

getting started: prospects for health and wellbeing boards

Edited by Neil Churchill



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The new Health and Wellbeing Boards are an important part of the NHS reforms and central to the push for greater integration of health and social care. This report offers a timely insight into how the boards operate and what challenges lie ahead. The fact that they have widespread support and explicitly seek to strengthen partnership working between councils and healthcare commissioning groups bodes well. However, as the contributors in this report make clear there are no simple solutions and the effectiveness of the boards will be judged by how they improve outcomes, not merely because they have secured greater involvement.

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Paul Hackett, Director of the Smith Institute

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Introduction: setting the scene

Neil Churchill, Chief Executive of Asthma UK

Despite all the controversy surrounding the Health & Social Care Act 2012, some elements did win widespread support. One such was the proposal to establish local health and well-being boards to encourage integration of health and social care around population needs.

The idea originated from the heart of the controversy, however. Nick Timmins has shown how the boards emerged from the combination of market reforms advocated by Conservatives and democratic reforms promoted by Liberal Democrats.¹ Originally, the Coalition's Programme for Government envisaged that primary care trusts (PCTs) would be governed by a mixture of directly elected and appointed directors. However, this unwieldy idea was soon replaced by the death knell for PCTs and the establishment of health and well-being boards (HWBs), which then minister Paul Burstow saw as a way to give local government greater involvement in the NHS in order to integrate health and social care.

The attempt to integrate services at a local level is not novel, but the new HWBs represent a grander scale of ambition. They will bring together GP commissioners, local councillors, adult social care, children's services, public health, providers, and patients and the public, as represented by the Local Healthwatch. Their mission will be to assess population needs, develop shared visions for change, and encourage integration of care. Yet they will have no enforcement powers at their disposal and must rely on the quality of relationships to effect change across multiple institutional and professional boundaries.

Over the past 12 months, I have seen attitudes towards HWBs evolve in successive waves of optimism and pessimism. This may be due to the fact that initially HWBs were seen as the answer to all ills, after which expectations dropped and many worried that they would be swamped by knotty questions of who would pay for social care. Now that opinion has settled and HWBs have formed and started to work, hopes are more realistic. Nevertheless, the danger of what David Rogers of the Local Government Association calls the "burning platform" of an ageing population remain very much the backdrop to the challenges the boards are taking on. Most of the contributors to this volume, it should be noted, are in the optimist camp that HWBs are better placed to address this challenge than have been previous structures.

¹ Timmins, N *Never Again? The Story of the Health & Social Care Act 2012* (King's Fund, 2012)

Nevertheless, several contributors point out gaps in the HWBs' worldview. Most worryingly, the commissioners of primary care, dentistry and pharmacy – the NHS Commissioning Board – are not occupying seats round the table. Will the absence of the Commissioning Board frustrate efforts to encourage more local decision making? And how can preventative services be developed without these vital planks of care? Time will tell. Other gaps might be the voluntary sector. Sir Stephen Bubb, of the Association of Chief Executives of Voluntary Organisations, points out the wide range of roles that voluntary organisations now fulfil in health, well-being and social care, and argues that the new boards must prioritise effective voluntary-sector engagement. Kathy Roberts and Annie Whelan from the Mental Health Providers' Forum suggest ways that HWBs can engage a diverse range of mental health organisations.

The boards do, nevertheless, have tools at their disposal. Richard Humphries and Claire Mundle of the King's Fund examine tools to encourage integration, such as joint strategic needs assessments (JSNAs), joint health and well-being strategies (JHWBs) and pooled budgets. Their survey of HWB leaders suggests grounds for optimism, but they also remind us of the lessons of history: some of the barriers to integration remain deep-seated.

Madeleine Knight of the British Medical Association is among those with high expectations of HWBs and their potential to assess local population needs. She argues that while the early JSNAs, introduced in 2007, were variable and had little influence, lessons have been learned. New JSNAs produced in 2012 have clearly set out challenges for commissioners. However, the lack of enforcement powers means that an HWB's success will depend on the strength of relationships between its members.

The Local Government Association's Councillor David Rogers agrees that the boards will be the engine house to drive new relationships within the health system. But to achieve this, a wholly new approach will be needed, unlike any previously tried. Relationships of trust will require shared values and behaviours, and yet local government is the only point of constancy in a changing health landscape. Nevertheless, this is a challenge for which Rogers believes local government is ready.

Will those relationships turn out to be a clinical commissioning group's best friend or its worst nightmare, ask Chris Drinkwater and Michael Dixon of the NHS Alliance. They argue, GPs and local councillors actually have much in common: running surgeries, living locally and sharing concern for local issues. Together they are best placed to achieve transparency about the costs and benefits of healthcare, which is needed to reduce unsustainable demand on local public services.

Yet some argue that important aspects of the original vision have been lost in translation. Pam Creaven and Ruthe Isden from Age UK observe that the Department of Health's focus on advancing health and well-being in HWBs has so far outweighed its focus on social care. In fact, it will be vital for the new boards to drive strategic change to meet the needs of older people: developing a local vision for holistic well-being, promoting common values across health and social care, assessing impact and stimulating innovation.

Barbara Herts, a consultant commissioner of children's services, also argues that meeting children's needs in a joined-up way will require boards to look beyond the framework of the Health & Social Care Act. The HWB in Essex has sought to promote a whole life-course approach to improving health outcomes, which includes an effort to ensure every child has the best start in life.

The HWB in Lambeth has drawn extensively on the successful children's trust board that preceded it, writes Debbie Jones of the Association of Directors of Children's Services. This has enabled continuity in its work. A national survey suggests, however, that although the boards are still in their infancy, children's health and well-being issues are not yet getting much traction, beyond the usual public health campaigns on teenage pregnancy, obesity and sexually transmitted infections. A change of gear is needed for HWBs to become effective drivers of change around early-years concerns.

Will HWBs work more effectively to address the most pressing problems in public health? Yvonne Doyle, a regional director of public health, notes that the link between health and local government began over 160 years ago when enterprising towns took it into their own hands to improve the quality of local people's lives. Yet the return of a function that has not been in local government for over a generation will require learning on both sides. In order to realise the vision, directors of public health will need to be able to retain their independence and work across the whole council without fear or favour.

Doyle goes on to warn that because the HWB represents the only accountability built into the new public health system at a local level, it could be much harsher than old-style performance management. Tim Gilling from the Centre for Public Scrutiny examines the boards' effectiveness in providing accountability and scrutiny. Here HWBs face familiar challenges: large boards can become talking shops, while small boards can lack the drive to tackle long-standing issues, and formal board meetings themselves are not enough to deliver change. Gilling sets out a practical set of principles for effective boards that will help them to hone their operations.

The development of one HWB, in Leicestershire, is described in detail by Sharon Cannaby, from the Association of Chartered Certified Accountants. From the appointment of a programme director in November 2010, it took just under two years for a draft health and well-being strategy to be presented to the shadow HWB in October 2012. Cannaby's chapter provides practical tips to sit alongside Gilling's principles. Together they address many of the key lessons learned by the early implementers of HWBs.

None of this will come cheap. Derek Miller suggests that the minimum cost for running an HWB will be £150,000 for six meetings of 10 people, rising to over £300,000 for larger boards that meet more frequently. He also notes that there is no evidence that integration by itself is cost-effective, which must be the ultimate antidote for seeing HWBs as the cure to all ills. There seems little doubt that the work ahead will be challenging and at times controversial, and that progress will be made in many small steps rather than in huge leaps and bounds.

Chapter 1

Development of the joint strategic needs assessment

Madeleine Knight, Policy Analyst at the British Medical Association

Development of the joint strategic needs assessment

The introduction of health and well-being boards (HWBs) is one of the few initiatives of the Health & Social Care Act 2012 to be welcomed by the majority of stakeholders without controversy. However, along with words of encouragement come high expectations on the boards to achieve the elusive goal of integrated services across health and social care that tackle the wider determinants of health. The joint strategic needs assessment (JSNA) and the new joint health and well-being strategy (JHWS) form the crux of this activity. The effectiveness of these strategies in influencing co-ordinated commissioning decisions will be the deciding factor in the success of HWBs. This essay examines the potential for HWBs as new bodies to take forward JSNAs and improve on the existing approach.

