The King's Fund

Ideas that change health care

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Health and wellbeing boards
One year on

Key messages

- Health and wellbeing boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the health and care system could work together to improve the health and wellbeing of their local population and to promote integrated services. They operated on a shadow basis for the first year, and became fully operational on 1 April 2013.
- The new boards seem to have used their shadow year well: relationships between clinical commissioning groups (CCGs) and local authorities are reported to be very good and getting better and have withstood a demanding year of complex organisational change and mounting pressures on services and budgets.
- Local authorities have shown strong leadership in establishing the boards, with most being chaired by a senior elected member. There is an emerging pattern of vice-chairs coming from CCGs, which augurs well for the partnership between CCGs and local authorities that is at the heart of an effective board.
- Most boards have invested time in developing and establishing themselves, and nearly all have produced joint strategic needs assessments (JSNAs) and health and wellbeing strategies. Although national development support through the national learning network for health and wellbeing boards has helped the shadow boards to plan and prepare, there is wide variation in the progress they have made and their capacity for further development. The financial climate plus confusion about the roles of new organisations in the reformed health and care system are seen as the biggest factors that will impede progress.
- The highest priorities in the health and wellbeing strategies of most boards concern public health and health inequalities. Although this shows that public health is having a real influence and impact on local authorities, there is little sign as yet that boards have begun to grapple with the immediate and urgent strategic challenges facing their local health and care systems. Unless they do, there is a real danger that they will become a side show rather than a source of system leadership.

- Most boards want to play a bigger role in commissioning services for their local populations. The requirement that boards sign off local plans for the Integration Transformation Fund will be an important test of their readiness to take on a stronger commissioning role across all services. Strong and purposeful relationships between CCGs and their respective local authorities – based on partnership not takeover – offer the best prospects for boards to lead the integration and transformation of local services effectively.
- Boards themselves recognise that that they need to change gear, building on the investment in their development during the shadow year to establish a firm grip on local issues and make a real difference to services and outcomes. If the boards are expected to shift from being a partnership forum to playing a bigger role in commissioning, this will have important implications for their size and composition and the professional support they will need.

Introduction

Health and wellbeing boards are an important feature of the reforms introduced by the government in the Health and Social Care Act 2012. Unlike other aspects of the changes, the creation of these new bodies has been widely welcomed and enjoys cross-party support. All upper-tier local authorities set up boards in shadow form from April 2012, and these became fully operational on 1 April 2013.

The overall purpose of the boards is unchanged from that envisaged – to bring together bodies from the NHS, public health and local government, including Healthwatch as the patient's voice, jointly to plan how best to meet local health and care needs. Their principal statutory duties are:

- to assess the needs of their local population through a JSNA
- to set out how these needs will be addressed through a joint health and wellbeing strategy that will offer a strategic framework in which CCGs, local authorities and NHS England can make their own commissioning decisions
- to promote greater integration and partnership, including joint commissioning, integrated provision and pooled budgets.

There has been general agreement about the value of boards as a means of bringing together the major local partners that are responsible for addressing the health and wellbeing needs of their local populations. The roles and responsibilities of different national and local organisations have become more complex as a result of the government's reforms, and the need for a local mechanism for partnership and co-ordination has never been greater.

However, the new boards became operational at a time not only of organisational challenge but also of unprecedented financial pressures on both the NHS and local government, and of changing patterns of need that demand radical changes to how we fund, commission and deliver health and care (Ham *et al* 2012).

This raises important questions about how health and wellbeing boards will work in practice and what difference they will make. In our previous report, published shortly after the shadow boards were established, we concluded that the single biggest test for the boards would be whether they could offer strong, credible and shared leadership across local organisational boundaries (Humphries *et al* 2012). One year on, expectations of what the boards should deliver have never been higher. What has changed? How have the boards used their shadow year and what have they achieved? Can they provide effective leadership across local systems of care?

Background to this report

This report forms part of a wider programme of work on health and wellbeing boards that is being carried out by The King's Fund. This reflects two of our strategic priorities – the future of the health and care system, and the integration of care for older people and people with complex conditions. The main objectives of our work on health and wellbeing boards are:

- to gain insight into how local authorities and their health partners are implementing health and wellbeing boards in the context of the government's reforms of the NHS and the adult social care system
- to identify the lessons that could be applied to the roll-out of health and wellbeing boards elsewhere, the issues that local authorities and their health partners need to address in the next stage of their development, and the implications for policy.

So far, we have supported several local authorities and their health partners to develop their shadow boards and have contributed to national development work led by the Local Government Association, NHS Confederation and Department of Health (Local Government Association 2013). In July 2011, we held a summit with more than 100 delegates from local government, the NHS and the third sector, and a further event in September 2012 (Humphries 2013).

In April 2012, our report *Health and Wellbeing Boards: System leaders or talking shops?* (Humphries *et al* 2012) set out our assessment of progress and prospects based on telephone interviews with 50 local authority areas covering all regions of England to find out how they and their health partners were implementing the new boards.

To discover how the shadow boards had developed and what had changed since our 2012 report, we carried out an online survey in May 2013. This survey was sent out to 152 local authority areas, of which 70 responded, a response rate of 46 per cent (for responder characteristics see Appendix A; for interview responses see Appendix B). This report sets out the findings of this latest survey, presents the changes that have happened in the policy context since last year, and discusses how the work of these boards may continue to develop in future.

Policy developments

The role of health and wellbeing boards was ratified by the enactment of the Health and Social Care Act 2012 and the new boards became fully operational in all upper tier local authority areas on 1 April 2013. The Act sets out the functions of the board – a statutory committee of the local authority – its powers, duties and membership. It allows local authorities considerable flexibility in how they set up and run their board, and the government has subsequently avoided prescribing this through further statutory guidance. The principles underlying boards have been summarised as:

- shared leadership of a strategic approach to the health and wellbeing of communities that reaches across all relevant organisations
- a commitment to driving real action and change to improve services and outcomes
- parity between board members in terms of their opportunity to contribute to the board's deliberations, strategies and activities
- shared ownership of the board by all its members (with commitment from their nominating organisations) and accountability to the communities it serves

- openness and transparency in the way that the board carries out its work
- inclusiveness in the way in which it engages with patients, service users and the public (Local Government Association and Association of Democratic Services Officers 2013).

The government has issued formal statutory guidance to explain the duties and powers relating to JSNAs and joint health and wellbeing strategies (Department of Health 2013b), but it should be emphasised that this does not cover the wider *modus operandi* of boards or which services should be commissioned in response to local needs: it is for boards themselves to determine what their overall priorities should be (*see* Figure 1 below).

Figure 1 Health and wellbeing boards at a glance

The boards will bring together those who buy services across the NHS, public health, social care and children's services, elected representatives and representatives from Healthwatch to plan the right services for their area. They will look at all health and care needs together, rather than creating artificial divisions between services.

(Department of Health 2011)

Core membership:
- local authority director of adult social care
- local authority director of children's services
- director of public health
- elected member (at least one)
- clinical commissioning group
- Healthwatch

Functions:
1. Fulfil duty to promote integrated working
2. Produce a joint strategic needs assessment
3. Develop a joint health and wellbeing strategy

Timescales:
- 132 early implementer sites announced in March 2011
- shadow boards in all 152 councils by April 2012
- full boards by April 2013

The NHS planning framework for 2013/14 described the boards as 'the key partnership forum for determining local priorities and providing oversight on their delivery', and affirmed the commitment of the NHS Commissioning Board (now NHS England) to be actively engaged in every board and its expectation that each clinical commissioning group will also be a strong contributor (NHS Commissioning Board 2012, p 11).

The core function of the boards to promote integration has been reinforced by policy developments in this area. A new national collaboration to promote integrated care has been established, supported by a new Integration Transformation Fund of £3.8 billion from 2015. Local plans for the use of this money have to be agreed between the local authority and CCGs, so health and wellbeing boards will be expected to sign off local plans: 'The [health and wellbeing board] is best placed to decide whether the plans are the best for the locality, engaging with local people and bringing a sector-led approach to the process' (Local Government Association/NHS England 2013, p 4).

