year Forward View envisages radical change in the health service and its relationship with social care and public health. Collaboration, integration, engagement and local leadership are central to what it is envisaged HWBs will deliver. They are also at the heart of the NHS Five Year Forward View. It specifically calls for:

- A radical upgrade in prevention and public health
- People to gain greater control of their own care
- Decisive steps to break down the barriers in how care is provided, including between health and social care
- The introduction of radical new delivery options at a local level.

The Forward View notes that "local authorities now have a statutory responsibility for improving the health of their people" and commits to greater collaboration and joint commissioning between the NHS and local government through HWBs.

This research has been published in the run-up to the general election in May 2015. In many ways the NHS Five Year Forward View sets the context for the political debate about the future of health and care which will inevitably be a key feature of the pre-election period. The wider context includes continued financial pressures on public services generally, but most acutely on local government. There is a concerted focus nationally on public service reform, including closer collaboration between organisations at a local level and through the Better Care Fund the government has created a £3.8 million budget for health and social care services to work more closely together in 2015/16.

In London the recommendations of the London Health Commission[2] broadly complement the Forward View. It calls, for example, for innovative and energetic engagement between health and care commissioners and providers and Londoners on health and care. Other recommendations include:

- The commissioning of holistic, integrated physical, mental and social care services
- Ambitious new service and quality standards for GPs
- NHS England to work with CCGs and local authorities to trial capitated budgets for specific population groups such as elderly people with long-term conditions.

Two other aspects of the organisational context in London are important. First, the existence of a programme to transform general practice services in the capital through NHS England's Primary Care Transformation Programme. And second, the formation of six London Strategic Planning Groups (SPGs) bringing together CCGs at a sub-regional level. SPGs are intended to provide a consolidated overview of the CCGs' operational plans and a joint five year strategy.

Finally, it is important to note the challenging health and wellbeing context in which London's HWBs operate. For example, London has:

- Almost a quarter of England's homeless population
- 40 per cent of TB cases in the UK
- Very high levels of childhood obesity
- A higher prevalence of problematic drug users than England as a whole
- A younger and more diverse population than the

1 NHS Five Year Forward View (NHS England October 2014)
2 London Health Commission: Better Health for London (GLA Revised November 2014)

country as a whole, leading to, for example, a higher demand for sexual health services.

In addition London has:

- A faster rate of population growth than any other region in England (an additional 7,000 per year) since 2008 bringing additional challenges for maternity services
- A greater proportion of the GP workforce closer to retirement age than other UK regions – almost 16 per cent of London GPs are over 60 compared to 10 per cent nationally
- 37 per cent of the nation's short-term residents, as a result patient turnover for general practice is around 30 per cent in some areas of London
- Life expectancy in London is going up, increasing by 5.2 years between 1990 and 2010[3] the number of older people likely to require care is predicted to rise over 60 per cent by 2030[4]. People over 65 are more likely to suffer from chronic health conditions with nearly two thirds of people admitted to hospital being of this age.

This is a difficult context for any new organisational form. The rest of this report shows how London's HWBs are developing in this context; it explores the factors which impinge on their effectiveness and the steps which can be taken locally to ensure that they deliver the objectives underpinning the 2012 Act and reiterated in the NHS Five Year Forward View.

3 Office for National Statistics (2011).

4 The King's Fund, Demographics, Future Trends, Ageing Population (2011) http://www.kingsfund.org.uk/time-to-think-differently/trends/demography/ageing-population

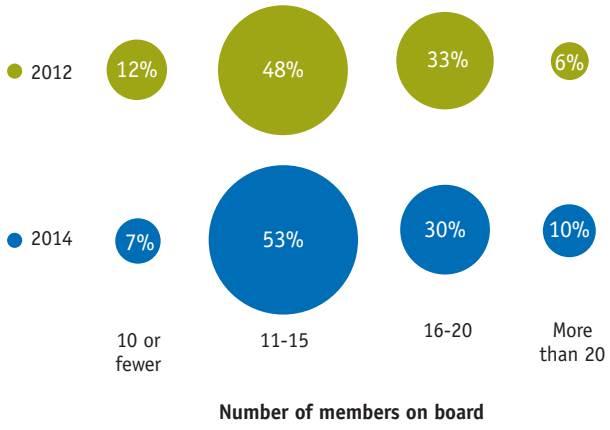
# 4. London's Health and Wellbeing Boards in 2014

An on-line survey carried out as part of this research provides a comprehensive picture of the membership, mode of operation and priorities of London's HWBs. Thirty of London's 33 HWBs responded to the survey.

## Board size and membership

There is a wide variation in the size of boards, from nine to 27 members. The average board has almost 16 members, up from 14 members in 2012 when an earlier survey (the Knowledge Share survey) was carried out (see figure 4.1).

*Figure 4.1:* **Board Size**




The membership of London's HWBs reflects the statutory requirements. Half the boards now have some provider representation, compared to less than a third in 2012. Just under half of London's boards have a wider membership than is statutorily required, including representatives from organisations such as the police, housing providers, safeguarding boards and the voluntary sector (figure 4.2)

A majority of boards are chaired by a local authority elected member, with this being the leader of the council in just under half the cases. Ten boards are chaired by the leader of the council (33 per cent of responses) and a further 12 (40 per cent of responses) are chaired by a portfolio holder (figure 4.3). This is a slight change from the previous survey in 2012 when leaders were marginally more likely to be chair than portfolio holders.

The vice-chair position is generally taken by someone from the CCG, implying a degree of power-sharing and cooperation between the local authority and CCG. Thirteen boards have the CCG chair as vice-chair, with another CCG representative taking the role in a further six HWBs (although some share the role i.e. where there are multiple vice-chairs) (figure 4.3).