When JSNAs were first introduced, the absence of formal levers to implement the strategy resulted in little influence over commissioning decisions. The proposals introduced by the act place JSNAs with the new HWBs and show some attempt to give greater weight to the strategy. However, there are still gaps in the process and there remains a lack of sanctions to ensure that commissioning decisions reflect the JSNA. Without funding to implement their proposals, the new system is reliant on each board's ability to act as an informal influencer and to facilitate effective negotiation between members to fund the priorities set out in the strategy.

Background

The aim of JSNAs is to identify the current and future health and well-being needs of a population by taking into account the wider determinants of health and aspiring to reduce health inequalities. The strategy should be a concise summary of the key health and well-being challenges for the area and should identify priority issues to be addressed through service changes.

JSNAs were introduced by the Local Government & Public Involvement in Health Act 2007, which placed a duty on upper-tier local authorities and primary care trusts (PCTs) to work together to produce the strategy. The intention was to bring together health and social care commissioners to encourage co-ordination of services reflected in their respective commissioning plans. The local authority commissioning arrangements took account of the strategy through existing bodies established for joint working across the sectors, the local strategic partnerships (LSPs). Representation on LSPs is decided at a local level, with the aim of bringing together the local authority, voluntary, community and private sectors.

LSPs are responsible for local area agreements (LAAs), targets representing three-year agreements between central government and local organisations. The JSNA was designed to examine the population's needs over a three- to five-year period to fit with the LAA cycle. In healthcare, the Department of Health's World Class Commissioning vision set out expectations that defined commissioning and raised ambitions for commissioning standards, including the impact on population health and well-being. This model encouraged PCTs to take an active interest in the strategy, but there was no formal process for the strategy to influence commissioning plans in either sector.

Early best-practice examples of JSNAs embrace the health and well-being approach, identifying key components of the wider determinants of health in the area, such as employment, housing and the environment. These covered a broad scope of issues, including most of the LAA themes.¹ The more impactful strategies focused on actions for improving health and well-being, rather than merely describing the circumstances in the area. This action-oriented approach presented a useful framework through which health and social care parties could work together. To assist work on JSNAs the Department of Health promoted a core dataset, which identified a list of indicators available for use in preparing a JSNA, to encourage local authorities and PCTs to use this information. However, there were no mandatory requirements in terms of the data to be gathered in the strategy.

The informal approach to the early JSNAs meant that the resulting documents varied considerably in their coverage, and few had significant influence on commissioning plans across the country. However, the freedom granted for different regions to develop their own process for the strategies resulted in naturally emerging best-practice examples.

The new joint strategic needs assessment

Building on the examples of existing best practice, the new approach attempts to address weaknesses in the strategy by putting it centre stage within wider plans to devolve decision making to the local level. The act places responsibility for producing the JSNA with the new HWBs. It places separate duties on local authorities, clinical commissioning groups (CCGs) and the new NHS Commissioning Board to contribute to the strategy through the boards. Local authority directors for adults', children's and public health services and councillors, together with CCGs, the NHS Commissioning Board and representatives from the new public and patient involvement groups, Healthwatch, will sit on the boards. This, therefore, gives local commissioners the lead

¹ Brotherton, P *Revising the JSNA Core Dataset: Analysts & Commissioning* (2010) (<http://www.swpho.nhs.uk/resource/item.aspx?RID=74875>)

and reflects a renewed intention to address the wider determinants of health through co-ordinated action across health and social care.

Recognising the need to translate the priorities identified in the JSNA into commissioning plans, the new arrangements introduce this next step in the form of a new joint health and well-being strategy. This is essentially an overarching commissioning strategy for the area through which the HWB should influence commissioning decisions informed by the evidence-based JSNA. The JHWS is concerned with establishing a strategic approach to meet the population's health needs, identified in the JSNA. This should take into account the available local assets and resources, setting out clear commissioning priorities and focusing on pooling resources. By mapping the existing available resources and capacity in the area, the JHWS should assess how best to make use of these and identify gaps that require new services. This assessment would consider available budgets, as well as human resources and any third-sector activities and capacity. The JHWS should then specify the services that should be provided and the desired outcomes that will be measured.

New JSNAs, produced this year, have already progressed to pointing out the challenges for commissioners in addressing the local population's needs, and explaining the issues in relation to the commissioning timeframe of three to five years. The intention is that both strategies should be living documents, continually revised to reflect the changing needs of the population as services develop. As proposed, the current plans follow the logical development of the existing JSNA approach by moving forward from assessing needs to influencing commissioning decisions.

Despite attempts to strengthen the HWBs' influence as the Health & Social Care Act was debated in parliament, the boards cannot enforce their recommendations. The HWBs do not hold any funds and therefore cannot commission any services directly, and there are no finances specifically attached to the JSNA and JHWS. However, there is an expectation that the strategies will be reflected in the separate commissioning plans of CCGs and local authorities. In order to facilitate this, the act includes duties on local authorities, CCGs and the NHS Commissioning Board to have regard to the JHWS in developing their commissioning plans.

However, the lack of clarity as to what this means in practice makes it a weak lever. In addition, the HWB holds some powers to uphold the JHWS through its ability to refer CCG commissioning plans to the NHS Commissioning Board if the plans do not sufficiently take account of the strategy. The HWB may also request information for assisting its functions, and the NHS Commissioning Board, CCGs, local authorities and Healthwatch are all obliged to provide information in accordance with a request. However, the HWB cannot

implement the JHWS, and holds no powers over local authority commissioners or the NHS Commissioning Board if their commissioning plans do not reflect its recommendations.

The HWB must therefore informally influence commissioning plans. This presents two issues which are critical to the success of the new strategies: building relationships between the commissioners represented on the board, and negotiating the use of separate funding streams to take forward the commissioning recommendations.

Relationships within the board

The lack of enforcement powers means the HWB will be entirely reliant on developing effective relationships between its members who will be responsible for commissioning decisions within their sector. It will effectively be a negotiating table for the commissioner representatives to make agreements around services.

The relationship between CCGs and the HWBs is likely to prove the most crucial to achieving these goals. Where previously PCTs were partners in producing the strategy, there was little incentive for it to be reflected in healthcare commissioning plans. Now, as equal members of the boards, CCGs will be the key partners to engage, particularly given that in aggregate they will be holding the largest budget on a national level.

The current NHS reforms attempt to establish coterminous boundaries between local authorities and CCGs to facilitate joined-up commissioning strategies. This is an improvement on the PCT landscape, where boundaries were unrelated to those of local authorities, but this is not entirely resolved in the new system. In most areas CCGs outnumber HWBs, which adds a layer of complexity to the relationships within the group, as the CCGs will need to form agreements among themselves. A potential issue would be fear that joint arrangements could skew funds to provide for the needs of a neighbouring CCG's population. A more difficult scenario exists with the possibility of boards outnumbering CCGs, which would mean that some CCGs will have the even greater challenge of negotiating commissioning strategies with more than one HWB.

All this is taking place in an environment experiencing significant upheaval following the restructuring of the health sector. CCGs will still be relatively new bodies, finding their feet; public health will be settling into its new environment in the local authorities, and the NHS Commissioning Board will be establishing its role. There is also a lack of clarity around the existing structures within the local authorities. If some areas choose to keep hold of local strategic partnerships and operate HWBs alongside existing structures and strategies, this could weaken their role.

Funding streams

Mapping resources is a key component of plans to move towards a more co-ordinated commissioning strategy across health and social care. This will lay the groundwork for the next part of the process, which will involve negotiation and agreement among the stakeholders to determine how new services will be funded out of the separate budgets.

Three separate funding streams will be represented by the membership of the HWB: CCGs, local authorities and the NHS Commissioning Board. This poses a significant challenge, not least owing to the constraints of the current economic climate. Most notably, the marked tightening of local authority budgets following the comprehensive spending review will put significant pressure on the resources available from local authorities. Despite relative protection from budget cuts, the NHS sources will also be squeezed by the expectation to gain £20 billion in efficiency savings by 2015, an effective cut given the growing demand for services and inflationary rises in the costs for new treatments and technologies in healthcare.²

Finally, these constraints from both sides are likely to magnify potential issues arising from the transfer of public health funds and responsibilities to local authorities. However, it is expected that this ring-fenced budget will be used for on-going provision of the public health activities previously commissioned by PCTs, such as sexual health and drug misuse services.

