HEALTH & WELLBEING
BOARDS: ORCHESTRATING
THE POSSIBLE FOR
INTEGRATED CARE

How Boards can harness
the energy of partnerships
to achieve real change

Carol Ward  Catherine Mangan  Robin Miller

Institute for Local
Government Studies
Health Services
Management Centre

CONNECTS
Health and Social Care
The Health & Wellbeing Collaborative is a joint initiative between OPM, the Institute for Local Government Studies and the Health Services Management Centre. It arises from a shared commitment to support health, social care and other sectors to work together to deliver better outcomes for service users, patients, their families and their communities. Focused in particular on the role, responsibilities and broader networks of the Health & Wellbeing Boards we seek to provide insight, research and support to facilitate integration with impact.

If you are interested in finding out more about the Health & Wellbeing Collaborative, please email HWBcollaborative@opm.co.uk.
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INTRODUCTION

On April 1st 2013 health and wellbeing boards moved out of the shadows to formally take on responsibility for improving health and wellbeing and reducing health inequalities in their areas. They face many challenges, not least reductions in local authority budgets, increasing demands due to an ageing population, the restructuring of the NHS, and a challenging public health agenda. They do, however, have new resources at their disposal such as new assistive and communicative technology, budgetary flexibility, and unprecedented opportunities for clinical and community engagement. There is also a growing consensus across the health, social care and wider system that integrated commissioning and delivery are necessities rather than optional extras. Health and wellbeing boards are uniquely positioned to exert their system leadership to deliver major transformational change.

An apt metaphor for the new health and wellbeing boards is the orchestra. Different musicians come together to play beautiful music, and their melodies, harmonies and rhythms blend so that the listener hears the piece holistically. While the conductor ensures all the musicians play their parts, each section of the orchestra has its principals, its own leaders. Leadership in the orchestra is, in essence, sharing the vision for a musical score, but also acknowledging the central role of individual players and their instruments. In a similar way, we think health and wellbeing boards can harness the energy of partnership working to realise the potential of integrated care. Through their powers, they can convene member agencies around a joint vision, strengthen working relationships and align resources.

We have taken this same notion of collaborative working to heart. Through our previous work with health and wellbeing boards, OPM, the Institute for Local Government Studies (InLOGOV) and the Health Services Management Centre (HSMC) have formed the Health and Wellbeing Collaborative. Our aim is to provide insight, research and support for health and wellbeing boards as a means to facilitate their development. We have collectively been privileged to work with over 70 shadow boards over the last year. This includes jointly facilitating regional challenge events as part of the broader joint Department of Health and Local Government Association (LGA) support offer to health and wellbeing boards. We helped participants work through ‘real life’ case studies whilst observing, reflecting back and challenging them during the process. Boards shared their frustrations, insights and approaches, and the events identified their emerging development needs and future action plans.

Many of the board members we met are excited about the potential to drive forward integration, better engage communities and to ultimately improve the health and wellbeing of their local community. The majority see this as a real opportunity to make a difference and overcome some of the barriers to integration that have existed previously. There are others, however, who are concerned that this may be another initiative that promises much, but delivers little. Historically, we have seen strategic partnerships bogged down with debates around structures and processes, a waning of initial enthusiasm and ultimately losing sight of what they were aspiring to achieve. So how can we ensure that we make a difference this time? What critical learning from our previous partnership experiences can we build on and what have we learned during the health and wellbeing board shadow period?

Based on our observations and the wealth of experiences that participants shared at the regional events and in our other engagement, we pose four key questions to health and wellbeing boards to ensure that they orchestrate system change and bring about integrated care.
1. HAVE YOU GOT THE BASICS RIGHT?

In the challenge events we found that ‘basic’ process issues were a major focus of concern for participants. These included a lack of clarity in terms of reference, roles and responsibilities, along with concern over how to develop good relationships within and external to the board. The checklist questions below may help you to consider your current position:

1.1 Have you got the right membership?

Beyond the core statutory members, membership is down to local area decision making. Some boards were intentionally staying small to ensure manageable meetings, whilst others opted to be more inclusive. The latter enables representation from district council leads, proportional representation of councillors, providers, voluntary and community sector representatives, police and crime commissioners, local housing and others. Choices on size and membership must be dependent on the local situation and there are other ways to engage and include other than membership. The key issue in terms of board functioning is ensuring that members are clear how they are expected to represent their agencies or stakeholder groups and that, in turn, they are given the authority to participate and make decisions.