*Figure 4.2:* **Composition of London's health and wellbeing boards**

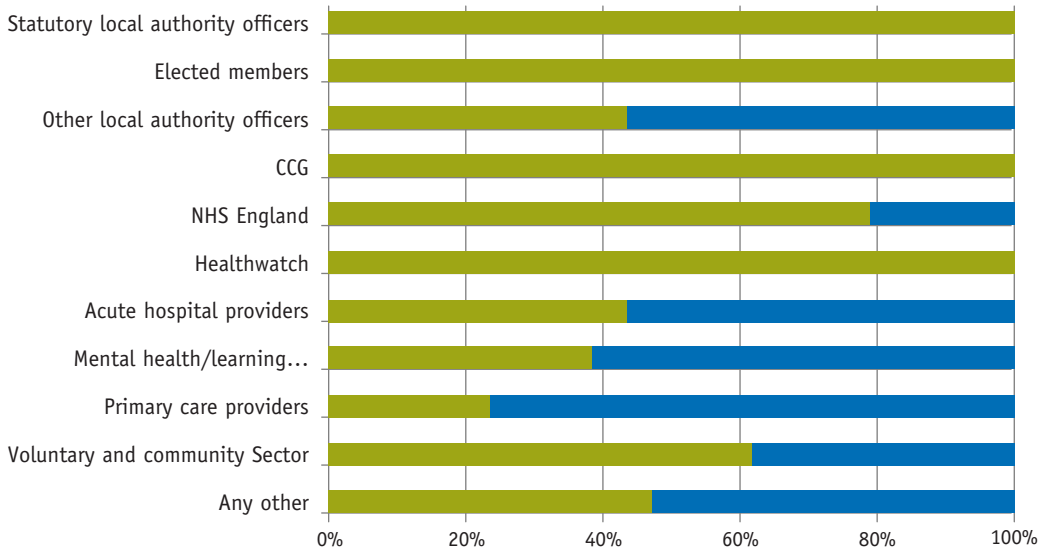
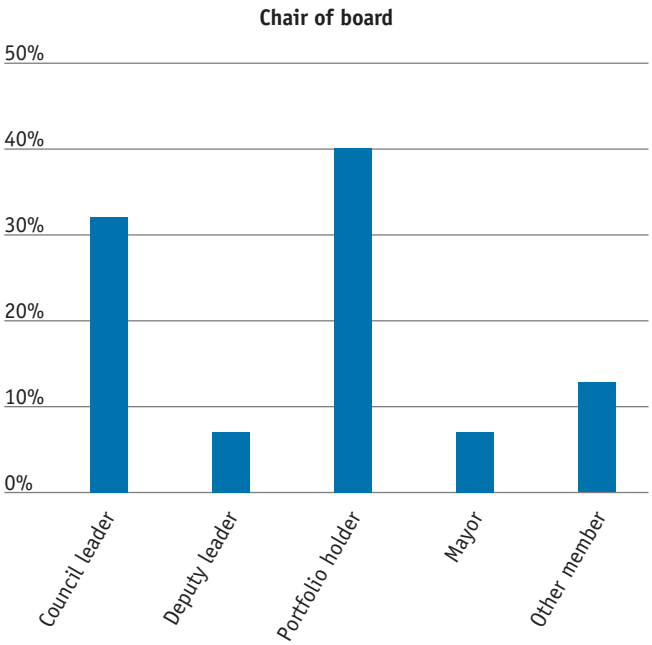
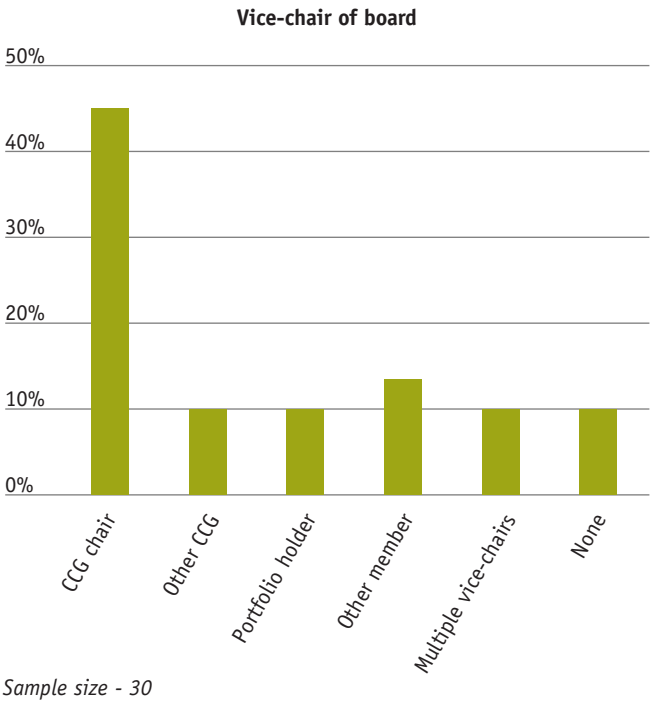