Financial constraints will no doubt be cause for concern among the membership of the HWB and may pose the most likely barrier to successful joint commissioning. Past attempts at such joint activities have shown mixed results, and concerns may be based on examples where attempts at joint arrangements introduced during times of financial constraint have effectively been used to divert resources to plug gaps in funding rather than provide new integrated services.³

This tension may be reinforced by the differing sizes of the commissioning budgets. CCGs may well feel like the most vulnerable parties. Baseline spending estimates for the new system expected to inform 2013/14 budgets suggest that CCGs will be responsible for budgets of around £64.7 billion, with the NHS Commissioning Board wielding around £20 billion, and the transferred public health budget will be around £2.2 billion.⁴ In contrast, local authorities will have a pot of less than £14.5 billion

2 Staite, C and Miller, R *Health & Well-Being Boards: Developing a Successful Partnership* (University of Birmingham, 2011)

3 *Health & Well-being Boards: System Leaders or Talking Shops?* (King's Fund, 2012)

4 *Baseline Spending Estimates for the New NHS & Public Health Commissioning Architecture* (Department of Health, 2012)

available for social care services.⁵ In order to agree the use of these separate streams, a good understanding of previous expenditure and realistic baseline calculations will be essential to enable the new commissioning architecture to work effectively.

It will be down to the HWB representatives to establish the boundaries of responsibility for the three budgets in terms of relative contribution to commissioning relevant services. Traditionally a difficult task, there is considerable scope for blurring these boundaries. There is potential overlap between these functions. For example:

- The boundary between adult social care and public health may focus on activities such as preventing avoidable ill health or injury, including services such as re-ablement and early intervention.
- The divide between the NHS and Public Health may focus on preventing ill health and lifestyle diseases.
- The borderline between adult social care and the NHS may involve services to support discharge from NHS to social care and the prevention of emergency readmission through effective re-ablement or intermediate care services.⁶

Adding to the challenge of agreeing financing responsibilities will be the nature of the three separate budgets, each distributed by different weighted capitation, which may act as an incentive for commissioners to protect their budgets for other activities. The three formulas are unlikely to be spent in a representative way across the population if they are each brought into a communal pot to cover joint commissioning activities. Furthermore, the HWB will need to account for different commissioning cycles and mechanisms across the sectors.

Conclusion

The expectations placed on HWBs are high and the current financial environment and upheaval within the health sector add significantly to the challenge. Without appropriate levers to implement the strategies it is unlikely that the boards will succeed in joining health, social care and public health efforts where previous attempts have lacked impact.

The proposals represent a logical development of the nascent JSNAs that have informed planning and priority setting, but have not had the teeth required to transform services. By mapping resources and translating the priority setting into an overarching commissioning strategy, the new JHWS should feed into commissioning activities. The

⁵ *Fairer Care Funding* (Dilnot Commission, 2011)

⁶ Staite, C and Miller, R, op cit

HWBs bring together the relevant local commissioners to make these decisions. However, the previous lack of influence seen with JSNAs, owing to their limited power to enforce decisions, is not sufficiently addressed through the new arrangements. Without the levers to drive the use of the overarching commissioning plan, or a separate funding stream to provide for new services, the boards will not be able to effect real change.

Agreement about which budget will pay for which service will be fundamental to the success of HWBs. This will be necessary to achieve the desired goal of co-ordinated services across health, social care and public health to address the local population's health needs. Therefore, HWBs will be reliant on developing strong relationships to act as influencers. The key relationship will be engaging CCGs to bring the healthcare budget and services closer into the co-ordinated commissioning picture.

Chapter 2

Delivering integrated services

Richard Humphries, Senior Fellow at the King's Fund, and Claire Mundle, Policy Officer at the King's Fund

Delivering integrated services

The policy context

Health and well-being boards (HWBs) are central to the government's vision of a more integrated approach to health and social care. A key ambition of the reforms – set out initially in the white paper *Equity & Excellence: Liberating the NHS*¹ and culminating in the Health & Social Care Act 2012 – was to strengthen the relationship between local government and the NHS and to achieve a much more joined-up approach to a range of services that have an impact on health and well-being. In the new organisational architecture the HWBs are the principal vehicle to promote local integration, bringing together key players from the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch, to plan jointly how they can best meet the needs of their local population.

Controversy about the government's NHS reforms, particularly concerns about competition, has served to emphasise the value of the new HWBs in promoting integration and collaboration. The NHS Operating Framework for 2012/13 describes the HWBs as central to the new system, providing "local system leadership across health, social care and public health".² The second report of the NHS Future Forum argued that "health and well-being boards must become a crucible for integration".³

At the same time there has been almost universal acceptance of the growing need for better co-ordinated and integrated care in response to the challenges of an ageing population and rising numbers of people with long-term health conditions. Our review of the evidence for integrated care concluded that there are significant benefits that can arise from the integration of services,⁴ especially for people with complex needs.

But the creation of HWBs coincides with a period of complex organisational change and unprecedented financial pressures on both the NHS and local government. Will HWBs be up to the challenge of leading the system towards a fundamentally new model of care in these circumstances?

This paper reflects on the policy levers at the disposal of HWBs to achieve greater integration of services and draws on the lessons from our research in assessing the prospects for success in promoting integrated care.

1 *Equity & Excellence: Liberating the NHS* (Department of Health, 2010)

2 *The Operating Framework for the NHS in England 2012/13* (Department of Health, 2011)

3 *NHS Future Forum: Summary Report – Second Phase* (NHS Future Forum/Department of Health, 2012) (www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132026)

4 Curry, N and Ham, C *Clinical & Service Integration: The Route to Improved Outcomes* (King's Fund, 2010)

Policy levers to encourage integration

HWBs have a number of levers at their disposal to support them in their ambition to deliver integrated services. These are the joint strategic needs assessments (JSNAs) and joint health and well-being strategies (JHWSs), joint commissioning and pooling of budgets where appropriate, and integrated provision.

JSNAs and JHWSs

The vision for the JSNA is that it will help HWBs to identify local health needs and to prioritise and plan service provision strategically around these needs. In doing so, JSNAs seek to create a sense of shared priorities across organisations. Participants in our research study were very supportive of this tool to guide them in service planning, but wanted to develop JSNAs that had a broader scope (including areas like housing, employment and culture); were more user-friendly, succinct and regularly updated; and were available as a web-based resource. Respondents felt that this would make the JSNA more helpful to commissioners, and thus have greater influence on their decisions.

Another core function of the new HWBs is to produce a locally agreed health and well-being strategy as the strategic framework for commissioning local services. This strategy will need to balance the priorities of different services in the local area; maximise the opportunities for working together, sharing resources and outcomes; and create a shared understanding of the local priorities.

Will these new strategies drive greater integration? Most respondents in our research study thought that their strategy would be very influential in the decisions of clinical commissioning groups (CCGs) and would foster positive relationships and negotiations across the NHS and the local authority. Respondents were, however, either negative or unsure about the influence they would have over the NHS Commissioning Board.

This is very significant, because the NHS Commissioning Board will be responsible for commissioning all local primary care, dentistry and pharmacy services as well as specialised services – comprising as much as £20 billion of the total NHS budget. If the new boards are to promote the strategic co-ordination of all local services relevant to health and well-being, they will need to influence all commissioning activity affecting their local population, including the NHS Commissioning Board.

Joint commissioning and pooled budgets where appropriate

HWBs will need to align the resources and commissioning plans from a number of providers in order to deliver integrated services. Research suggests it is clinical and

service integration rather than organisational integration that makes the biggest difference to outcomes for people. Pooled budgets are another means of improving outcomes for those with complex needs, who rely heavily on a range of services and need seamless co-ordination among the providers responsible for their care.