For example: One two tier area we worked with has more than 20 members, including the chair and CEO of each clinical commissioning group (CCG) and representation from the districts, whereas others have included only core members, whilst also trying to find alternative ways to engage other key stakeholders. Another county has created district level boards, with functions delegated to them by the county level board.
1.2 How will the board be chaired?
A large number of health and wellbeing boards have selected the leader of the council to be the chair, based on a rationale that the board is a sub-committee of the council’s cabinet. Others have identified clinical commissioning group leads, public health directors or even shared chair roles between health and local authority members in an attempt to promote collegiate working.

The role of the chair is vital for the effectiveness of the board. The chair will at times be expected to engage board members and facilitate difficult conversations and decision making processes. In many cases we observed excellent chairs who were inclusive, focused and able to engage all members. However, there were occasions when these skills were lacking as some chaired the sessions in the style of formal council committees, which stifled discussion and debate. Alongside the skills needed to make sure that they get through the agenda and focus on key priorities, chairs will also be expected to be good facilitators who can enable discussion, read group and individual interactions, and ensure that the public voice is heard. It is therefore essential that whoever chairs the board is not only the appropriate representative, but that they also have the right skills to do so. It is also vital that a deputy is appointed and that the Chair will trust their deputy to lead in their absence.

1.3 Where does the board fit in with existing structures?
Most boards are recognising that there are a number of existing partnerships and governing bodies that they need to work with in order to achieve their joint priorities. These include children’s trusts/partnerships, existing integrated care groups and joint commissioning groups. Most participants were also concerned about their future relationships with the health overview and scrutiny committee and safeguarding boards.

An example of how one board (Luton) has reviewed existing structures and developed a working model for the future is set out on page 111.
1.4 Are you clear about the functions and responsibility of the board?

Health and wellbeing boards have a number of defined core, statutory functions:

- To prepare joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies (JHWSs);
- A duty to encourage integrated working between health and social care commissioners, including providing advice or assistance or other support to encourage section 75 (NHS Act 2006) arrangements around lead commissioning, pooled budgets and/or integrated provision;
- The power to encourage close working between commissioners of health related services and the board itself;
- The power to encourage close working between commissioners of health related services, such as housing and other local authority services and commissioners of health and social care services; and
- A duty to involve the public in preparation of JSNAs and JHWSs.
- Other functions delegated by the council, e.g. public health or joint commissioning functions.

We found that boards were not totally clear about their role, as shown by the typical questions raised during the events (see below).

**Examples of questions raised by challenge event participants on the role of the board:**

- ‘Are we a commissioning board or an overarching scrutiny/discussion process?’
- ‘What is the HWB board accountable for?’
- ‘What are the HWB board’s decision making powers?’

The interpretation of these functions also differed within the boards we worked with. These ranged from those who were focusing purely on the production of the joint strategic needs assessment and joint health and wellbeing strategy, (i.e. those who thought ‘we are a board of commissioners, not a commissioning board’), to those who were seizing the opportunity to integrate commissioning and support the provision of integrated care.

Accountability for quality of care and services for the local population was a heavily debated issue. This brought into focus the relationship between the board and other bodies, including the local authority cabinet, the local Overview and Scrutiny Committee (OSC), the safeguarding board, the NHS England and local area teams, and the Care Quality Commission (CQC). This is of even greater importance since the publication of the Francis Report.

Most boards were starting to consider how to operationalise their health and wellbeing strategies and how to hold constituent members to account for their participation in progressing the joint priorities. Those who seemed more confident were those who are utilising existing partnership arrangements such as the Children’s Partnership or an existing Integrated Care Partnership.
1.5 Is the role of Healthwatch clear?
A significant number of board members expressed unease and a lack of clarity around the role and responsibilities of, and relationships with the local and national Healthwatch. It was telling that Healthwatch participants made up only 8% of participants at the events.