*Figure 4.3:* **Leadership of London health and wellbeing boards**




*Sample size - 30*



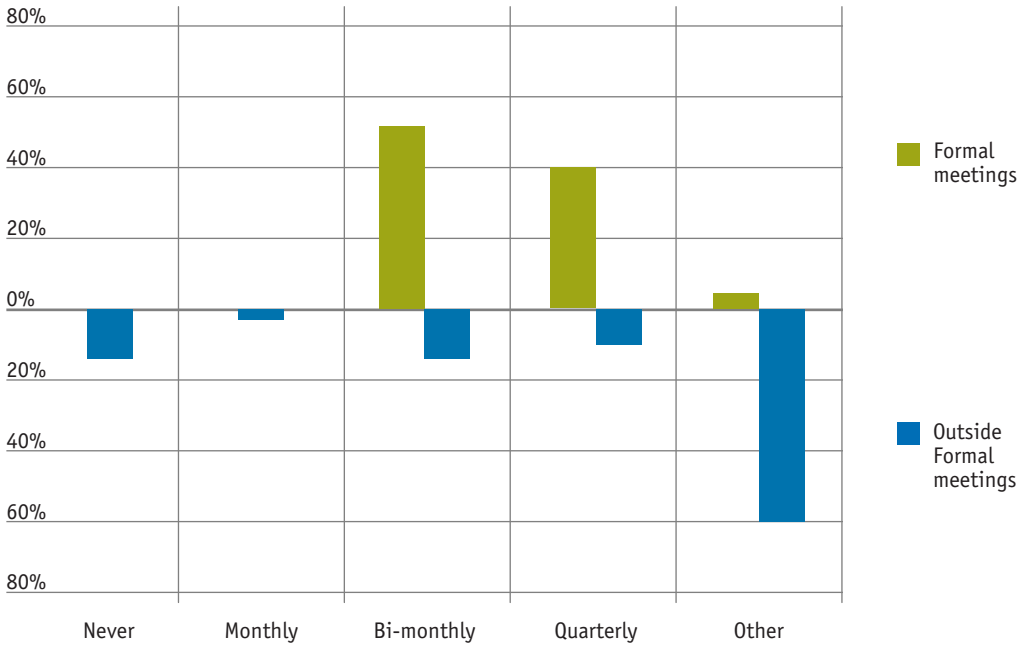

*Sample size - 30*

## Board organisation

Six boards report to an executive and eight said that an executive reports to the HWB [this may either relate to a specific executive body or the formal executive committee]. Seventeen boards said they had a formal relationship with overview and scrutiny. Fifteen HWBs said they report to full council.

Twenty-five HWBs said they have access to dedicated support (89 per cent of respondents) - often provided by the local authority. Seven respondents specifically cited support from "democratic services".

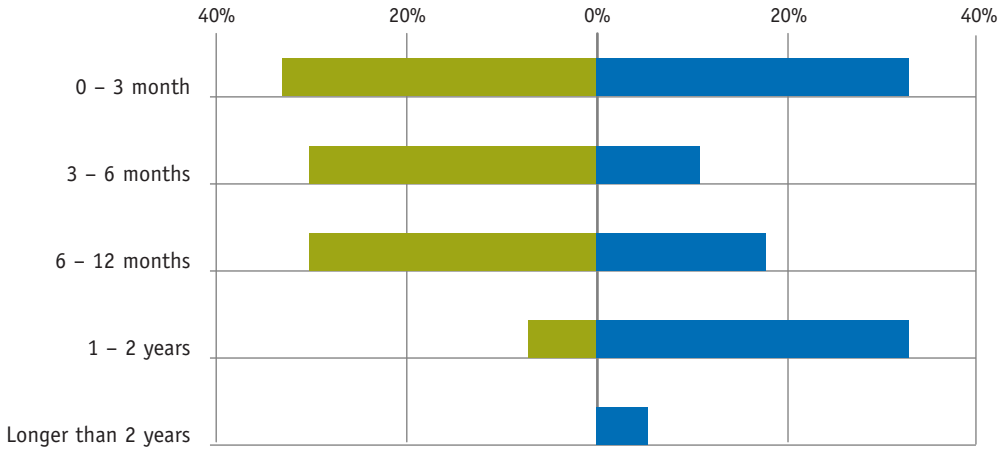
*Figure 4.4*: **Frequency of meetings**




Nearly half, 14 HWBs, said they have steering groups, covering topics such as the Joint Strategic Needs Assessment (JSNA) or Pharmaceutical Needs Assessment, integrated care partnerships, and executive planning. Thirteen HWBs said they have delivery groups, with mental health a frequent topic. Meetings outside formal meetings took place on a variety of schedules, with the majority described as ad-hoc, informal or not regular ("other", 16, 57 per cent) (figure 4.4).

## Board priorities

*Figure 4.5:* **Last updates of the JSNA and JHWS**

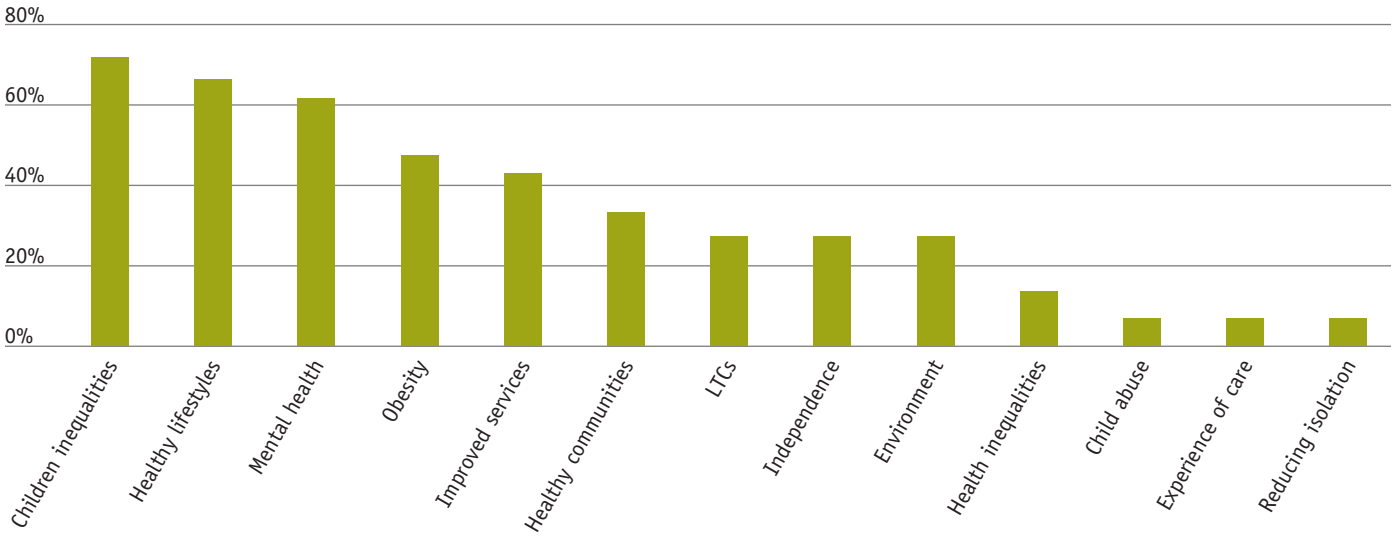



*Sample size - 27*

All HWBs had reviewed their JSNA within the last two years, with 25 HWBs saying this had taken place in the last year. Similarly, all boards had reviewed their Joint Health and Wellbeing Strategy (JHWS), although this tended to have been less recent than the JSNA, with 9 HWBs saying this had taken place within 1-2 years (figure 4.5).