This reflects the conclusion of the House of Commons Health Committee that the role of the boards should be strengthened even further so that the funding, planning

and commissioning of all services be brought under their remit. It recommended that 'health and wellbeing boards and clinical commissioning groups should be placed under a duty to demonstrate how they intend to deliver a commissioning process which provides integrated health, social care and social housing services in their area' (House of Commons Health Committee 2013a, para 100, p 30).

Enthusiasm for the boards is not confined to the government. The Labour Party has launched a policy discussion about a different approach to integration based on 'whole person care' that could see the commissioning of all health and social care services becoming the responsibility of health and wellbeing boards, while services would be integrated into local NHS trusts (Health and Care Policy Commission of the Labour Party 2013).

There are tensions, however. The creation by NHS England of Local Urgent Care boards to develop plans to address pressures in local accident and emergency services appears to cut across the role of health and wellbeing boards. As the House of Commons Health Committee put it: 'Any coherent plan to restructure the system to meet urgent care needs will need to involve all participants in a Health and Wellbeing Board; it is unclear … why a second coordinating body needs to be created in parallel with health and wellbeing boards which are not yet four months old' (House of Commons Health Committee 2013b, para 52, p 21). That in the eagerness to address an immediate and pressing problem, the role of the health and wellbeing boards appears to have been overlooked suggests that it is easier to change new organisational structures than behaviour.

Nevertheless, there do seem to be generally clear, shared policy messages about the importance of boards and, if anything, an appetite to strengthen their role. This raises important questions about the ability of boards to deliver these expectations. What do we know about the work of the shadow boards, how they are operating, what priorities they have chosen and what they have achieved?

Overview of the 2012 survey

Our last report, based on a survey of shadow boards in late 2011, painted a positive and optimistic picture in which boards were seen to offer new and exciting opportunities to co-ordinate local services, create new partnerships with general practice and deliver greater democratic accountability. The key messages that emerged were as follows.

- Boards needed to be clear about what they wanted to achieve. We found potential tensions between their role in overseeing commissioning and in promoting integration across public health, local government, the local NHS and the third sector.
- Despite the rhetoric of localism, many of the shadow boards were concerned that national policy imperatives would override locally agreed priorities and were uncertain about the extent to which they would be able to influence decisions made by NHS England. The roles and responsibilities of all the new bodies needed to be defined more clearly.
- Although some shadow boards were taking an imaginative approach to engaging with stakeholders, the exclusion of providers had the potential to undermine integrated working. Local authorities needed to look at fresh ways of working with local partners rather than rebadging previous arrangements.
- The creation of health and wellbeing boards was not going automatically to remove all of the barriers to effective joined-up care. For boards to succeed, a stronger national framework for integrated care was required, with a single outcomes framework to promote joint accountability.

- The discretion given to local authorities in setting up boards meant that different approaches would emerge, with some inevitably being more effective than others. Capturing and sharing the lessons learned by shadow boards was likely to be vital for avoiding simply adding a further layer of unacceptable variation to the system.
- The biggest challenge facing new boards was whether they would be able to deliver strong, credible and shared leadership across local organisational boundaries. Unprecedented financial pressures, rising demand and complex organisational change was expected to severely test their political leadership. Board members needed time and resources to develop their skills and relationships with other stakeholders.

One year on, what has changed as a result of the shadow experience?

Survey findings

Who leads the board?

Most boards – 83 per cent – are chaired by a local authority elected member, with this being the leader of the council in nearly half the cases. The seniority of the people appointed to these roles reflects the importance that local authorities attach to the boards, and there seems to be a high level of political leadership.

Unusually, two local authorities sought an independent chair, and another two had yet to decide who should be their chair at the time of our survey.

In the case of the vice-chair, 48 per cent had come from the CCG, and 34 per cent were elected members. The remainder were drawn from a variety of different backgrounds, such as the director of public health, the Healthwatch representative or the director of adult social care.

Size and composition of the board

Size

This size of the board is important because if there are too many people around the table, the effectiveness of meetings is greatly reduced and boards run the risk of becoming 'talking shops'.

Evidence from private sector organisations shows that high-performing boards usually have between eight and twelve members (Eversheds 2011; Imison *et al* 2011). Almost two-thirds of the boards that responded to our survey have a larger membership than this. Of the total number of respondents, 46 of the boards had between 13 and 20 members; 20 had fewer than 12 members; and 4 had more than 20 members (*see* Figure 2 opposite).

When comparing our survey results with those from 2012, it would appear that overall more boards have opted for a board of 13–20 members. Striving to achieve a balance between inclusion of stakeholders and board effectiveness is a struggle.

Most boards (76 per cent) have met more than five times, 16 per cent between two to five times, and 9 per cent less than twice. Having met more than five times may show that the board members have a strong commitment to it. At the early stages of a new board, meeting frequently may help nurture and sustain the momentum of new working relationships.

Figure 2 How many members are on the board?

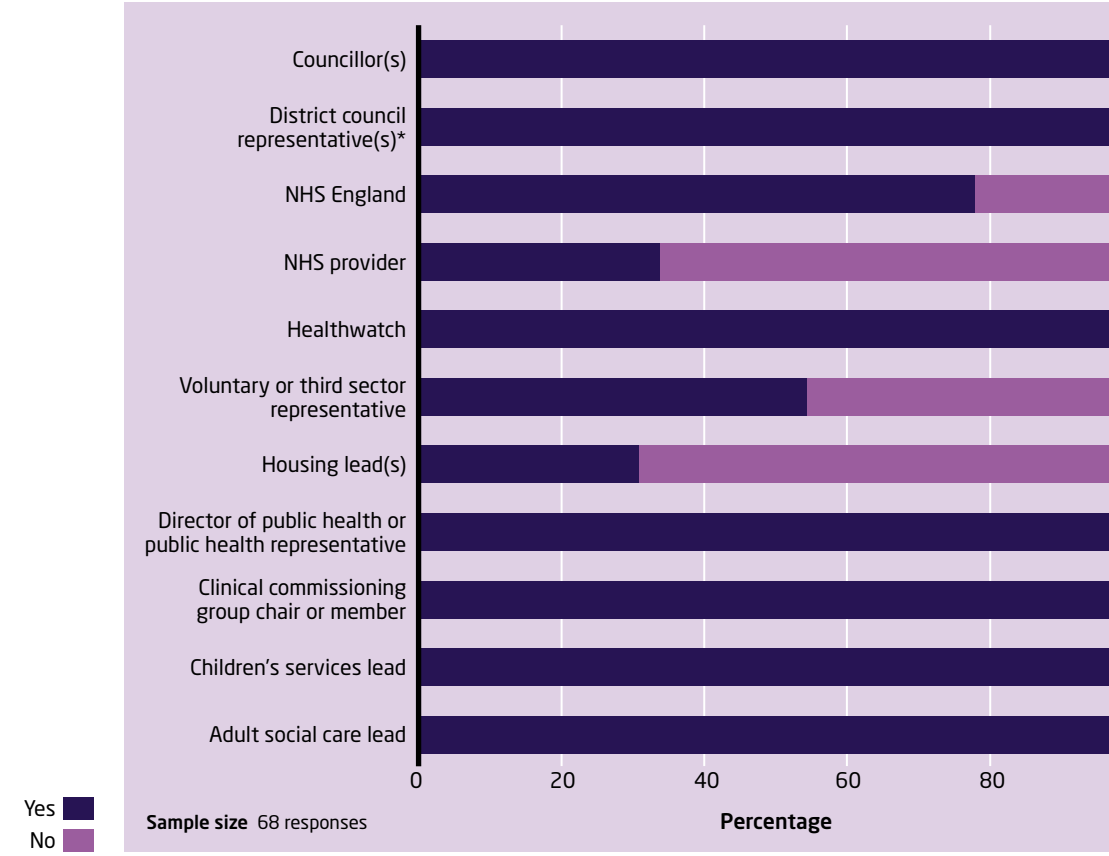
Sample size 2012: 48 responses; 2013: 70 responses

Composition

The composition of boards (*see* Figure 3 below) largely reflects the prescribed core membership set out in the Health and Social Care Act 2012 and has changed little from the findings of our previous survey.