Some areas were using existing representatives, such as previous Local Involvement Networks (LINKs) reps.

Although this promotes continuity, there is a danger that nothing will change and that this could be seen as tokenism. Conversely, a number of other councils were commissioning a different form of representation from new organisations. Most recognised the inherent tensions and a current lack of clarity in the Healthwatch role.

1.6 Can board members have difficult conversations?
A crucial function of health and wellbeing boards is to strengthen working relationships between health and social care and encourage the development of integrated commissioning. This will only happen if strong partnership relationships are in place. In the challenge events, we identified a number of partnership enablers and disablers. These are not new, but they need to be recognised if the boards are to make a difference.

‘Board members need to be able to deal with issues of conflict in the future. They are currently very polite and respectful to each other’
— Facilitator at an East of England HWB Challenge Event

Disabling factors included the different organisational cultures, terminology and language used, a lack of common understanding and a perceived potential future protection of organisational budgets. Examples given were that open difficult conversations are not always had, partners often don’t understand each other’s language and health leaders may find it hard to understand the role of democratically elected leaders and cabinet. Even environmental factors such as holding meetings in an officious council chamber can impact on the quality of debate, discussions, and ultimately, the effectiveness of the overall board.

Enabling factors were defined as recognising that there will always be different views, but that difficult honest conversations need to be had to define an aligned purpose, a common voice, ongoing trust in each other and a sense of where the board adds value. Effective leadership was also seen as being critical to the board’s future success.

Key lessons from the Gloucestershire health and wellbeing board:

1. Invest time in developing and nurturing relationships. Be inclusive of all board members as communication within the board is as important as communication from the board.

2. Try not to get too bogged down in process – use scenarios or real examples to test out how the board will operate. Ask challenging questions of each other; and

3. Acknowledge the difference between the different organisations that make up the board. Find out about each other so there is a good understanding of the drivers and challenges for each organisation.

(LGA Case studies)
2. HOW WILL YOU ENGAGE STAKEHOLDERS?

Patient and public engagement needs to be part of the DNA of health and wellbeing boards from the start. However, boards are operating in a crowded and undefined space when it comes to patient and public engagement and there is a danger of duplication between organisations, for example, between CCG activities and Healthwatch. Boards need to consider how they are engaging different groups, and how this will build on and not duplicate pre-existing arrangements.

2.1 How will you engage the public?

Most health and wellbeing boards appear to have been involving local people in the preparation of the joint strategic needs assessment and the development of their joint health and wellbeing strategies, with varying degrees of success. Some are using this as an opportunity to engage the public in determining local assets that are available to address local needs, truly enabling co-production of their strategy. This includes using innovative methods to involve the public, for example, hosting ‘big debates’ on key health issues such as alcohol being held in Worcestershire.

Others are seeing the consultation process as a duty, rather than an opportunity. One director of adults services asked ‘How much does the Health and Wellbeing Board have to do?’. She went on to explain that this was in the context of a lot of local patient and public engagement activities, which are currently organised by either the local authority, clinical commissioning groups or local patient/public representative groups. This demonstrates the need to identify an engagement strategy across the partnership, which builds on each others’ activities rather than duplicating.
2.2 How will you engage providers?

Engaging providers, without compromising the decision-making authority of commissioners, was increasingly recognised as an issue. Concerns were expressed about the power of large providers, particularly acute foundation trusts in determining strategic direction. Some referred to it as being ‘the tail wagging the dog’. Local authority commissioners in the main are more comfortable and experienced in involving providers in the co-designing and development of new services.

Providers we worked with felt their operational experience and detailed understanding of user and patient needs, especially with regard to developing new provision, supports their view that they should be involved in strategic decisions, rather than simply ‘receiving’ plans and implementing them.