Twenty-one HWBs have identified their priorities. A further four said their priorities were due to be updated. A wide ranging number of priorities were identified – from a high of 16 priorities to a low of just two.

*Figure 4.6:* **Agreed priorities for 2014/15**



Looking at the stated priorities in broad categories, the most often cited are a better start for children/ reducing child inequalities (15 mentions, 71 per cent); healthy lifestyles/prevention (14 mentions, 67 per cent); mental health (13 mentions, 62 per cent); and obesity (10 mentions, 48 per cent).

### Decisions

The number of decisions taken at board meetings was reported as ranging from a maximum of nine to a minimum of one. The median number of decisions was three.

Submission of the Better Care Fund (BCF) figured highly on the agenda of a number of HWBs (17 in total). When only a sole decision was taken by a board this related to the BCF submission.

### Major challenges

Twenty-five HWBs identified up to three major challenges faced over the last 12 months (see figure 4.7). The Better Care Fund featured heavily, and was cited by 14 boards. This was mentioned in relation to the timescales and complexities associated with agreeing the BCF submission and how this fits with other priorities.

Leadership, in particular the need to play a system leadership role, was also felt to be a major challenge for eight boards. Financial pressures, the need to manage expectations, and integration and engagement also all featured.

### Key Achievements

Twenty-five HWBs listed key achievements. The most often cited success related to relationship/ partnership building, working together, or developing relationships, with nearly 20 boards giving an answer around this. Six Boards said a major achievement had been greater integration. The BCF was also a major achievement for six boards. The JSNA was mentioned by three boards.

*Figure 4.7:* **What have been the major challenges over the last 12 months?**

- Constitutional challenge of joint working through a council committee
- Time line for completing the BCF
- Significant changes in health and social care at a national level
- Developing system wide leadership
- Council's financial challenge
- Delivering statutory duties
- Financial pressures facing partners potentially undermining relationships
- Integrated care
- Change in leadership following local elections
- Understanding the role of a 'systems leader'
- Managing timescales for major submissions within cycle of Health and Wellbeing Board meetings, for example Better Care Fund submission
- Changes to National Better Care Fund framework over the summer leading to the need to work very quickly to revise local plan
- Positioning Hillingdon priorities and plans (e.g. BCF) alongside wider NHS reconfiguration across NW London
- Better Care Fund and increasing workload
- Participation of NHS England and the CCG
- Breadth of the agenda and keeping the work focused
- Integration agenda with commissioning partners particularly through the ITF/BCF submission, respective budget tensions and cultural differences
- Formation of new acute trust (LGT) following disestablishment of SLHT
- Better Care Fund
- Maintaining focus on JHWS priorities while pursuing Better Care Fund agenda
- Complexities and timescales associated with agreeing the Better Care Fund
- Better Care Fund
- The financial challenges that all partner organisations face and potential strain this will place on joint work.
- Better Care Fund and increasing workload
- Balancing its system leadership role with the multiple requests/ requirements for 'sign off' for example of the NHS medication errors target
- Giving adequate time and attention to a very broad set of agenda items, some of which have been set locally and some of which have been set for the HWB by national agencies

# 5. The London Health and Wellbeing Board Journey

As noted in the introduction, most people interviewed for this research referred to HWBs as being on a journey. Very few felt that boards are fulfilling their full potential. A description of an effective board – the destination of this journey – is set out below. This is based on evidence from a number of sources, most notably how respondents in this study described effectiveness. It is also informed by a review of health and wellbeing peer challenges nationally that Shared Intelligence has carried out for the Local Government Association.

On the basis of that evidence it is suggested that an effective HWB would:

- Create the conditions in which there is genuine collaboration between the key players in the local health and wellbeing system
- Ensure the existence of effective systems leadership
- Ensure effective engagement with the public and other stakeholders.

A board operating in this way would deliver:

- Focused, prioritised action which impacts on the wider determinants of health
- A shared vision for future of health and care in the place, which has traction with the strategies and business planning processes of the key local organisations
- A work programme to deliver and monitor this.

This research has not identified any London HWBs which fully match this description, but many boards display elements of it. The box below summarises three composite boards[5], drawing on the information collected through the case study work, which illustrate the different points on the journey that London HWBs have reached.

**Tightly focussed**

This small board is chaired by the council leader. Providers are represented and the well-respected Healthwatch member serves on a small executive group that manages the board's agenda. The board has a small number of priorities, its agenda contains very few items for noting. The board benefits from close links with the CCG which reflects the time the chair personally put into building a close relationship with his opposite number.

The chief executive and other senior officers play a lead role in, for example, an integrated commissioning executive with neighbouring CCGs. This work is all done under the auspices of the HWB and the results are reported to board meetings.

Recently, priority has been given to dealing with the local acute hospital which is in special measures. The HWB has led the initiative, but much of the work has been done through a group comprising the accountable officers of the three relevant CCGs, the councils, the hospital and the mental health trust. The solid foundation of this board has enabled the council's chief executive to play a lead role on behalf of the wider health and care system.

The Healthwatch representative of the board sees it as the most important meeting she attends. She welcomes the role of the board in keeping the big picture in mind and has used the board's priorities as the framework for Healthwatch's annual plan and work programme.

The board is aware that it has done little work on the wider determinants of health or other public health priorities. This reflects the primary focus of the chairs of the HWB and CCG being on service improvement and public health recruitment challenges.

5 These composites are informed by the case study work and other interviews. They are not descriptions of any one board, but each element does feature in a London HWB and the composites have been crafted to reflect the range of boards in London.

## Challenged

The portfolio holder for health and adult social care chairs this board. It is one of the largest in London and operates very much as a council committee. The board is widely seen to have raised the profile of public health within the council and discussion of the Better Care Fund and Care Act has raised the general level of understanding of board members on the operation of the local health and care system. Providers are not engaged in the board's work and the relationship between the chair and the CCG is poor.