Our survey asked if boards included a housing lead, and 31 per cent did. This is quite a low percentage and perhaps surprising given the increasing recognition of the important contribution made by housing to health and wellbeing (World Health Organization Regional Office for Europe 2012).

Figure 3 Who is represented on the board?



Sample size 68 responses

* Note: this only applies to shire counties

Membership beyond the core is left at the discretion of the individual local authorities, and their broad remit means that they will need to engage with a wide range of stakeholders as well as local people and communities. Our findings suggest that boards have moved away from the core membership to appoint 'such persons or representatives of other such persons as the local authority think appropriate' (House of Lords and House of Commons 2011).

A total of 42 boards (60 per cent) mentioned that other roles within the community are represented on their board (*see* Figure 4 below). There is a range and diversity of local groups involved, with the main groups represented being the police, community safety and rescue forces. This might suggest that health protection issues, resilience and broader local issues are being discussed at such meetings.

Figure 4 Which other stakeholders are represented on your board?

In our last survey we were concerned by the lack of engagement with providers, but things do seem to have moved on. Board meetings are not the only way in which key stakeholders may be involved in the decision-making process: the top three ways in which engagement is happening is though partnership groups, provider forums and specific workshops where priorities are discussed. Figure 5 opposite summarises the results collected.

Relationships

Respondents were asked to rate their current working relationship with their local CCG. Almost all expressed a positive view: on a scale of one (poor) to six (excellent), 93 per cent (65 boards) chose between four and six (*see* Figure 6 opposite). This is even higher than the response to a similar question last year, when 84 per cent had a good working relationship with their local NHS. (In 2012 the question asked how respondents would rate the current working relationship between the local authority and the NHS.)

It is very encouraging that relationships that were already generally very good appear to have improved still further. When asked how their relationship had changed over the past 12 months, 67 per cent of respondents said it had improved, 21 per cent that it had stayed the same and only 1 per cent that it had deteriorated. It should be noted that respondents were drawn from local authorities, but there is some evidence that CCGs also share this view (Association of Directors of Adult Social Services and NHS Confederation 2013).

Figure 5 How are providers engaged with the work of the board if they are not members of it?

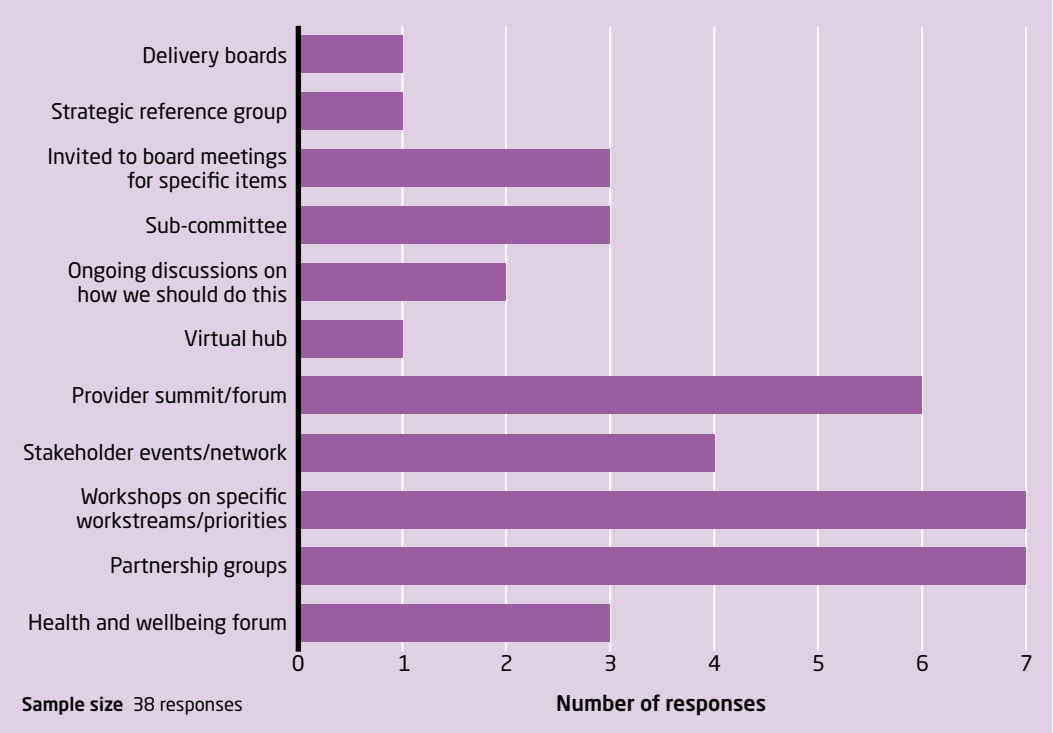
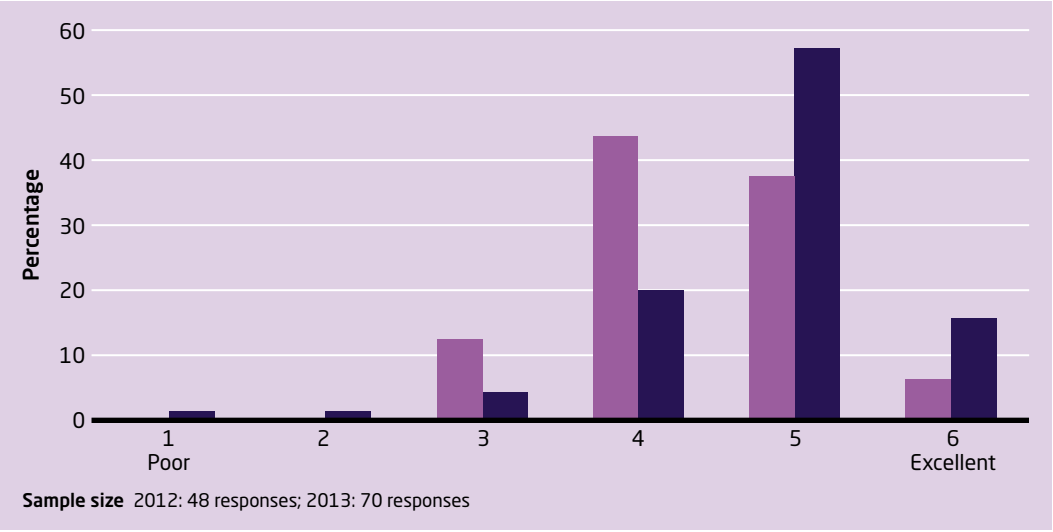