The practice of joint commissioning involves a number of difficulties that HWBs will need to try to overcome. According to the Department of Health, "the accountability for joint commissioning can be weak, leading to misunderstandings and the breakdown of relationships. Incentives within commissioning systems do not yet fully support the delivery of better health and well-being. Funding routes, for example, can be real barriers to effective partnerships, service integration and innovative use of the health and social care estate. Clarification of rules and freedoms... would help."⁵

There are many examples of poorly executed commissioning in health and social care, and the current skills gap in commissioning remains a challenge for many local areas as the reforms begin to be implemented.⁶ Different commissioning cycles also exist for local authorities and the NHS – they will need to be reconciled where possible, to enable HWBs to drive joint commissioning forward.

The use of pooled budgets is another means of aligning resources but at present these represent less than 5% of total NHS and social care expenditure. HWBs will need to explore a range of ways to develop a more integrated approach to commissioning and the use of resources across organisational boundaries.

Integrated commissioning and provision

In some cases integration may involve sharing responsibility for commissioning and provision. There is evidence to suggest that approaches to integrated care work best when some of the responsibilities for commissioning services are given to those responsible for delivery.⁷ Importantly, it promotes collective accountability among providers for the quality, costs and outcomes of care, as incentives to integrate services are aligned and this approach becomes more culturally and systematically embedded.⁸

Clinicians in CCGs, who will be both "making and buying" services for their resident

⁵ *Commissioning Framework for Health & Well-Being* (Department of Health, 2007)

⁶ *Improving the Quality of Care in General Practice: Report of an Independent Inquiry Commissioned by the King's Fund* (King's Fund, 2011)

⁷ Christensen, CM, Grossman, JH and Hwang, J *The Innovator's Prescription: A Disruptive Solution for Healthcare* (McGraw Hill, 2009)

⁸ Ham, C, Imison, C, Goodwin, N, Dixon, A and South, P *Where Next for the NHS Reforms? The Case for Integrated Care* (King's Fund, 2011)

populations, will be included in all of the HWBs we interviewed. However, many boards have chosen to exclude other providers. Research has suggested that many integrated care partnerships are likely to be led by providers rather than commissioners in the first few years, given the difficulties commissioners have historically had in progressing integrated care plans.⁹

If HWBs are to be a genuinely new and effective vehicle for integration, it is vital that all local authorities look afresh at ways of working with local partners. They must avoid uncritically carrying forward previous partnership arrangements, with a hard separation of commissioner and provider roles.

Will the boards achieve success?

We interviewed 50 HWB leaders about how their boards were developing. The research specifically probed efforts to develop more integrated care. On this, the majority of respondents were optimistic that they would be able to make headway. Over 90% felt that HWBs would act as a vehicle for closer working relationships between the NHS and local authorities. Over 80% believed that HWBs would be able to drive co-ordinated care planning and encourage increased pooling of commissioning budgets. Only a very small number were less convinced that HWBs would have a positive impact on integration (see figure 1).

Despite the optimism that HWBs will make progress in integrating services, local leaders were very aware that achieving these ambitions will require a lot of effort and commitment. On top of the issues set out above, the research identified a further set of conditions under which integration would flourish, and a number under which integration would fail to take off.

What else will help HWBs to deliver integrated services?

A clear commitment to integration, particularly through closer alignment and sharing of resources, will be very important. Defining what integration will look like locally, and how it will be achieved, will be a key priority for boards, expressed in their HWB strategies as well as through their commitment to working together better.

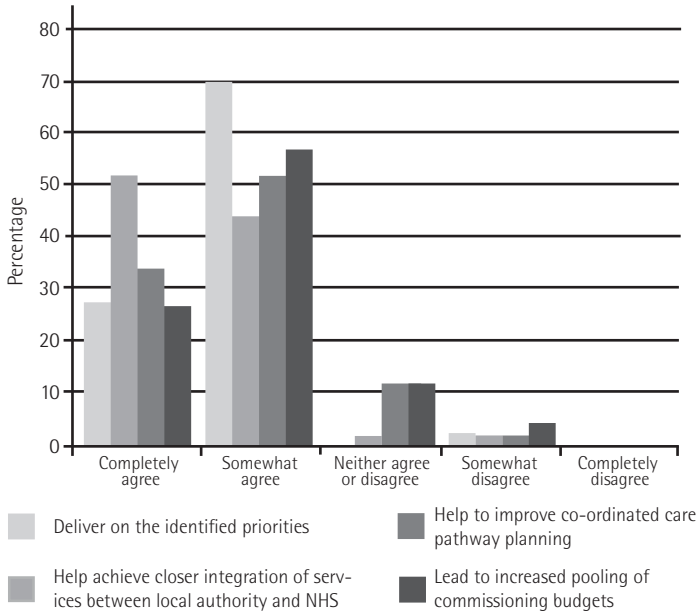
Indeed, respondents in our research study cited strong working relationships as the most important factor that will help them deliver on their objectives, but achieving this will require board members to work in ways they may not previously have been

⁹ Goodwin, N, Smith, J, Davies, A, Perry, C, Rosen, R, Dixon, A, Dixon, J and Ham, C *Integrated Care for Patients & Populations: Improving Outcomes by Working Together*, a report to the Department of Health and the NHS Future Forum (King's Fund/Nuffield Trust, 2012)

required or able to do. They will need to have frank and full discussions themselves, a genuine willingness to work with one another, and a commitment to building on and learning from the positive relationships that already exist.

Figure 1: HWB leaders' expectations of success

Percentage of leaders expecting that their HWB will achieve the following:



Dedication to working on the board, and the ability to agree on priorities for the good of the area, rather than solely on the good of a particular service, will help foster strong working relationships, as will visionary leadership and competent management qualities among board members. Many respondents were easily able to identify these factors as ingredients to success, but also indicated that hard work would be needed at the local level to develop and embed these practices across organisations.

Interestingly, a small number of respondents viewed the economic downturn as an opportunity rather than a constraint. Resource pressures might encourage organisations to think of "new ways of doing things" in partnership, as opposed to on their own, to ensure that the scope and scale of local provision stretches across the populations that need it.

And what are the other obstacles?

A number of other barriers to integrated working were identified in the research study. The biggest challenge for HWBs is whether they can deliver strong, credible and shared leadership across local organisational boundaries. Budgetary constraints may well make it difficult to overcome this challenge. The financial pressures on the NHS and local government may lead organisations to try to manage these pressures by retreating into silos instead of fully embracing the opportunity to develop shared plans and resources. Financial pressures might also inhibit investment in prevention and well-being services, or for tackling health inequalities and the wider causes of ill health – services that are badly needed but hard to implement without strong partnership working across the NHS and the local authority.

Structural change was frequently mentioned as another factor that would hinder the effectiveness of the new boards, at least in the short term. Many respondents feared that the continued changes at both local and national levels would create fatigue and confusion within their local system, and this would undermine relationship building and the ability to reach local agreements. Although the government's approach to the boards is relatively non-prescriptive, some respondents saw a high level of national control as a potential threat and were concerned that national "interference" would inhibit boards from working on what really matters to their local populations.

Lack of clarity about the scope and purpose of the boards was also a significant concern at the time of our research, although as the HWB strategies are developed, and the boards meet more regularly, we hope that these concerns will be resolved.

Lessons from history

It is worth remembering that the vision of joined-up, effectively co-ordinated and jointly planned services is not new. Past efforts – including joint consultative committees, joint care planning teams and, more recently, local strategic partnerships – have achieved mixed results, often coming up short against the question of why this is.

Joint consultative committees (introduced in the 1970s), aside from lacking sufficient decision-making powers, were largely ineffective because the joint funding under their oversight was small and the main impact appeared to be offsetting local authority budget cuts rather than pioneering new forms of joint investment.¹⁰

¹⁰ Webb, A and Wistow, G *Social Work, Social Care & Social Planning: The Personal Social Services Since Seebomh* (Longman, 1987)

A recent review of the experience of local strategic partnerships also offers some relevant insights for HWBs, namely that:

- important lessons can be learned from other local strategic partnerships despite their unique features;
- they must seek to influence partners' mainstream spending and activity despite not having control of the resources;
- there is a need to develop strong cultures to achieve shared goals; and
- in multi-tier areas, there are greater challenges for these partnership arrangements than for those in single tiers; despite the fact that they are voluntary, unincorporated associations, they must recognise their strategic, executive and operational roles.¹¹

Scotland's community health partnerships, which were established to integrate health and social care services and shift provision from acute care into the community, have also recently been hindered by persistent siloed management of resources, staff and information.¹²

Conclusions

HWBs are likely to face similar challenges to previous partnership bodies. While they will differ from past arrangements in a number of important ways, including their statutory footing, they will, like their predecessors, be tasked with achieving greater integration and better outcomes for their local population. They will have to do this not through exercising managerial authority or control, but through influencing and leading across organisational and professional boundaries.