The board recently discussed the CCG's commissioning intentions taking very much the form of council overview and scrutiny approach adding no additional value to the scrutiny which had already been carried out by the health scrutiny panel. The board also recently considered a CCG paper on dementia (which the CCG perceived to be very important). At the HWB meeting the paper was noted with no detailed discussion or follow-up action plan. This reinforced the CCG's perception of the board as an added burden rather than added value.

The council's chief executive recently convened a series of meetings with the chief executives of the key local health bodies to generate more momentum around health and social care integration. These discussions are taking place outside the ambit of the board because the board is not seen as a safe place for honest conversations.

There are some signs of improvement. There is a commitment to refreshing the board's development days which had become business planning meetings and there was more discussion and debate at the board's most recent meeting. The upcoming review of the joint strategic needs assessment is seen by the senior officer responsible for the board as an opportunity to encourage the board to change gear.

## Changing

This board has a new chair: an up-and-coming local politician, but not a member of the cabinet. The new chair has had a number of informal meetings with the CCG chair (the board's vice chair) and is working to develop a style of shared leadership with him.

The change in chair has coincided with an increase in the level of support the board receives and the deputy chief executive is now leading the officer input to and support for the board. Following the appointment of the new chair, the board's strategy is being refreshed with a view to agreeing a smaller number of more tightly focused priorities. The council's standard report format is being replaced to address perceptions that the board is a council-dominated body and to reflect its partnership role.

The board will provide governance oversight of the integrated commissioning executive. A providers' sub-group is being established and will be represented on the main board by one of the chief executives who is widely respected by the other board members. The board has decided to have regular "deep dive" discussions at board meetings on one of its priorities.

One of the board's early successes has been a wider, more strategic approach to alcohol than would otherwise have been the case without the discussion at the HWB, involving planning and licensing functions. The informal public sessions before the public meetings are now working well and provide an opportunity for debate and discussion.

Many of the interviewees identified examples of their boards adding real value. Most of these examples relate to specific initiatives focusing on a particular part of the health and care system or the needs of a particular user group. As the figure 5.1 illustrates, many of these examples arise from a constructively challenging discussion at a HWB meeting.

### *Figure 5.1:* Constructive challenge enables boards to add value

A constructively challenging discussion in a HWB meeting, agreement on the board's direction of travel and a time-limited piece of work to develop a more detailed way forward. These are the common features of most of the examples of boards having an impact which have been identified during the course of this work.

One board's decision to commission work on improved access to primary care services in one part of the borough was agreed at a board meeting at which there was a deputation on the topic and a discussion with the NHS England representative. The ability of boards to receive formal deputations is a good example of the value of their status as council committees.

Another board received a presentation on dementia by the CCG's clinical director. The subsequent discussion was a robust one, as a result of which a working group on the subject has been set up and is developing a revised approach. The CCG's accountable officer confirms that this was a good example of the CCG being held to account in a constructive way on an issue of strategic importance for the area concerned.

A third board, with an acute hospital in special measures, devoted part of a board meeting to a review of the key performance data. A task and finish group was set up including senior people from the acute trust, the CCG and the council to identify ways of reducing pressure on A&E. Action already taken includes the opening of a GP base in the A&E department and weekend opening of some GP surgeries.

Many of those involved in HWBs refer to the need for boards to create the conditions in which discussions can take place between the council, CCGs and providers on the future shape of the health and care system in their area. This is an important task, and enabling what will often be difficult conversations to take place in a safe environment is no mean feat. In terms of the broader health and care context this research has not identified examples of boards providing real leverage in the system or genuine systems leadership yet, although this is an ambition which many board members aspire to.

Boards have considered CCG commissioning intentions and their two and five year plans, but no respondents pointed to examples of where that has made a significant difference. People referred to the Better Care Fund (BCF) process doing more for HWBs (by bringing partners together) than HWBs did for the BCF.

A senior officer with responsibility for one HWB said that the board had added value by enabling people to keep on talking during a difficult reconfiguration process. But the board had not influenced the eventual outcome. It held the ring but it was not influential in crafting the eventual way forward.

The different perspectives of different board members shed some useful light on the dynamics within London's health and wellbeing boards.

It is clear from the case study research that HWB chairs have the single biggest influence over a board's focus and tone. Their relationship with the CCG and its representatives on the board lies at the heart of this. The chairs are the most likely to speak positively about their boards and to articulate its role in creating the conditions in which the leaders of the health and care system can work together (see figure 5.2). The more reflective chairs recognise that their boards, in common with most others, are on a journey with some way to go. They are the most enthusiastic about the possibility of boards taking on additional powers and responsibilities as part of a wider devolution of more power and responsibility to a local level.

*Figure 5.2:* **A chair's vision**

One chair of a London HWB has a clear vision of how she would like to see her board operating in 12 months' time.

Central to her vision is a board with a strong sense of shared leadership and where it is not obvious which organisation or function each member represents. She wants the board to become a place in which people are collectively held to account in a mature way.

In a year's time, she wants the board's agenda to be tightly focused on the big strategic issues with a shared understanding of the outcomes the board is seeking to achieve.

In her view at least three things need to be addressed if this vision is to be achieved:

- The board needs a common language: too often members use the same words but mean different things
- The board must be more confident in fending off local and national pressures which do not reflect its priorities
- The board requires high quality support, despite the financial pressures faced by councils and their partners.

Senior local authority officers are enthusiastic about the potential of HWBs. Almost all of them refer to boards being on a journey and are committed to sticking with it. They are pragmatic about the status of boards as council committees and the implications of that. They see the importance of boards in creating an environment of trust, enabling difficult conversations to take place in other settings, but they are also pragmatic about by-passing board structures if they think it is necessary in order to make progress.

CCG representatives are most likely to be frustrated by the lack of decision-making at board meetings and are less satisfied with the "condition-creating" role referred to above. They are frustrated by the formality of HWB public meetings, the lack of focus in some boards and the impact of "mission creep". Where they perceive a board to be working effectively they are powerful enthusiasts of it, but are most sceptical about the case for them taking on additional roles and responsibilities at this stage.