Figure 6 Relationship between the local authority and the CCG*



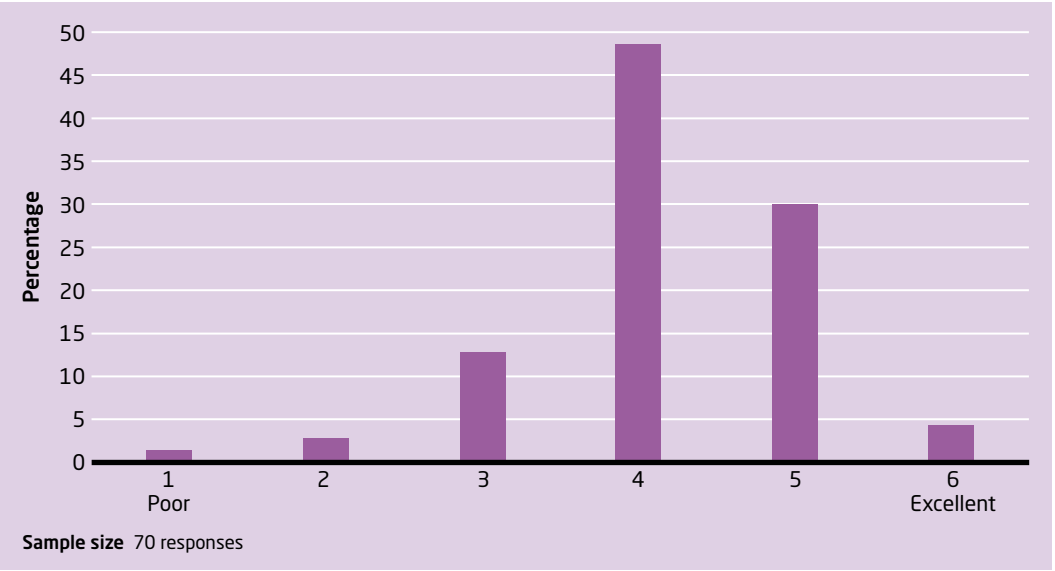
Note: * In 2012 respondents were asked to rate the current working relationship between the local authority and the NHS

This upbeat view of relationships bodes well for the future. Although respondents were all drawn from a local authority background, it suggests that the significant amount of time invested in board development has been justified (NHS Confederation 2011). This is also reflected in the choice of chairs and vice-chairs, which, on most boards, are a combination of a local authority elected members and CCG leads.

Boards would appear to have heeded the evidence on integrated care that points to the importance of investing time in developing relationships (Ham and Walsh 2013). This has created a firm foundation from which boards can address the difficult challenges ahead as financial and service pressures begin to mount.

Local authorities shared a similar view about their relationships with stakeholders and other groups (*see* Figure 7 below). On a scale of one (poor) to six (excellent), 80 per cent chose between four and six. There was no difference among different types of local authorities in response to this question.

Figure 7 Local authority relationships with stakeholders and other groups



Sample size 70 responses

Progress and priorities

The JSNA and local health and wellbeing strategy

In our last survey, 78 per cent of respondents thought that their JSNA was very useful, and all intended to develop them further. The main ideas for improving JSNAs were:

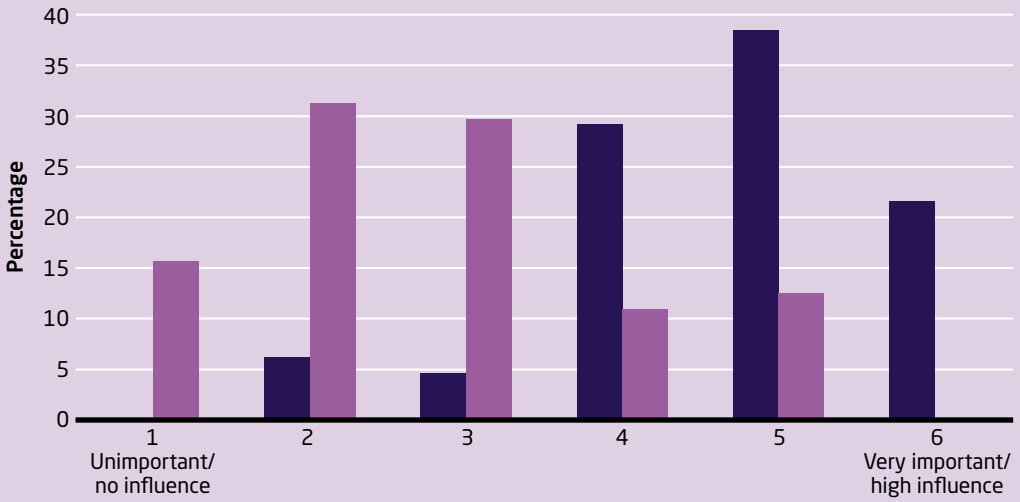
- to make them more comprehensive by widening them to include other areas such as housing, employment and culture
- to enhance their user-friendliness by making them more succinct, web-based and regularly updated
- to make them a more useful tool for end-users.

In this survey, we asked if a new JSNA had been produced (as opposed to an existing one being refreshed). Of the 65 boards that responded, 79 per cent said that they had created a new one; 3 per cent (two boards) had not; and 19 per cent said that the matter was still in progress.

We also asked if they had produced a health and wellbeing strategy. Of the 65 who responded to this question, 88 per cent had already produced one, and 11 per cent were still in the process of doing so. Only one board had not yet produced a strategy (2 per cent).

We asked respondents to rate how important they thought their health and wellbeing strategy would be in influencing the commissioning decisions of CCGs, on the one hand, and NHS England, on the other (*see* Figure 8 opposite). Using a scale of one to six (with six being highly influential), 89 per cent felt that their strategy would have an impact of between four and six on the commissioning decisions of the CCGs. However, the reverse was the case in relation to NHS England, with 77 per cent thinking that their strategy would have little or no influence on its commissioning decisions.

Figure 8 How important/influential do you think your local health and wellbeing strategy will be in influencing the commissioning decisions of CCGs and NHS England?



Sample size CCG question: 65 responses; NHS England question: 64 responses

Board priorities

We asked participants to list the priorities agreed by their health and wellbeing boards. Of the 65 boards that responded, only four had not yet agreed their priorities.

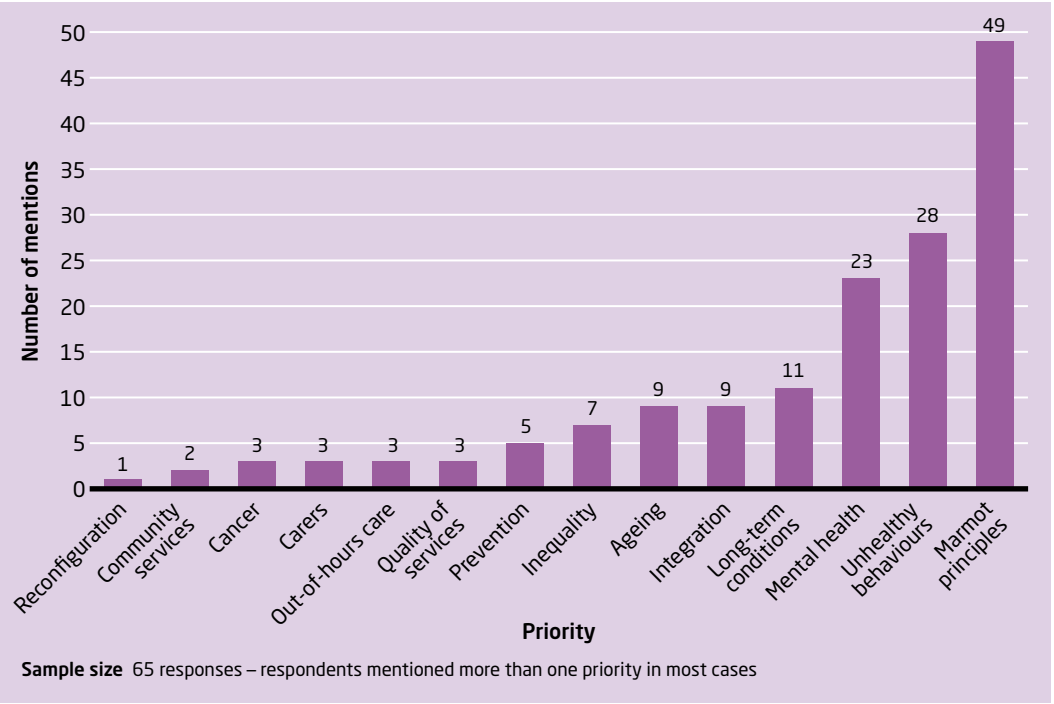
There was great emphasis among the answers on the six policy objectives set out in the Marmot Review of health inequalities in England (Marmot Review 2010) (*see* box below). Almost all of these principles were mentioned by the respondents to our survey, with 25 per cent of them highlighting the first principle, namely 'giving every child the best start in life'.