They will also grapple with the same logistical challenges as previous partnership bodies, but in the context of the much more complex organisational architecture arising from the NHS reforms, in which the roles of CCGs, the NHS Commissioning Board and local authorities remain unclear. In addition, HWBs begin their task in the face of even greater financial pressures than those that helped to undermine the early efforts of their joint consultative committee.

In rising to these challenges it is critical that HWBs have:

- sufficient time and resources devoted to the boards to ensure they deliver strong, credible and shared leadership between local organisations;

¹¹ *Working Better Together? Managing Local Strategic Partnerships* (Audit Commission, 2009)

¹² *Review of Community Health Partnerships* (Audit Scotland, 2011)

- clearly defined responsibilities and roles of all new bodies in the new health system, that balance national and local priorities;
- access to a national framework for integrated care to provide clearer joint accountabilities across health and social care, and to ensure joined-up care; and
- providers at the table, to provide a catalyst for driving integrated care.

Finally, it is important to recognise that HWBs on their own will struggle to overcome some of the deep national fault lines that have bedevilled past efforts to achieve integrated care. The government has committed itself to producing a new framework to remove some of the barriers to integrated care. The success of HWBs at the local level requires a stronger national framework based on a clear, ambitious and measurable goal to improve people's experience of integrated care – a must-do priority for the next decade akin to that of reducing hospital waiting times in the past decade.¹³

13 Goodwin et al, *op cit*

Chapter 3

Developing relationships – the role of local government

Cllr David Rogers OBE, Chair of the Community Wellbeing Board at the Local Government Association

Developing relationships – the role of local government

It is something of an understatement to say that the Health & Social Care Act 2012 has been one of the most controversial pieces of legislation in recent years. But now that the sound and fury that accompanied the legislative process have abated, we in local government are firmly focused on preparing to play a leading role in the new landscape for health. A key task for local government will be to build on our existing relationships, forged over many years, and develop robust and purposeful relationships with new partners.

For councils, health and well-being boards (HWBs) are *the single most important* component of the new health landscape created by the Health & Social Care Act 2012. They will be the engine that drives a new system-wide approach to health improvement based on a shared understanding of health and well-being needs, developed through the joint strategic needs assessments (JSNAs), a shared understanding of priorities outlined in the joint health and well-being strategy (JHWS) and deployment of shared resources to achieve lasting health improvements.

This is a radical new approach, which will need to shift partnership working and integration from a marginal activity to the main way of doing business. Integration and shared priorities have been an aspiration for health and social care for many years. How do we ensure that this time we achieve this shift? I strongly believe that the only way we can do this is by moving our focus from structures and processes to outcomes and relationship building. HWBs are the primary means through which we will agree on shared outcomes and build strong relationships. But relationships with whom? It will take considerable skill for HWBs to hold the ring in this complex system of relationships, as illustrated in figure 1.

The challenge for HWBs will be to develop strong, clear and purposeful relationships in four broad categories:

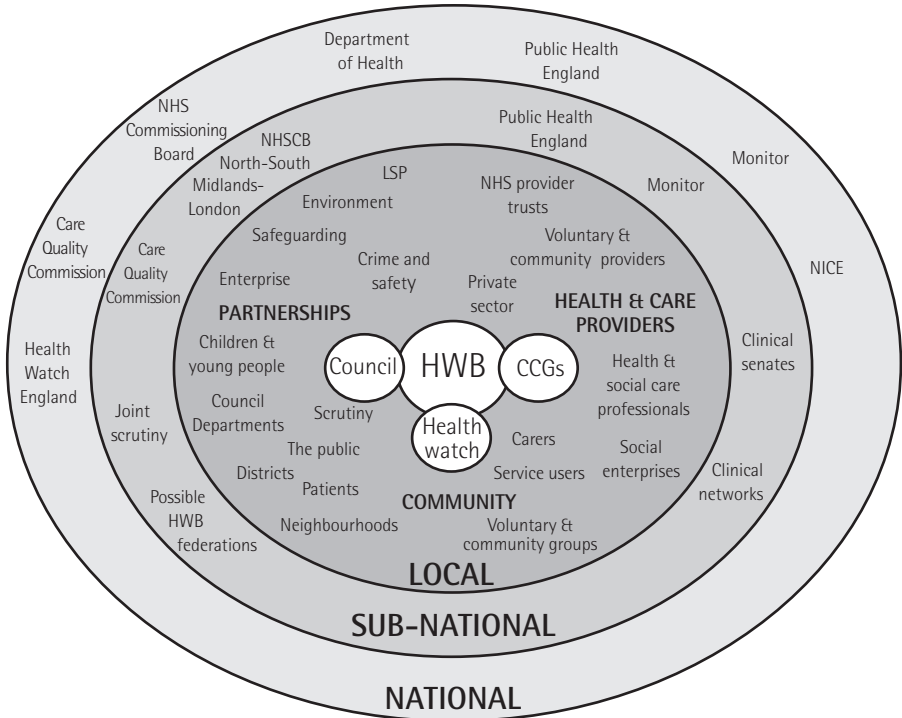
- within the HWB itself;
- with communities;
- between commissioners; and
- between local, regional and national levels.

Relationship building within HWBs

For many areas, HWBs will be the first partnership in which GPs and elected members work jointly on a shared agenda as equal partners, with equal and shared statutory

Figure 1: HWBs – developing relationships

Some of the national, subnational and local bodies with which HWBs will need to form relationships



responsibilities. Similarly, officers – the directors of adult social care, children's services and public health – who have previously occupied the role of advisers to elected members will now participate as equal members of HWBs alongside councillors. Patient-public representatives, in the form of Local Healthwatch, will have a statutory place on HWBs and will need to participate fully, taking shared responsibility for difficult decisions on local commissioning priorities that could, potentially, lead to reconfiguration of services and challenges from service user groups. Local Healthwatch will need to address how it participates in HWBs as an equal partner and provides a representative voice for service users and the public.

Elected members are also likely to find themselves facing new challenges, not least in how they hold together and balance the politics of place, their democratic mandates

as conferred by the local electorate, and their responsibility to the collective leadership of the HWB.

In such circumstances it might be tempting for HWB members to avoid difficult issues by focusing on structures, governance and constitutional architecture for the board. While all these components are important, they should not distract from the important task of making sure that the board works effectively.

A number of boards have made sure that they limit the amount of time they spend on structural and constitutional issues at each meeting to ensure that they focus on organisational development. For example, Wigan is one of several boards to use an external facilitator to:

- talk to individual board members to get a sense of their hopes, concerns, challenges and priorities in joint working, and identify potential cultural differences between different local government and the NHS;
- organise workshops with the board to establish a common purpose and vision;
- get a sense from "critical friends" not on the board to gain their views; and
- bring together all this information to agree shared values, relationships and behaviours, as well as operational processes.

But we need to remember that, while this vital organisational development activity is under way, some members are not yet *sitting at the table*. Representatives of the NHS Commissioning Board and Local Healthwatch will be arriving later than other members; how existing board members help to create the space for meaningful participation by new members will be an important consideration.

The ability to engage and work with diversity will be another challenge for HWBs. Diversity takes many forms, including the diversity of the partner organisations represented at the HWB, with their different cultures, governance and priorities. There is diversity too in the preferred working style of each board member. Some board members will bring expert and specialist knowledge, while others will have a more generalist perspective. Diversity can bring new insights and ways of knowing to encourage innovation and creativity. The trick will be to recognise and maximise the unique contribution of each HWB member.