Board members from Healthwatch generally see HWB meetings as important, but they are very aware of their limited capacity (in terms of resource and time) and what that means for their ability to contribute to the board alongside, for example, senior officers from the council and CCG. They share the CCGs' frustration with the "set piece" nature of many council committees and are particularly sensitive to the potentially exclusive nature of small executive groups or briefing meetings.

Health providers are potentially strong supporters of boards playing a systems leadership role but are the most critical of and frustrated by the current reality

– in particular their perception that boards lack any decision-making powers. Their representatives express concern about what they perceive to be too much CCG influence over HWBs.

Several people interviewed for this research welcomed the NHS England representation at HWB meetings but expressed concern about sporadic attendance which they attributed to the resources available.

## Navigating the journey

A primary task of this research has been to understand those factors which can enable HWBs to become more effective and those which are likely to impede effectiveness. These factors can be grouped under five headings:

- How boards operate, how they organise themselves
- How boards set priorities and their strategic approach
- The context in which a board operates
- Engagement
- How boards approach the twin peaks of population health and the future of health and care.

### How boards operate

The government's decision that HWBs should be council committees was intended to provide them with a more formal status than, for example, local strategic partnerships had. Many of the interviewees, however, cited this as one of the main challenges facing boards. There are a number of dimensions to this. The apparatus associated with being a council committee can reinforce perceptions of HWBs as a "council thing". It can focus attention on the meeting rather than the board as an institution or system leader. There is also a tension between the way in which public meetings are managed in local government – balancing the requirements of formal meetings in public and political debate and challenge - and the type of forum required for constructive discussion and debate about action to improve health and wellbeing.

The more effective HWBs in London have created forums for honest and open debate either by ensuring that board meetings are planned and managed differently to other committee meetings or, more often, by creating alternative opportunities for board members to meet in informal settings. These include sub groups, chair's briefing meetings and development days.

Less effective boards often focus on council business and/or have long agendas with a large number of items for noting. The relationship with the scrutiny function is an important one (see figure 5.3): boards often revert to a scrutiny role which can duplicate the work of the council's health overview and scrutiny committee.

*Figure 5.3:* **HWBs and overview and scrutiny**

The relationship between the work of HWBs and councils' overview and scrutiny processes is seen as an important issue by many of the people interviewed as part of this work.

In one council a concerted effort is made to avoid duplication between the work of the board and the overview and scrutiny committee (OSC) and agendas for the two bodies are looked at in tandem. In one case the scrutiny committee asked the HWB to pursue a particular issue. In another case – an item on children's safeguarding – the HWB was advised that the topic would be scrutinised in detail by the OSC and as a result focused on more strategic dimensions and the potential contribution of other members of the board.

Another council has introduced a convention whereby the HWB's annual report is considered at an annual health scrutiny session. Scrutiny members also receive the HWB's forward plan which enables them to attend the board's meeting if they wish or to ask for a particular strategy or initiative to be scrutinised.

Some places have found that simple changes can have a big impact: for example not using council headed paper for board papers and splitting meetings into two sessions, one intended for informal discussion and the second comprising the formal meeting of the board.

Two other factors have a significant impact on how HWBs operate, both of which apply to many types of board. First, is that size matters. It is very difficult for a group comprising more than 15 people to operate as a board (rather than a committee). The experience of London HWBs reinforces this. Second, the role of the chair is critically important in at least three respects: setting the tone for the meetings themselves; influencing how the board operates – the number of priorities, what appears on agendas; and building relationships between the members of the board.

As reported above, the trend across London is for a marginal reduction in the number of boards that are chaired by the council leader. However, as part of its drive to strengthen the systems leadership role of its board, one borough has moved against that trend and recently appointed its leader as chair. It is also worth noting that in at least two cases where a councillor who is not in the cabinet has been appointed as chair they are well respected councillors with an undoubted ability to influence their councillor colleagues and command the respect of other board members.

## Priorities and strategy

It is clear from this research that those boards which are closest to our definition of effectiveness have a small number of priorities (five or fewer). They are also alert to the fact that, while having a shared vision or strategy in place is essential, it is important to go one stage further and ensure that the strategy has traction with the key organisations, most notably the CCG and major providers.

As the survey demonstrated many London HWBs have too many priorities. It is particularly important that boards are able to stick with their agreed priorities, yet this research shows how easy it is for boards to be distracted. Many of the people interviewed referred to the difficulty of "sticking with it" in the face of pressures from national bodies, including NHS England, and local pressures, for example requests from a multiplicity of local groups asking the board to consider a particular topic.

The danger of "mission creep" was identified by many of our respondents as a key challenge for boards. Many HWB chairs see one of their main roles as being to establish and maintain the board's focus, fending off potential distractions, national and local, with the support of their vice chair and/or executive group. However this research identified circumstances in which a desire to be seen to be responsive to local groups is in danger of undermining the coherence of the board's work programme.

## Context

The local context in which boards have been established and operate is critically important in understanding why a board operates as it does, where it is on the journey and how it can be helped to progress. This can take a variety of forms: cultural, political, financial and the impact of personalities.

Reference has already been made to the potential tension between the way in which many council committee meetings are managed and the need for HWBs to create a space for creative discussion. Where a council has a culture of relatively short public meetings, moving to a different, more discursive format and style of meeting would require considerable cultural change particularly for the council's representatives.

The potential for and impact of political change is part of the life blood of local government, but it can be the source of instability for a partnership body such as a HWB, with the potential to disrupt relationships and working patterns. This can apply specifically to the change in a board chair. This research has, however, identified at least two examples of a change in chair being part of a drive to improve the effectiveness of a board.

The difference in the scale of financial pressures facing health and local government, and different parts of a local health system, has been identified as an issue by a number of people. The contrast between a "burning platform" and a "smouldering" is seen as a cause of dissonance within boards – with one group seen as having an "easier time" than the other - hindering collaboration and joint working.

Personalities matter on HWBs as much as on other boards. The influence of Healthwatch appears to be particularly dependent on the personality and style of working of their representative. And, as was noted earlier, the relationship between the chairs of the HWB and CCG is very important. An acid test of board effectiveness is when the latter refers to the HWB as "us" rather than "you".