The Marmot Review's six policy objectives for reducing health inequalities

- Give every child the best start in life.
- Enable all children, young people and adults to maximise their capabilities and have control over their lives.
- Create fair employment and good work for all.
- Ensure a healthy standard of living for all.
- Create and develop healthy and sustainable places and communities.
- Strengthen the role and impact of ill-health prevention.

As well as the Marmot principles, the other areas cited most often by our respondents were unhealthy behaviours and mental health issues (*see* Figure 9 overleaf). These may indicate the influence of the directors of public health board members. It is encouraging that the welfare of children and mental health are priorities for many boards, but it is surprising that other vital issues – such as out-of-hours care, carers, quality of services and reconfiguration – barely registered among board priorities. Integration, which is a primary purpose of the boards, was mentioned by only nine respondents.

Figure 9 Priorities agreed by the board



Sample size 65 responses – respondents mentioned more than one priority in most cases

Supporting the boards

Boards have invested a lot of time developing their members. However, they are emerging into a new world that is organisationally more complex than under the previous arrangements, with responsibilities distributed across a multiplicity of clinical commissioning groups, commissioning support organisations, NHS England, clinical senates and clinical networks. Public health functions are now shared between local government and Public Health England. There is considerable uncertainty about the respective roles and responsibilities of different bodies involved.

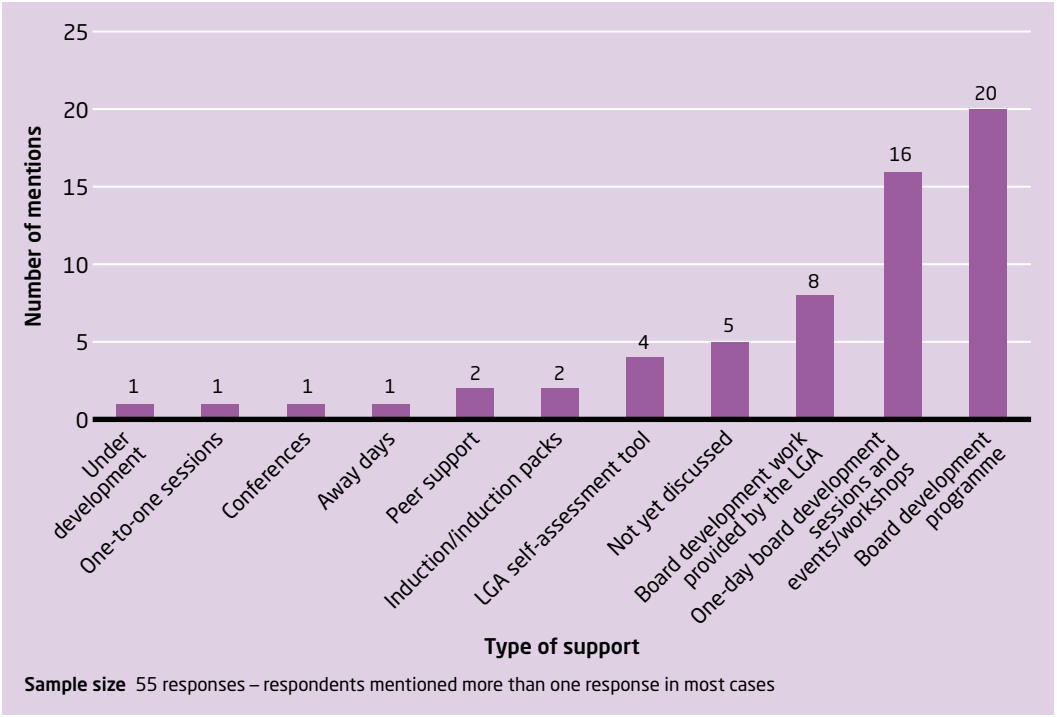
Furthermore, these challenges come at a time when the boards need to move from setting strategy to implementing it – a goal that is complicated by the fact that their powers are limited. The way in which board members work together to wield their power of influence and persuasion over their local health and care system will therefore become critical to their success.

It is encouraging to see that most boards have been thinking about how they will be developing their members and the board. Figure 10 opposite shows a breakdown of the different ways in which this is happening – from light-touch peer support to more formalised board development programmes.

Measuring success

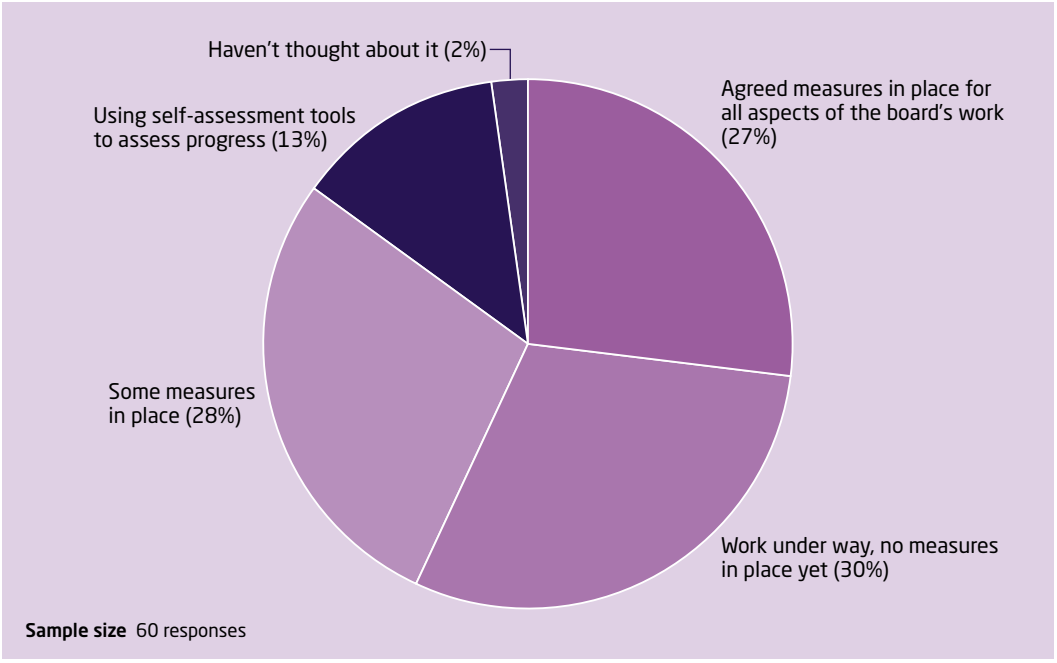
Our previous research revealed that at those early stages boards had only just begun to consider how they would assess their impact and success, with more than one-third having not yet discussed how they planned to assess this. This current research shows that most boards are now addressing how they should be measuring their success. Nearly all have measures in place that address some, if not all, of their objectives (*see* Figure 11 opposite). About 13 per cent are using self-assessment tools, while others are being a bit more creative in their approach. One respondent mentioned that the board is developing a wellbeing index, which will incorporate lessons from both national and international developments. This index will be developed through workshops with a wide group of stakeholders.