Some boards had providers as members, whereas others had set up alternative engagement systems for providers. An example of the latter is Derbyshire health and wellbeing board, who set up a provider forum in 2012 to ensure that key providers are engaged in the board’s priority areas.5

2.3 How will you identify and engage with other key stakeholders?

A number of other key stakeholders were identified as critical to the ongoing success of health and wellbeing boards. These included those who are within the organisational structures of the constituent board partners (e.g. CCGs and their wider GP membership, local councillors and cabinet members), along with those involved in the wider determinants of health and well being, such as police and crime commissioners, housing, employment leads and the education sector. A proportion of boards are including a number of these stakeholders on the board, with the associated effect on board size, whereas others are developing other approaches (see example from Bristol, page 19).

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**Case study: Bristol**

Bristol shadow health and wellbeing board hosted a stakeholder conference involving board members and other stakeholders such as local universities and third sector representatives who are not members of the board, to discuss priorities for the board’s first joint health and wellbeing strategy. Voluntary and community sector organisations in Bristol also organised an event to feed into the development of the strategy. The priorities identified are now being developed by a small strategy group chaired by a GP member of the health and wellbeing board, supported by officers and reporting regularly to the board. A draft strategy will be published for formal public consultation before being finalised.

To find out more, you can get in touch with Kathy Eastwood, Service Manager, Health Strategy (kathy.eastwood@bristol.gov.uk)

(LGA Case study6)

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Boards have also been considering how they will relate to NHS England (previously known as the NHSCB), and the local area teams (LATs). Again, some boards have included their local LAT member on the Board. However, there were some recognised tensions around future accountability and some concern was expressed that boards may be less open and honest in the presence of local area team representatives.
3. HOW WILL YOU ADD VALUE?

Common to all the boards was a wish to genuinely make a difference and to use the new arrangements as an opportunity to achieve their individual and collective aspirations for the local population. Also, shared though, was an uncertainty about how best to do add value above the existing and previous arrangements.

3.1 How will you add value above single agency working?

In early shadow form most boards were understandably focusing on developing new structures, systems and undertaking their JSNAs and JHWWBs. Some were unclear as to how they could differentiate their activity from their predecessor partnerships.

More of the same?

‘Our health and wellbeing strategy is currently just a culmination of our separate plans, not convinced yet about improvements in integration’

— Participant at a HWB Challenge Event

As the boards are starting to mature, there is an increasing focus on how they will differentiate their combined activities from those of their individual partners. This is critical for the board being able to demonstrate future impact. The partnership working around the process of undertaking the JSNAs and developing the board strategies, whilst beneficial in itself as a commitment to future activity, will be more meaningful if the boards can identify specific priorities that board members can commit to. This would utilise their combined energy and resources to promote integration of care.

Adding Value:

‘Boards need to identify their value added contribution – what they are doing that is in addition to what currently exists. They need to be strategic and be able to ask key questions’

— Trevor Boyd, Buckinghamshire speaking after a HWB Challenge Event on the LGA video
3.2 How will you encourage integrated working?

The duty to encourage integrated working is being interpreted differently across health and wellbeing boards. Some boards are taking a ‘hands off’ strategic approach, believing that current joint commissioning and integrated approaches are sufficient. Others are taking the opportunity to strengthen and oversee joint commissioning and operational delivery via sub structures of the board. This was identified by some as particularly important due to the major changes to health care commissioning, and the risk of partners protecting organisational budgets within the current context. Although there will always be distinct health and local authority budgets, for boards to succeed in any integrated working there will need to be transparency and potential alignment of resources to effectively achieve shared priorities.

3.3 What resources are the different agencies willing to bring to the table?

Agencies around the board table need to understand what resources are available to achieve the health and wellbeing board strategic priorities and to promote integrated working. We heard that sharing of information around individual partners resources has often been quite a difficult arrangement, with some partners more reticent to divulge or unable to accurately differentiate allocated budgets. An example given was children’s health budgets.

Some health and wellbeing boards are transparent regarding the available budgets available from all parties, but have not yet taken additional steps to pool or align resources. Others (as can be seen in the Barnsley example, page 23), are seizing the opportunity to be the ringmasters of integration and are pooling their budgets to transform services and care.