Relationships with communities

A central tenet of the government's reform agenda for health is local accountability of health services – addressing the so-called "democratic deficit" in health that has

existed for decades. We strongly support this move towards localism. At present, priorities for the health service are set by the secretary of state for health; this applies to all areas, irrespective of their varying demographic profiles and health needs. After April 2013, aside from broad outcome frameworks, priorities for health will be identified locally by the HWB and clinical commissioning groups (CCGs) in the joint health and well-being strategy based on a comprehensive and inclusive process of joint strategic needs assessment. This is a massive cultural shift and will require HWBs to engage their communities in an "honest conversation" about the most effective ways of investing public resources to achieve improved services, reduced costs and improved health outcomes. In the context of shrinking resources and growing demand, in many areas this "honest conversation" will have to consider service reconfiguration, decommissioning of some services and development of more effective and efficient services. In many areas, this will be a difficult conversation to have.

But HWBs are not shirking this responsibility. Many are already developing new and purposeful engagement with their communities to inform their joint health and well-being strategies. For example:

- representation on the HWB of other voluntary and community organisations to represent community interests;
- creating large standing conferences or assemblies, which meet a couple of times a year, to inform the work of the HWB;
- stakeholder involvement in the subgroups or task and finish groups that HWBs set up to focus on particular issues – for example, children's health, services for people with diabetes, teenage pregnancy and sexual health;
- separate advisory forums for providers from across health, social care, the community and voluntary sector, and associated sectors such as housing or the police; and
- HWB subgroups set up to reflect geographies within the HWB areas, such as districts, town councils and neighbourhood areas, including existing community and voluntary organisations.

Local government will also commission Local Healthwatch services, the new patient and public consumer champion for health, well-being and care services. Local Healthwatch is an important new addition to the rich tapestry of community and voluntary organisations that already exist in our communities. These bodies will be statutory members of HWBs and will have joint and collective responsibility for HWB decisions. They will also need to build on and join up with existing community and voluntary organisations to ensure that all voices on health and well-being are heard.

Relationships between new commissioners – striking a balance between continuity and change

Some of the more sceptical commentators have questioned whether HWBs really represent a new form of partnership or simply reflect what has gone before. My strong response is that unless we do things differently, HWBs will not be effective in driving system change. And we urgently need system change because our current system of health and social care will not be able to withstand the "burning platform" of rising health and social care needs of an ageing and sicker population with diminishing resources.

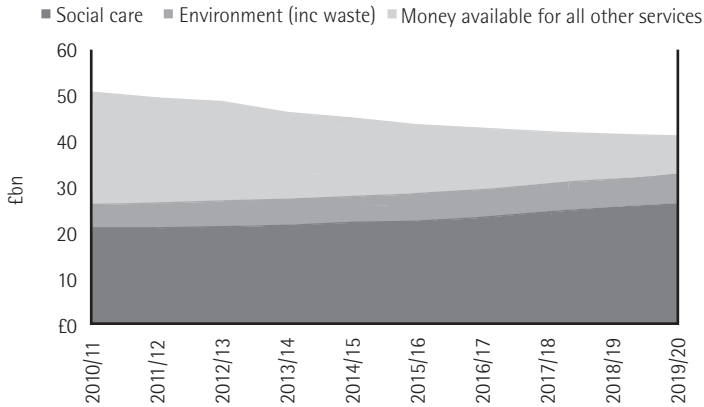
The recent report by the King's Fund on NHS funding¹ observes that, 18 months into the Nicholson challenge to deliver £20 billion of efficiencies by 2015, concerns are growing about how the NHS can continue to improve service quality. In local government, we are facing our own funding challenges. The Local Government Association's own financial modelling estimates that adult social care expenditure will increase 84% from 2010 to 2030, from £14.5 billion to £26.7 billion,² with major consequences for local government. The figure below forecasts how money available for all other council services will be severely squeezed unless we significantly increase resources for adult social care and change the pattern of service provision so that we intervene early to provide preventative services that promote health and independence, reducing the need for more intensive and high-cost health and social care services.

HWBs will need to identify how commissioners can work together to redirect public resources from treating the ever-growing burden of sickness to actively promoting health and well-being.

Early evidence from HWBs is that they are committed to taking this approach. Blackburn with Darwen HWB is reshaping well-being services from separate programmes to an integrated self-care and well-being service based in GP practices, including support to tackle the wider determinants of health such as employment, and aligned with a range of neighbourhood providers. Oxfordshire is looking to develop a "new public health" working through the "organised efforts of society". This starts with a coherent work plan involving the voluntary and faith sectors, local entrepreneurs, philanthropists and universities to harness energy and

1 *How Is the NHS Performing?* (King's Fund, September 2012) (http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/how-is-the-nhs-performing-quarterly-monitoring-report-sept12.pdf)

2 *Funding Outlook for Councils from 2010/11 to 2019/20: Preliminary Modelling* (Local Government Association, June 2012) (http://www.local.gov.uk/c/document_library/get_file?uuid=01a7770d-ed32-4bac-ae43-8fb4090e5d65&groupId=10171)

Figure 2: Local government expenditure forecast 2010-20

creativity. These are just two examples of a new approach to health and well-being, involving new partnerships and led by the HWBs.

But while change is imperative, it is important to recognise that local government is the only point of constancy in a changing health landscape. It will be our responsibility to reach out to new partners in CCGs, Local Healthwatch and the local teams of the NHS Commissioning Board, and Public Health England to establish relationships based on the shared aim of improving local health and well-being.

Relationships between local, regional and national levels

At national level the most striking change in the health landscape is the diminishing role of the Department of Health in the management of health services and public health, and the appearance of new players – the NHS Commissioning Board and Public Health England. The NHS Commissioning Board is the performance manager of CCGs (which will commission the majority of healthcare), as well as the direct commissioner of local primary care services (GPs, dentists, pharmacy) and for some public health services including screening, immunisation and vaccination. Public Health England is an executive agency of government and will be responsible for health protection, emergency preparedness and provision of public health information and evidence. Clearly, they will need to work closely with local government and with HWBs to operate effectively. For example, the NHS Commissioning Board will need to have a clear understanding of the HWB joint health and well-being strategy in order to ensure that the commissioning plans of the CCGs address local priorities, and Public Health England will need to work closely with local government on arrangements for

emergency planning and health protection.

Both organisations will have a regional and local presence and will need to develop a clear understanding of the role of HWBs in improving and protecting health and planning effective services.

How are HWBs being supported by the Local Government Association?

As committees of local councils, local government will be charged with overall responsibility for the effective operation of HWBs. There is a real momentum around sector-led improvement, with the Local Government Association (LGA) taking a lead role in overseeing and supporting the performance of the sector. The LGA is delivering a variety of programmes to support and develop the effective operation of HWBs. For example, *From Transition to Transformation in Public Health*³ provides advice and case study examples on how to maximise the transformative potential of the new public health function within local government. The LGA's peer challenge programmes have touched upon HWBs, for example through corporate peer reviews, and children's and adults' peer challenges.

The LGA is delivering a comprehensive programme to support the leadership and development of HWBs. Funded by the Department of Health as part of the overall national learning network for HWBs, the programme focuses on the critical leadership role of HWBs and is aimed at equipping board members with the leadership behaviours, skills and knowledge to help them operate effectively in a complex cross-organisational environment.

The programme comprises an "offer" to HWBs that includes national, regional and board-specific activity.

Nationally – We have developed a tool for use by all HWBs that challenges them to consider their position now and their ambitions for the future. It encourages board members to think about their role and vision, their behaviours within the partnership, governance arrangements and the achievement of outcomes for their communities. The LGA is working with key partners to develop a shared concept of system leadership to identify what good system leadership looks like and how boards can embed effective leadership throughout local health and care systems.

Regionally – A programme of simulation workshops is being delivered to test how

³ Local Government Association *From Transition to Transformation in Public Health* (2012)

boards will deal with big and difficult issues. Each board will be encouraged to produce an action plan identifying learning and development needs.

We are also supporting HWB Chairs Networks across each region to share their experience and learn from and support each other.

Locally – The LGA is working with the NHS Leadership Academy to provide customised support to a small number of boards facing particular challenges, those that are further forward in their journey and where boards have made a specific development request.