Figure 10 Support being given to boards/board members



Sample size 55 responses – respondents mentioned more than one response in most cases

Figure 11 Measuring the success of health and wellbeing boards



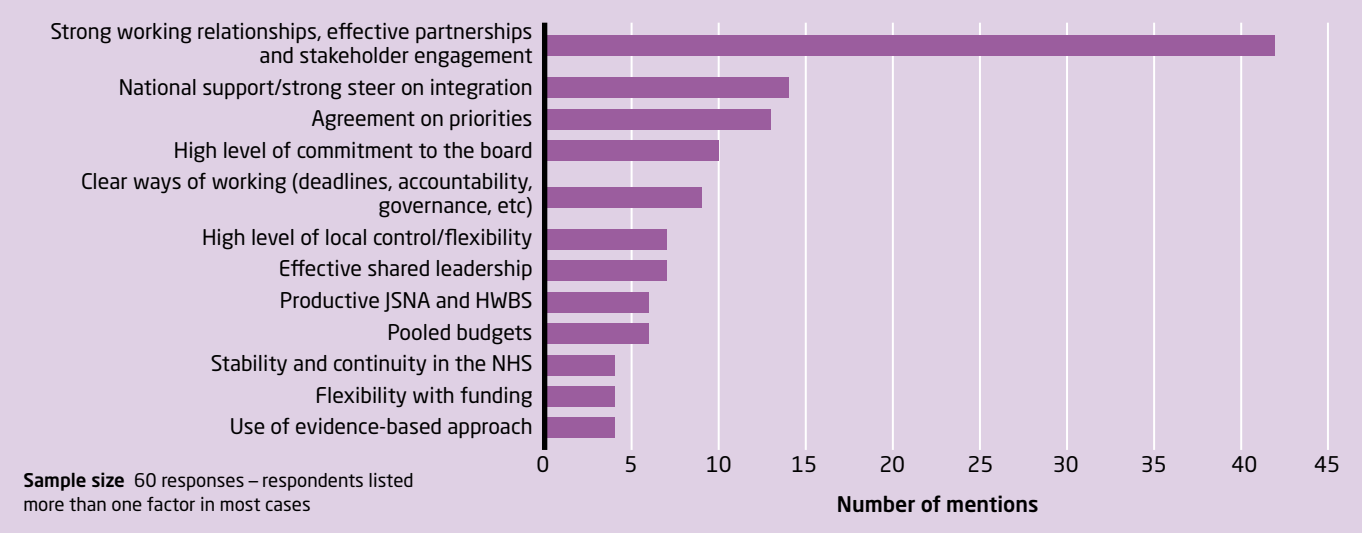
Sample size 60 responses

Prospects for success

What will help and hinder boards in achieving their objectives?

We asked respondents which three factors (local or national) would most help their boards to achieve their priorities. A total of 31 different areas were mentioned, but strong working relationships was considered by far the most important, with 70 per cent of our 60 respondents citing this as the factor that would best help them to achieve their objectives (*see* Figure 12 opposite).

Figure 12 Which factors will most help boards to achieve their objectives?

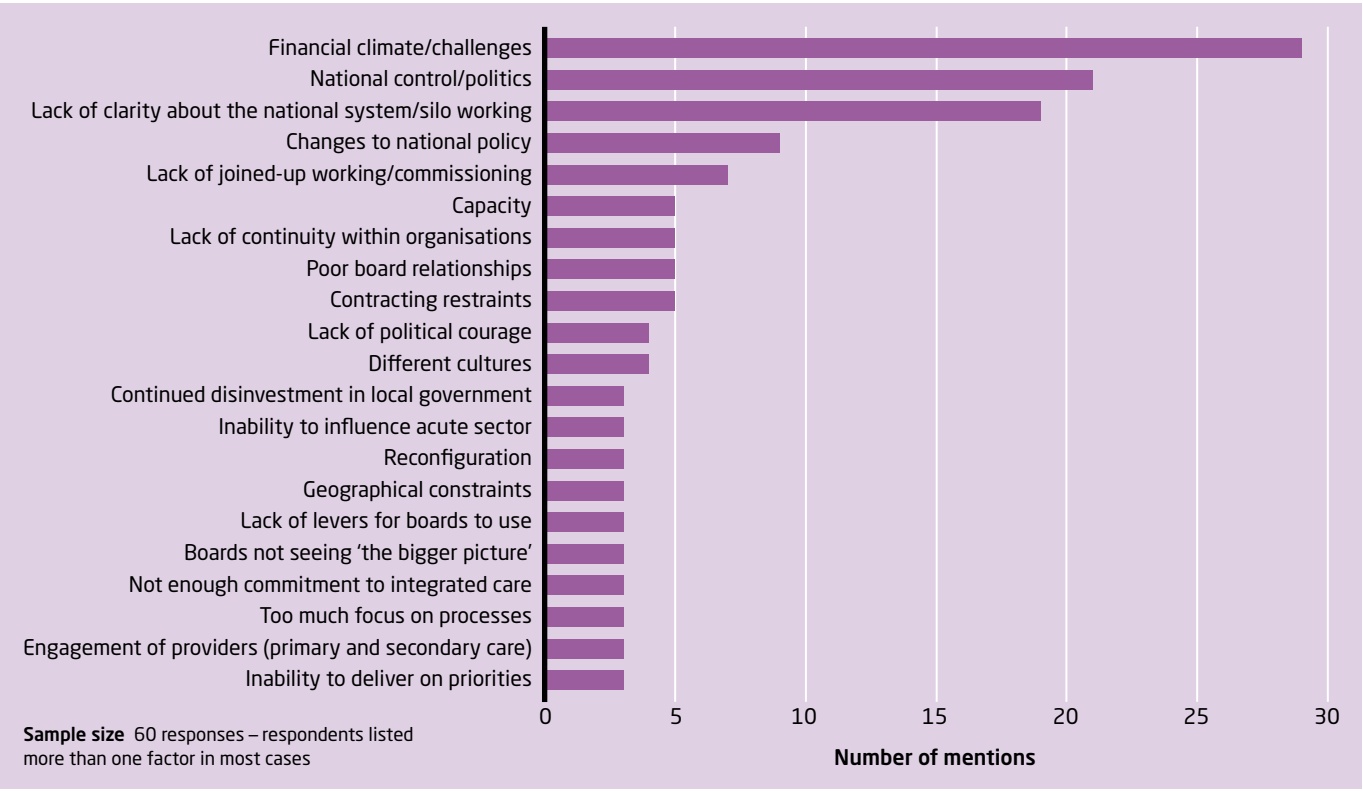


Note: JSNA, joint strategic needs assessment; HWBS, health and wellbeing board strategies

Conversely, we also asked which three factors (local or national) would most hinder boards in achieving their objectives. Once again, 31 different areas were mentioned. The financial climate, and the challenges that accompany it, was cited most often (48 per cent of our respondents), with national control/politics being the next most mentioned factor with 35 per cent (*see* Figure 13 below).

The themes that emerged in response to these two questions (factors that are helping and hindering) are not greatly different from those raised last year.

Figure 13 Which factors will most hinder boards in achieving their objectives?



Should boards have a greater role?

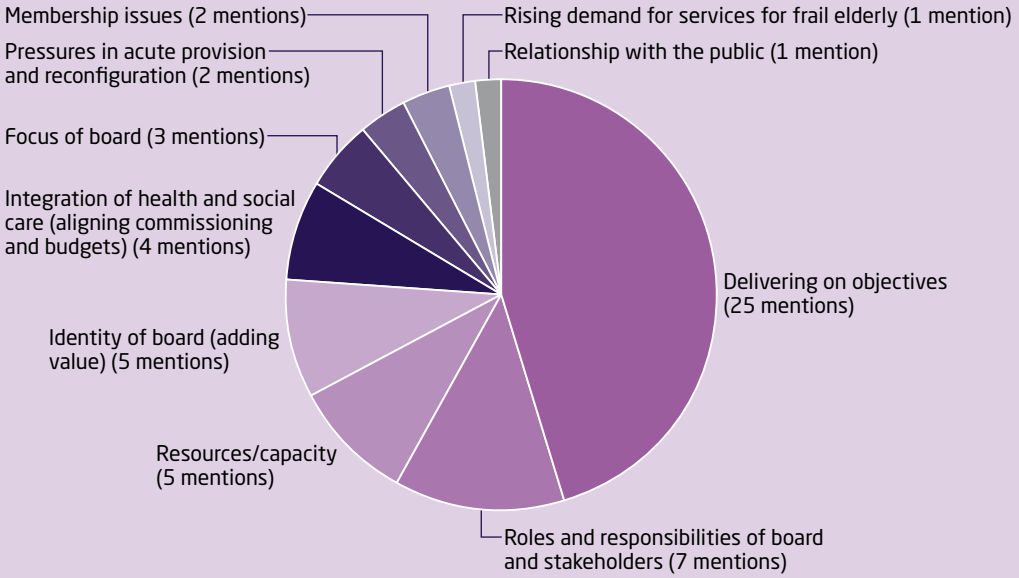
With the rhetoric surrounding health and wellbeing boards changing, we thought we would ask our panel whether health and wellbeing boards should have a greater role in the commissioning of services for their local populations. Of the 65 who responded, 62 per cent agreed that they should, 22 per cent did not know, and 17 per cent disagreed.