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**Case study: Barnsley**

The intention in Barnsley is for the health and wellbeing board to identify the totality of spend on health and social care and to use this on a pooled/aligned basis to address the needs of the Barnsley population. Due to the strategic nature of the board, a series of supporting sub groups will take elements of the work forward, on behalf of the board, and report back periodically to inform policy direction and resource allocation. This includes a senior strategic development group – effectively the executive group reporting to the main board. The role of this executive group is to ensure that implementation and actions are delivered by those responsible and to pull together the different agencies’ ‘transformation plans’ into a whole system plan which supports the health and wellbeing board in delivering its vision and outcomes. In addition, a joint commissioning group is being developed to coordinate the use of public funding and resources.

To find out more, contact Martin Farran, Executive Director of Adults and Communities (martinfarran@barnsley.gov.uk)

(LGA Case study 6)
4. HOW WILL YOU KNOW IF YOU ARE MAKING A DIFFERENCE?

Evidencing the impact of partnership working is notoriously difficult, due to difficulties of clarifying which initiatives have contributed to any changes, which would have happened in any case, and the wider ripples (good and bad) that a partnership has introduced into the system. However, understanding the results of these new ways of working is vital if the boards are to have credibility and introduce more reflective and learning approaches to the oversight of integrated working.

4.1 Have you agreed what you are trying to change?

An important first step in evaluating the impact of the board is reaching an agreed view on how you want things to be different. This will include changes in patient and service user experience, achievement of clinical, personal and population outcomes, and efficient use of resources. It will also potentially incorporate how commissioners and providers work together, the process through which decisions are made and the degree of reciprocity and trust that has been developed.

4.2 What kind of performance measures will you use?

Measuring the effectiveness of the board will be a challenge. From the discussions heard, there is a danger that the focus will be on process and output measures. For example, the timely production of joint strategic needs assessments and board strategies, or the effectiveness of the partnership e.g. by measuring board meeting attendance. Whilst useful, these will not measure the impact of the board on improving the health and wellbeing of the local population and in reducing health inequalities.

The priority outcomes identified in the health and wellbeing board strategies are often long term expectations and more difficult to measure in the short term. Intermediate outcomes and evidence-based attributable outputs will need to be identified and built into future performance management.
SUMMARY

Health and wellbeing boards are facing significant challenges as they take on their formal role as orchestrators of integrated care. In the context of increasing population needs, decreasing resources and the reorganisation of health service commissioning, there are a number of key challenges and difficult decisions that they will need to make.

They will need to consider their leadership and governance as an iterative process. Learning through action, and accepting that appropriate governance and ways of working will emerge over time. In the spirit of promoting ongoing development and continuous learning, we offer these thoughts and a summative checklist of key questions below that boards can use to challenge themselves and to support them in overseeing an orchestra that enjoys a long and successful run.

CHECKLIST OF QUESTIONS FOR HEALTH AND WELLBEING BOARDS

1   Have you got the basics right?
1.1  Have you got the right membership?
1.2  How will the board be chaired?
1.3  Where does the board fit in with existing structures?
1.4  Are you clear about the functions and responsibility of the board?
1.5  Is the role of Healthwatch clear?
1.6  Can board members have difficult conversations?

2   How will you engage stakeholders?
2.1  How will you engage the public?
2.2  How will you engage providers?
2.3  How will you identify and engage with other key stakeholders?

3   How will you add value?
3.1  How will you add value above single agency working?
3.2  How will you encourage integrated working?
3.3  What resources are the different agencies willing to bring to the table?

4   How will you know if you are making a difference?
4.1  Have you agreed what you are trying to change?
4.2  What kind of performance measures will you use?
REFERENCES

1. LGA. Health and Well Being Boards: A practical guide to governance and constitutional issues. 2013
“The real art of conducting consists in transitions.”
— Gustav Mahler

“Here are two golden rules for an orchestra: start together and finish together. The public doesn’t give a damn what goes on in between.”
— Sir Thomas Beecham

“An orchestra conductor faces the ultimate leadership challenge: creating perfect harmony without saying a word.”
— Itay Talgam