### Relationship with other structures

*Figure 5.4:* **HWBs and their sub-structures**

London's HWBs have adopted a variety of sub-structures to both enable delivery and provide a focus on specific topics.

One of the most elaborate set of arrangements comprises a formal sub-committee, three working groups and three task and finish groups. The sub-committee, which is a formally constituted body in the council's constitution, is the Health Protection Forum. It provides assurance on the adequacy of prevention surveillance, planning and response on health protection issues. Chaired by the director of public health, the forum's work includes communicable disease control, emergency planning and immunisation and screening programmes.

The working groups include:
- An Operational Partnership Group, designed to ensure delivery of the HWB's decisions
- A Provider Forum, to improve communication between commissioners and providers
- A User Patient Community Forum, chaired by the Healthwatch representative on the board, which aims to ensure that the concerns and interests of patients and users are the HWB's strategic focus.

These standing bodies are supplemented by a number of time-limited task and finish groups which currently focus on:
- Integrated care
- Hospital performance
- The Joint Strategic Needs Assessment.

This HWB also has a chair's group which plans the board's overall work programme and prepares for individual board meetings.

Another board follows a similar structure with an officer group, co-chaired by the DPH and the CCG's Director of Strategy and Planning. It agrees the board's forward plan, coordinates papers and ensures follow up to board decisions. The board also has:

- Delivery Groups taking forward each of the board's priorities
- Time limited task and finish groups focussing on the refresh of the JSNA and of the health and wellbeing strategy.

In most cases sub-groups and task and finish groups are chaired by officers, but in at least one case they are chaired by councillors and cover diabetes, dementia, children's mental health and obesity. In most parts of London the lead on cross-boundary working has been taken by the relevant CCGs, but in one case, as part of a long-standing and wider partnership arrangement, the three HWBs have charged a joint Children's Trust Board with responsibility for managing delivery of health and wellbeing priorities and work streams relating to children and young people.

Given the status of HWBs as council committees it is both natural and desirable that parallel structures have been established involving many of the organisations and people on the boards to have the honest conversations necessary to drive health and social care integration and joint commissioning. These structures, which vary widely in terms of scope, membership and purpose, include integrated commissioning executives and informal summits and may cover a wider geographical area than a single borough. Structures such as this (see figure 5.4) exist in the vast majority of places we have studied as part of this work.

In some cases these arrangements are explicitly within the auspices of the HWB, may report to it and may involve the chair. In some cases groups have been consciously established independently of the board because of concerns about the nature of board meetings and the quality of the relationships between board members. In other cases the relationship is ambiguous. Getting these relationships right is critically important in the light of the definition of effective HWBs set out in this report, which includes creating the conditions in which there is genuine collaboration between the key players and ensuring effective systems leadership.

The decision to establish a parallel structure to the HWB may well be sensible in a particular local context. There is, however, a danger that doing so could further weaken the board and make it more difficult for it to build the conditions for collaboration and lead systems change.

This research has identified little evidence of cross-border collaboration by HWBs, although one example is referred to in figure 5.4. There is much more evidence of collaborative working between CCGs, which in a number of cases involves local authority officers and in at least one case is led by a council chief executive. A number of interviewees referred to what they saw as a lack of impetus on the part of boards to engage in cross boundary working, reflecting the value they place on their single-borough focus. Discussions with HWB Chairs revealed that there is some evidence that boards are beginning to recognise the importance of cross boundary with an indication that there is an appetite to explore this further.

## Engagement

The engagement of HWBs with health and care providers has been the subject of much debate, particularly in the light of the Better Care Fund process. This often focuses on the question of whether they are on the board or not, and whether they have a vote or not. This research has identified a number of different approaches to involving providers, including one board which has done so through a sub-group with one representative on the board itself. Providers are concerned about board membership, but our work suggests that having one or more providers on a board does not necessarily lead to effective engagement with them. For many providers, seeing boards playing an effective systems leadership role is particularly important.

Wider engagement is a key factor in determining whether a board is effective or not (see figure 5.5). This is a two-way process, involving both listening and communicating. The most effective boards have an ability to influence all the key organisations in the wider health system. Less effective boards are not able to do so and are constrained by concerns about parity within the board's membership.

## The twin peaks

One of the board members interviewed described one of the challenges facing HWBs as being to "conquer the twin peaks". They were referring to the need to take action to both tackle the wider determinants of health and to play a systems leadership role, particularly in relation to the integration of health and social care. This involves a focus on the short and long term and on organisational, cultural and behaviour change. The vast majority of the board members interviewed aspired to achieve this objective, but none of the boards reviewed had achieved a truly effective balance, with interviewees referring to boards being either "public health-led" or "dominated by short term organisational issues".

*Figure 5.5:* **Engaging boards**

One HWB held a local Health Summit in 2013 to co-produce its Health and Wellbeing Strategy. Before each public formal board meeting (6-8pm) the board holds a one-hour seminar at 5-6pm on an important theme/item that the board is considering to which partners, residents and VCS organisations (including VCS providers) are invited. The approach is very informal, sitting in circles, so that everyone can contribute and citizens and voluntary organisations such as Age UK, MENCAP and Disability Advice can discuss issues directly with board members without the formal rules of the committee process. The subject is introduced for 10 minutes followed by the discussion. Usually about 20-50 people attend depending on the popularity of the subject, which have included prioritisation, integrated care and action planning from the Black Health and Wellbeing Commission report commissioned by the board. Generally about half stay for the formal public board meeting.

Attendance is advertised on the council website but the role of Healthwatch is seen as key to encouraging people to attend and ensuring a good representation of those keen to be involved in the local accountability arrangements for health and social care. Having an effective local Healthwatch (described by one board member as "our route to 200,000 people") was seen as key to being able to carry out these informal sessions at all as otherwise they would be "a huge amount of work" to organise.

The local Healthwatch has an engagement and research programme with academic partners, carers, the Learning Disabled Assembly, mystery shopping and assessment of care to get a "comprehensive bank of what good quality care looks like and user experience". It recently reviewed dementia services leading to a debate locally about loneliness, which the board has put on the agenda for its January 2015 meeting. This will also be the theme of the pre-meeting informal seminar between the board and the community.