Biggest single challenge facing the board

There has been a great deal of commentary about the difficulties that would surround the inception of the health and wellbeing boards, so we wanted to know what they perceived to be the single biggest challenge facing them. Of the 55 responses received, 45 per cent said that their main concern was delivering on their priorities; as one respondent put it: 'Turning positive relationships and high level strategy into tangible outcomes and benefits for people.'

Other main issues of concern were roles and responsibilities (13 per cent), resources (9 per cent), the identity of the board (9 per cent) and how they were going to add real value (*see* Figure 14 below).

Figure 14 The biggest challenge facing the boards



Sample size 55 responses – one response per respondent

Where next for health and wellbeing boards?

Our survey suggests that, overall, the new boards have generally made a positive and encouraging beginning. It should be noted that these conclusions are based on the views expressed by board leads, but it does appear that most have used the shadow year wisely, heeding evidence about the importance of investing time in relationships and in their development as a board. This echoes an assessment of the progress of 138 'early implementer' boards, which noted that most had made 'significant advances', although there is evidence of clear differences emerging in the pace and scale of progress towards being effective boards (NHS Confederation 2012). The support offered through the National Learning Network for Health and Wellbeing Boards, among others, including The King's Fund and the Office for Public Management, seems to have enabled boards to make faster progress. Planning and preparation have been important success factors.

The creation of the boards is symbolic of the new relationship between the NHS and local government ushered in the by the Health and Social Care Act 2012. Local authorities have taken their new role seriously and have brought strong leadership to the task of establishing and developing the boards. Respondents say that relationships between local authorities and CCGs have grown even stronger, and that this is reflected in an emerging pattern of a senior elected member – most often the leader of the council – chairing the board, with the vice-chair coming from the CCG. At a time of unprecedented financial pressures on local government and the NHS, this is a substantial achievement, especially as it has occurred in the context of major organisational change within the NHS.

Boards have moved quickly to develop their JSNAs, and most have gone on to produce joint health and wellbeing strategies. The priorities selected by boards, which are overwhelmingly focused around the Marmot policy objectives (*see* p 11), suggest that public health issues are being taken very seriously, and this should help allay concerns about the transfer of public health responsibilities to local government.

However, boards are showing few signs of getting to grips with the more urgent and pressing strategic issues facing their local health and care systems that require whole-system leadership. These include the need:

- to transform local services in the light of changes in demographics, the burden of disease and pressures on urgent care that reflect problems in the wider system
- to maintain and improve the quality and safety of treatment and care, and the development of integrated care.

It is disappointing that so few boards identified public engagement as a priority, and there is no evidence of boards being creative in reaching out to local communities through, for example, social media.

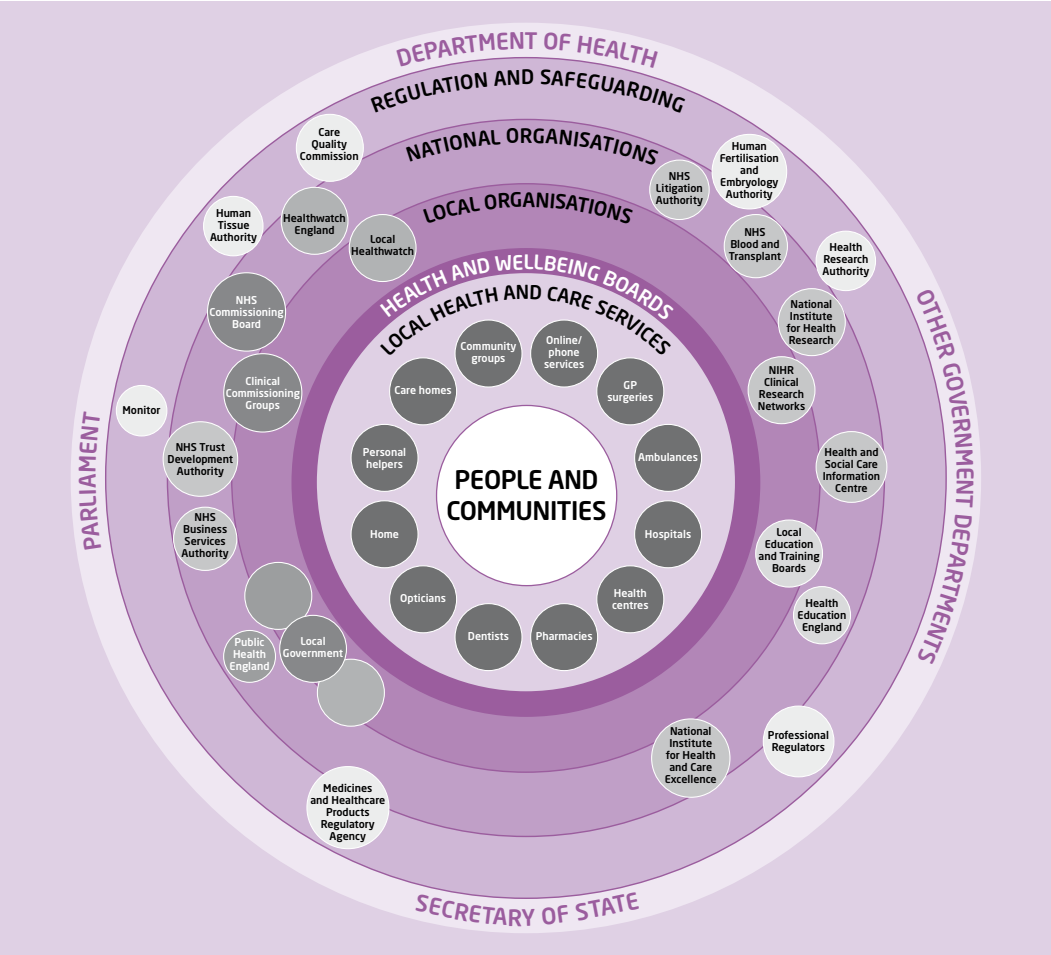
In fairness, many boards recognise that they now need to move on from development to delivery, and to demonstrate that they are making a real difference to the priorities they have identified.

Most boards seem keen to play a stronger role in commissioning, and have begun to measure their progress and effectiveness. It is possible that many boards have simply endorsed existing programmes of work on issues such as integration and service reconfiguration instead of adopting them as new priorities. Alternatively, some boards may be strongly driven by a public health agenda, reflecting the influence of directors of public health board members and the fact that public health has become a local authority responsibility, with the commissioning of health services seen as the province of CCGs alone. These perceptions will almost certainly vary from place to place.

The literature and evidence is clear that, although the potential benefits of partnership working are considerable, they are very hard to realise in practice, and effective partnerships do not happen overnight. Health and wellbeing boards are still in their infancy, and with only a few months having elapsed since they became fully operational, there is a danger of unrealistic expectations of how much they can deliver and how soon.