Conclusion

The transfer of public health to local government, and the responsibility of councils for the effective operation of shared leadership through HWBs, brings both opportunities and challenges for local government and our partners, particularly in a climate of financial constraints. Nevertheless, local government has been unanimous in its support for taking leadership of public health, recognising that local councils can make a difference to the lives of local communities but only by doing things differently.

The extent to which HWBs will be successful in making a difference to the health and well-being of local communities and in tackling health inequalities will be dependent upon the extent to which relationships of trust are developed, whether or not boards have evolved shared values and behaviours, and the formation of a clear vision about what board members are working to achieve for local people. HWBs – with elected members, professionals, health commissioners and community representatives taking tough decisions about the local priorities and plans that will be the most effective in achieving good health and well-being – must be acknowledged as the driving force behind system change.

Chapter 4

Engagement with clinical commissioners

Dr Michael Dixon OBE, Chair of the NHS Alliance and Senior Member of the NHS Clinical Commissioning Coalition, and Professor Chris Drinkwater CBE, FRCGP, MFPH (Hon), President and Public Health Lead at the NHS Alliance

Engagement with clinical commissioners

Medicine is a social science and politics nothing else but medicine on a large scale.

Rudolf Virchow 1821-1902

Rudolf Virchow is best known to generations of doctors as an eminent 19th-century pathologist. He is less well known as a civic reformer and both a member of the Municipal Council of Berlin and leader of the Radical or Progressive Party in the Prussian Diet, largely responsible for introducing modern water and sewage systems to Germany. His view was that medicine and politics need to act in tandem and that while medicine, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution, the politician must find the means for their actual solution.¹

The juxtaposition of clinical commissioning groups (CCGs) and health and well-being boards (HWBs) has the potential to create a new, and potentially dynamic and creative alliance, between clinicians and local politicians. Indeed, the ability of CCGs to work effectively in tandem with HWBs, on a shared agenda of engaging with local communities to address inequalities and an epidemic of behaviourally determined long-term conditions, will be critical to the success or failure of the current reforms.

The omens are not universally encouraging. The passing of the Health & Social Care Act 2012 has resulted in the proliferation of multiple detailed guidelines from the Department of Health. These include *The Functions of Clinical Commissioning Groups*,² *Clinical Commissioning Groups: Draft Authorisation Guidelines*,³ *JSNAs & Joint Health Strategies – Draft Guidelines*⁴ and most recently a *Draft Mandate for the NHS Commissioning Board*,⁵ to name but four. The common feature of all these documents is that they are about outlining the duties and powers of particular bodies in order that they can be held to account in a linear model, based on delegation down and accountability up. The most recent letter from the NHS Commissioning Board on compliance with NICE guidelines appears to be more of the same. Some of this may be necessary, but much of it is "old-style" in execution, with its implementation led by those who were leaders of the previous NHS order.

1 http://en.wikipedia.org/wiki/Rudolf_Virchow

2 Department of Health *The Functions of Clinical Commissioning Groups* (June 2012)

3 <http://healthandcare.dh.gov.uk/authorisation-guide-published>.

4 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131702

5 <http://www.dh.gov.uk/health/2012/07/draft-mandate-consultation>

Indeed, some might interpret this plethora of advice from on high as an apparent desire to prevent CCGs from engaging effectively with the HWBs and with local politicians. The most recent document on the general duties and powers of HWBs states, for instance, that "to reduce the burden of every CCG in a local authority area being required to appoint its own representative, two or more CCGs may be represented by the same person on the HWB".⁶ This document also states that the NHS Commissioning Board must appoint an HWB representative for the purpose of participating in the preparation of joint strategic needs assessments (JSNAs) and joint health and well-being strategies (JHWSs). And more recently the Department of Health has confirmed that local councillors will not be allowed to sit on CCG boards.

It is not hard to read into this a desire to protect CCGs from local political processes together with a wish to impose a top-down, mechanistic linear model with in-built controls and regulators. Such models have a powerful and attractive provenance for those seeking to bring order out of chaos. They do, however, have significant limitations when applied to complex local health and social care eco-systems, and sadly we have yet to discover a mechanistic model that delivers effective partnership working.

This approach also overlooks the fact that, at grassroots level, GPs and local councillors have much in common. They both run surgeries and they often share and feel a common concern for local issues and for the wider determinants of health. Furthermore, they have often lived in their local area for many years and share the pain of local success and failure in health and services to a much greater degree than those from outside or anyone temporarily placed in their local patch. Together, they provide potentially a very powerful political platform from which to challenge an overbearing centre.

The nightmare scenario against which the Department of Health seems to be trying to guard is that the HWB in tandem with Healthwatch will challenge commissioning plans, decommissioning decisions and any attempt to reduce unsustainable demand or to change the status quo. This brief article will argue that the development of effective partnerships with local politicians, service providers, and patients and the public, which will need to include greater transparency about the costs and benefits of healthcare, is the only way to reduce unsustainable demand on local public services. This will require CCGs to give a high priority to HWBs if they are to become effective commissioners. Harmony between the two will be the *sine qua non* for the success of current reforms.

6 <http://www.dh.gov.uk/health/2012/07/consultation-jsna>

Why CCGs need to work with HWBs

CCGs' most important commissioning relationships will be with local NHS provider trusts. They will need all the help and support that they can get in managing that relationship, which will necessarily include discussions about decommissioning, service redesign and procurement. The NHS Commissioning Board and commissioning support organisations can provide some of that support, but at a local level there is a real opportunity for the HWB to become a forum for high-level discussions about local needs, priorities and integrated working. At present much of this discussion takes place in the context of cost pressures and adversarial annual contract negotiations that sometimes end in time-consuming arbitration.

If this is to happen, the joint strategic needs assessment and the local health strategy need to be widely owned, accepted and understood at all levels of the whole local health and social care system and by service users and the wider public. The challenge for the HWB is to build this wider understanding and engagement. This is probably best done using a mixture of methods, which might include some or all of the following:

- widening the membership of the HWB beyond that specified by the Health & Social Care Act to include local NHS and voluntary sector providers;
- if not widening the membership, then ensuring that there is an effective local provider forum that includes the voluntary sector and GPs as providers. The goal should be integrated provision, and this means local providers talking to one another about how they are going to work together more effectively;
- ensuring that the JSNA and the strategy are written in accessible language, that they focus on assets as well as deficits, and that they are widely available and supported by a communications strategy;
- working with all partners to ensure that there is a local framework for wider discussion and debate about how best to translate the strategy into action – from a CCG perspective this means discussion with all the GP practices within a CCG and with their patient participation groups, preferably as collective events.

HWBs could also become a forum for transparent discussion of local financial pressures. In the current economic climate public services, whether directly provided or commissioned, will need to make savings. This will require more effective use of the total amount of public-sector funding coming into a local area.

There is a natural tendency for organisations to focus on their own interests, but an exploration of how local public-sector funding is spent is likely to demonstrate some or all of the following features: budgets from separate organisations being used

to support the same group of people or geographical area without any overall co-ordination; cost shunting between organisations and/or organisations investing in preventive initiatives that result in benefits to other parts of the system; and lack of clarity about financial flows through the system, in terms of what it purchases and what outcomes it produces.

It is in the interest of the HWBs and CCGs that local providers, whether private, public, voluntary or social enterprises, thrive and deliver sustainable high-quality services. Facilitating joint working in order to align resources so that they meet identified priorities and improve outcomes should be a key part of delivering the local health strategy.

How CCGs might work with HWBs

The concept of co-production is gaining increasing interest and a higher profile in health system reform. It lay behind the 2002 Wanless report,⁷ which postulated a "fully engaged" scenario in which the public took more responsibility for their own health, with a predicted saving of £30 billion a year by 2022 when compared with a "slow uptake" of engagement in taking responsibility.

More recently it has been taken up by NESTA and the Innovations Unit to support the design and delivery of innovative services for people that are living with long-term health conditions, as part of their People Powered Health Programme.⁸ As described by NESTA, the programme focuses on co-production – the principle that people's needs are better met when they are involved in an equal and reciprocal relationship with professionals, working together to get things done. It is a radical approach to public services that is built around six characteristics:

- recognising people as assets;
- building on people's capabilities;
- promoting mutuality and reciprocity;
- developing peer support networks;
- breaking down barriers between professionals and users; and
- facilitating rather than delivering.