The board sees its challenge for the future to be to get beyond this tier of involvement to set a strategy around engaging citizens and residents as a whole, with its role being to "hold the ring" and "challenge and cajole" its member organisations around community engagement in health and wellbeing.

## Setting the direction

Everybody interviewed for this research was convinced about the potential health and wellbeing boards have to offer. But, as noted earlier, they also acknowledged that all boards, including their own, are "work in progress". Many of the people who took part in this research, particularly HWB chairs, argued that HWBs should be given additional responsibilities especially in relation to commissioning. But they did so on the assumption that the capacity of boards to exercise a systems leadership role would be significantly strengthened.

In this context it is important to consider whether the issues identified as being enablers of HWB effectiveness (or likely to impede it) can be influenced at a local level. An important conclusion from this research is that the vast major of such factors can indeed be influenced locally – a view which was shared by the participants in the sense-making event held towards the end of this research. Indeed many of the boards reviewed are taking steps to address one or more of these issues by, for example, reviewing their priorities, changing their pattern and format of meetings or introducing new report templates.

There are choices to be made about the most important determinants of HWB effectiveness, most notably about:

I. The balance of board attention being devoted to the wider determinants of health as opposed to the future of health and care

II. How tightly to prioritise, how rigorously to stick with those priorities and how to respond to national and local pressure to address issues which are not a high priority locally

III. The settings in which boards meet, the balance between formal and informal settings and the extent to which all the protocols applying to other council committees should apply to a HWB.

IV. The length of board agendas and the balance between items for debate, decision and noting

V. What sub-groups and associated groups are necessary both to support and manage the work of the board and to provide a focus for action on, for example, joint commissioning, integration, or the future of health and care in the area (and how such groups should relate to the board, or not)

VI. What support is available to the board and, in particular, to the chair and vice-chair

VII. How inclusive the board is and how it engages with key stakeholders including health and care providers

VIII. How precise the board's strategy is and whether it is designed to influence the actions on key organisations in the local health system.

# 6. Conclusions

When HWBs were first established there were very high expectations about what they could deliver. A number of stakeholders argued that how well councils and their partners took on their new roles would be critical both in relation to improving the health and wellbeing outcomes of local communities, and to the reputation of local government and the broader case for localism and devolution. The NHS Five Year Forward View, with its focus on joint commissioning, integration, patient and community engagement and local leadership reinforces the potential importance of the contribution of HWBs. In addition, there is a debate nationally about the potential for giving HWBs additional powers and responsibilities.

The vast majority of the people interviewed for this research are convinced of the potential of HWBs to fulfil the roles envisaged for them in the Health and Social Care Act 2012. Many, particularly chairs, are confident that they could successfully undertake a broader range of responsibilities. But they almost all referred to their boards being "on a journey" or "work in progress" and not yet realising their full potential.

There are many examples of specific initiatives by London HWBs adding real value – to for example action to tackle dementia or reduce the pressures on A&E services. Where London boards have so far made less progress is in exercising effective systems leadership and really driving the transformation of the health and care system. Some boards are seen to be very much a local authority body, often reverting to a scrutiny type role with long agendas but few items for decision.

It is important to note that work Shared Intelligence is carrying out for the Local Government Association suggests that the picture in terms of HWBs nationally is very similar to that in London. This would suggest that London HWBs are coping well given the additional London pressures they face – in terms of the scale and complexity of its population, the complicated nature of the health economies in the capital, high levels of deprivation and health inequalities and specific public health challenges including sexual health, high levels of substance misuse, TB, mental health and very high levels of childhood obesity.

Many of the chairs and local authority officers interviewed during the course of this research had a good understanding of where their board is on its journey and were either taking or considering action to enable the board to become more effective. This ranged from a new chair being appointed through to abandoning standard council report templates.

This is encouraging, but it is important to acknowledge that boards were formally established over 18 months ago. If the aspirations that many people have of HWBs are to be met, if the boards are to successfully contribute to the implementation of the NHS Five Year Forward View, if boards are to be given additional powers, and if they are to pass the localism litmus test it will be important that faster and sustained progress is made.

A core conclusion of this research is that the factors which determine the effectiveness of HWBs are capable of being influenced locally. Key to this is ensuring that effective collaborative leadership is in place. A board which wishes to establish where it is on the HWB journey and what steps it should take to make faster progress should ask itself the questions set out in figure 6.1.

*Figure 6.1:* **The HWB Journey: Self-Assessment Questions**

Are we achieving a sensible balance of activity between the wider determinants of health and the future of health and care?

- Is our prioritisation robust enough?
  - Are we sticking with our priorities?
  - Are we resisting national and local pressures which would divert us from our agreed priorities?
- Have we created the conditions for honest and open discussion?
  - Are we meeting in formats which enable honest conversations, open debate, decision-making in public and effective engagement?
  - Do our agendas support these tasks?
- Have we created appropriate sub-groups to manage our business, deliver our work programme and provide effective systems leadership?
- Is our strategy influencing actions and decisions by all the key organisations in the local health system?
- Are we clear who we need to engage with and how? Is our work relevant to the pressures being faced by health and care providers?
- Do our board, chair and vice chair have appropriate support?

A thread running through this report has been the analogy of HWBs being on a journey. The impending general election means that there is some uncertainty about where that journey might go next. What is clear, however, is that health and care are a key election issue and will inevitably feature high on the list of priorities of any future government. All the major political parties are committed to devolution and to a continuing role for HWBs – indeed the Labour Party is committed to strengthening their commissioning responsibilities. In addition, as noted earlier, a central theme of the NHS Five Year Forward View is greater collaboration and innovation at a local level.

This presents a major opportunity for Health and Wellbeing Boards to play the lead role in developing health and care systems which meet the needs of their local communities. That will require collaborative local leadership of the highest quality. HWBs provide a vehicle for exercising that leadership. This research shows that they have not yet achieved their full potential. It has also identified a number of actions that can be taken locally to realise that potential.

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