In our 2012 report, we highlighted uncertainty about how the roles and responsibilities of the new organisations introduced by the NHS reforms would play out in practice, and the need for the role and purpose of health and wellbeing boards to be defined more clearly. Less than a year into the implementation of the reforms, the complex set of arrangements shown in Figure 15 opposite are still bedding down. In the absence of formal statutory guidance, the role of health and wellbeing boards is open to differing interpretation, and boards are not necessarily clear about their role and powers (Ward *et al* 2013). There are tensions between the boards' role in overseeing commissioning and promoting integration, between high-level strategic planning as opposed to involvement in the operational management of

Figure 15 The new health and care system



Source: Department of Health 2013a

pooled budgets or integrated services, and between tackling population-level health issues and driving forward service changes. In the context of continuing uncertainty, the 152 boards are unlikely to be able to work through these complex issues with any great speed.

In the meantime, many of the biggest pressures and challenges facing numerous local health and care systems are becoming increasingly urgent. Demand for services continues to rise, despite no real-terms increases in NHS resources and local government budgets being cut by more than 30 per cent. The need for comprehensive changes to health care in London, for example, has long been recognised but has become harder as a result of the organisational changes (Ham *et al* 2013).

The scale of change required in many, if not all, local health and care systems demands effective system leadership, and it is far from clear where this will come from under the new arrangements. There is a real danger that if health and wellbeing boards are unable to fill this leadership vacuum, they will become irrelevant spectators reacting to decisions and proposals made elsewhere. In some places, where the extent of the change needed exceeds the geographical footprint of a single board (such as in London and other major densely populated conurbations), wider leadership arrangements must be put in place and committed to and engaged with by the boards thus affected.

With all the policy indicators suggesting a stronger future role for health and wellbeing boards, whether they can deliver real change for local populations in their current form is doubtful. The legal powers and duties of boards are largely permissive and discretionary, that is, CCGs and local authorities can do anything they wish providing that they are in

agreement. In this guise, the boards are vehicles for partnership rather than executive decision-making. The government intends that boards should 'sign off' on local plans for the use of the new £3.8 billion Integration Transformation Fund. Although this represents only 3 per cent of the combined total NHS and adult social care budget, in the current financial climate it is a substantial sum that offers boards an unprecedented opportunity to shape key spending decisions. This development could also be used by boards as a stepping stone to their overseeing the total health and social care budget in time.

The principal currency of the health and wellbeing boards is to influence and lead across organisational and professional boundaries rather than to exercise formal managerial control over each organisation's budgets, priorities and commissioning decisions. Achieving change in this way requires exceptionally strong and skilful leadership, and places a high premium on these 'soft' skills.

A further consideration is that, although boards feel they will have a real influence on the commissioning plans of their principal local partners, most have no confidence in their ability to influence NHS England, which controls more than a quarter of the total NHS commissioning budget and is responsible for commissioning local primary care services. Unless NHS England is seen as an active and engaged partner in its commissioning role, it will be difficult, if not impossible, for the boards to lead the development of integrated care, which is intended to be their primary purpose.

This suggests several possible scenarios for the future development of health and wellbeing boards.

- The first is that, based on their current trajectory of development, most boards will default to a limited role of information-sharing and high level co-oordination of plans and strategies. They will react to proposals and plans from partners, and some boards will make progress in overseeing specific public health programmes, but few, if any, will initiate or lead system-wide change.
- A second scenario is that in some places where there is little confidence in the board, local planning and decisions could be made in separate channels in the local authority or CCG, for example, the use of the Integration Transformation Fund, or through urgent care boards. This would see the health and wellbeing boards by-passed and sidelined.
- A third scenario is that boards develop an executive decision-making role across the whole local system of health, social care and public health, with an explicit remit to oversee commissioning of all services, produce an agreed framework for integrated care and drive through the transformation of local services. This would be consistent with a policy thrust towards more integrated commissioning across the local NHS and local government.

It should be emphasised that the development of boards into executive decision-making bodies – the third scenario – would mark a fundamental change from their current role as a partnership forum, with important implications for their size and composition. The boards would need substantial new capacity and expertise to address effectively the complexity of many aspects of health care commissioning.

The requirement on boards to sign off on local plans for the Integration Transformation Fund by April 2014 will be an important test of their ability to offer credible, shared leadership and show whether they are ready to play a bigger role in the planning and commissioning of all local services. The legal powers already exist for CCGs and local authorities to establish joint or integrated commissioning arrangements, which offers scope for strengthening the role of the boards in an evolutionary way without the need for further reorganisation. Strong and purposeful relationships between CCGs and their respective local authorities – based on partnership not takeover – offer the best prospects for boards to lead the integration and transformation of local services effectively.

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Appendix A Characteristics of our population sample

Regions	Number of boards that responded
London	14
North-East	5
North-West	5
West Midlands	8
East	4
East Midlands	5
South-East	6
South-West	6
Yorkshire and Humber	7
No response	10
Answered question	**60**

Structure	Number of boards that responded
Unitary authority	22
Metropolitan districts	14
London boroughs	14
Shire counties	10
No response	10
Answered question	**60**

Respondent characteristics	Number of boards that responded
Director of social care (adult, children, combined role)	16
Assistant director/third tier	7
Directors of public health	2
Other	34
No response	11
Answered question	**59**

Appendix B Interview responses

1. How many members does your board have in total?

Number of members on board	Number responding
Fewer than 12	20
13–20	46
More than 20	4
Answered question	**70**

2. Who are they?

Groups on the board	Number responding
Adult social care lead	68
Children's services lead	68
Clinical commissioning group chair or member	68
Director of public health or public health representative	68
Housing lead(s)	21
Voluntary or third-sector representative	37
Healthwatch	68
NHS provider	23
NHS England	53
District council representatives (applicable only to shire counties)	12
Other	42
No response	2

3. How many times has the board met?

Frequency of meetings	Number responding
Less than twice	6
Two to five times	11
More than five times	53
No response	0
Answered question	**70**

4. Who is the chair and vice-chair of your board?

Response	Chair	Vice-Chair
Leader of council	26	1
Council member	31	19
Director of public health	1	2
CCG lead	2	28
Other	9	6
No response	1	14
Answered question	**69**	**56**

5. How would you rate the current working relationship between your board and clinical commissioning groups on a scale of 1 (poor) to 6 (excellent)?

Rating	Number responding
1 (poor)	1
2	1
3	3
4	14
5	40
6 (excellent)	11
No response	0
Answered question	**70**

6. Over the past twelve months how has this relationship changed?

Change in relationship	Number responding
Improved	48
Stayed the same	21
Deteriorated	0
Don't know	1
No response	0
Answered question	**70**

7. How would you rate the current working relationship between your board and stakeholders or other groups on a scale of 1 (poor) to 6 (excellent)?

Rating	Number responding
1 (poor)	1
2	2
3	9
4	34
5	21
6 (excellent)	3
No response	0
Answered question	**70**

8. Has a new joint strategic needs assessment been produced or was the existing one refreshed?

Response	Number responding
Yes	51
No	2
Don't know	12
No response	5
Answered question	**65**

9. Has a health and wellbeing strategy been produced?

Response	Number responding
Yes	57
No	1
Don't know	7
No response	5
Answered question	**65**

10. Please rate how influential your local health and wellbeing strategy will be on a scale of 1 (unimportant/no influence) to 6 (very important/highly influential)

Response	1	2	3	4	5	6
Influencing the commissioning decisions of clinical commissioning groups	0	4	3	19	25	14
Influencing the commissioning decisions of NHS England?	10	20	19	7	8	0
No response						5
Answered question (CCGs)						**65**
Answered question (NHS England)						**64**

11. Do you think health and wellbeing boards should have a greater role in commissioning services for their local population?

Response	Number
Yes	40
No	11
Don't know	14
No response	5
Answered question	**65**

12. How will you be measuring the success of your health and wellbeing board?

Response	Number responding
Agreed measures in place for all aspects of the board's work	16
Work underway, no measures in place yet	18
Some measures in place	17
Using self-assessment tools to assess progress	8
Haven't thought about it	1
No response	10
Answered question	**60**

About the authors

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