Much of the work on co-production has been done at the level of the interaction between the individual service user and the health professional, but it also has resonance for co-production of better local health outcomes between the component

7 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009293

8 http://www.nesta.org.uk/areas_of_work/public_services_lab/people_powered_health

parts of the local health and social care economy: in essence this is about pooling resources and recognising and building local assets. It is about promoting stronger, "health-creating" local communities, who are better able to take responsibility for their own health.

HWBs and CCGs represent a unique coming together of individual patient/clinician interactions (at general practice level) and the coming together of patients/people and clinicians collectively at the level of the HWB and CCG. This gives them an equally unique yet crucial ability to drive co-production – a concept that has been too often mentioned nationally without being implemented locally.

In order to achieve this, HWBs and CCGs will need to develop a style of facilitative leadership that drives effective partnership working between local providers and local professional tribes. There will also need to be an open and transparent approach to working with Healthwatch, together with a focus on addressing inequalities at an intensity and scale that is proportionate to the level of disadvantage (proportionate universalism).⁹

Apart from the style of working, there is also an issue about the main focus of the work. GPs as a breed (and CCGs are likely to be no different) are pragmatic and action-oriented. If HWBs become talking shops rather than local system leaders, GPs are likely to walk away. Given the present time pressures and service demands, CCGs are also likely to recognise that there needs to be agreement on a few clear local priorities where commissioners and a wide range of local providers have a common interest. These priorities are most likely to be older people, mental health or long-term conditions. As well as providing challenges and needing new approaches, they are an excellent opportunity for local partners to learn to work in more effective and integrated ways. The remainder of this article will focus on older people as an example of how this might work.

Working together for the benefit of older people

Most current JSNAs for older people focus on categorising the increasing number of older people who are likely to have health and social care needs, and pay relatively little attention to prevention or to older people as assets. This tends to reinforce the demand-led reactive model of care, at the same time as it ignores the increasing number of older people who want to enjoy life, stay engaged and contribute to their local communities. In order to shift from a deficit model to an asset model, HWBs and

⁹ <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

CCGs need to work together to create a story that makes sense and that fully engages all local partners, including patients and the wider public. This story also needs to be built into a long-term vision that is part of the local strategy for older people.

The most important part of this vision is that it takes a life course approach and that it focuses on prevention. Much of the current focus around inequalities in health is on the early developmental life cycle. Arguably, in the developed world we now live in an era with two sequential life cycles: a developmental life cycle from pre-conception to mid-life and a later life cycle from mid-life to end of life. There are already more people aged over 65 than under 15.¹⁰ If we are going to make best use of our assets, we therefore need to pay as much attention to protecting and nurturing people in the later life cycle as we invest in the early life cycle.

The strongest argument for this relates to disability-free life expectancy: the poorest people die on average seven years earlier but, more importantly, they have on average 17 years of disabled living before they die. The Marmot report estimated the total public finance cost of this (NHS costs, productivity losses, lost taxes and welfare payments) at around £56.5 million a year.¹¹

One possible framework for this is to split the second half of life into four phases:

- preparation for active old age;
- active old age;
- vulnerable old age; and
- dependent old age.

The nearest the NHS gets to preparation for active old age is the Health Check Programme for people aged 40-74, which consists of measuring cholesterol, blood pressure and body mass index and doing a diabetes risk assessment. The outcome can be a clean bill of health, lifestyle advice, medication or further investigation.

Commissioning of this programme will be a local authority public health responsibility under the new arrangements. This provides an ideal opportunity for public health and local authorities to work closely together to ensure that this programme is targeted at those who most need it and to ensure that, as well as lifestyle advice, there are services available – such as health trainers – to motivate and support people to change their behaviours in the areas of diet, physical activity, smoking and stress levels.

¹⁰ <http://www.guardian.co.uk/world/2008/aug/22/population.socialtrends>

¹¹ <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

The increasing number of active older people who want to stay engaged with their local communities is possibly the biggest untapped social asset in the UK. A 2007 North American research review of the health benefits of volunteering in older people found a significant relationship between volunteering and good health and stated that when individuals volunteered they not only helped their community, but also experienced better health in later years, whether in terms of greater longevity, higher functional ability, or lower rates of depression.¹² These findings have subsequently been reinforced by work done by the European Foundation for the Improvement of Living & Working Conditions as part of the 2011 European Year of the Volunteer, which stated that "the scope for involving older people in volunteering could be increased by taking steps to involve all people of working age to a greater extent in preparation for a retirement spent volunteering".¹³

At a local level, emerging HWBs, voluntary-sector partners and CCGs need to look at how they work together to develop a systematic approach to increasing levels of volunteering in active older people. This would need to take on board some of the barriers to volunteering identified in a report by the Joseph Rowntree Foundation, which recommended that organisations broaden their base of recruitment to include those older people currently underrepresented as volunteers for stakeholder groups.¹⁴ Done sensitively with existing local voluntary sector providers, this approach provides an opportunity to develop a network of local peer support befrienders, who can work with vulnerable older people identified by health and social care in order to prevent vulnerability becoming expensive dependency.

Conclusion

HWBs need to become leaders of the local health and social care economy, facilitating and driving effective local partnership working and ensuring that commissioning plans are consistent with the HWBs. CCGs will need to give a high priority to working with the HWBs, and they will need to explore imaginative and innovative approaches to reducing unsustainable demand without compromising quality or provision for appropriate and justifiable needs.

A successful relationship between CCGs and HWBs will inevitably lead to rebalancing of the relative importance of patient and public views, clinical judgment and scientific evidence, just as it will lead to a rebalancing of local and central priorities. Indeed,

12 Grimm, R, Spring, K and Dietz, N *The Health Benefits of Volunteering: A Review of Recent Research* (Corporation for National & Community Service, 2007)

13 www.eurofund.europa.eu/resourcepacks/volunteering.htm

14 Joseph Rowntree Foundation "Volunteering in Retirement" (www.jrf.org.uk/publications/volunteering-retirement)

their relationship could prove to be the NHS's first real brush with complexity theory,¹⁵ bringing clinicians and local politicians together and enabling the results of their combustion. If CCGs and HWBs get it right then they could bring about that radical shift in health and services that is so needed by our patients and the wider NHS, and so desired by those who introduced the current reforms.

15 Sweeney, K and Griffiths, F *Complexity & Healthcare: An Introduction* (Radcliffe Medical Press, 2002)

Chapter 5

Adult social care

Pam Creaven, Director of Services at Age UK and Ruthe Isden, Public Services Programme Manager at Age UK

Adult social care

It is striking that health and well-being boards (HWBs) are referenced on only three occasions in *Caring for our Futures*, the white paper setting out future reform of the social care system. Of those three mentions, two directly refer to integration and the third briefly highlights HWBs as a route to involving the public in decisions about health and care services.

There is no doubt that HWBs have hugely important work ahead of them to promote integration and deliver joined-up strategic leadership across health, social care, housing and local services. However, to set that aside for one moment, it is also true that the white paper hardly paints a compelling vision of what HWBs could achieve in social care or where boards could really add value to the existing work of local authorities and their social services commissioners.

While of course at local level many HWBs will be taking an active look at how to incorporate social care into the work of their board, it is still notable that the Department of Health seemed to overlook their potential contribution when setting out the direction of travel for social care. The fact that boards were originally conceived as “health and well-being” and introduced as part of an act focused almost exclusively on healthcare would seem to indicate that more thinking needs to be done where social care is concerned.

To see integration as the sole contribution of boards to improving well-being would be short-sighted. Although it is a clear part of the HWB’s remit to tackle siloed working, we cannot divorce overall system improvement and strategic leadership from the need to challenge existing ways of working and support innovation in individual parts of the machine. This speaks straight to the need for HWBs to articulate a clear vision for care locally. Yet it seems there is a danger we may overlook the role HWBs could, and should, play in some of the very real work that needs to happen to lead fundamental and sustainable reform of both the health and social care system at local level.

Landmark changes ahead

Social care services are set to change, we hope, dramatically over the coming years. The care and support white paper sets out landmark changes to the way that care and support are provided. It envisages that in future people’s care and support needs will be met by: harnessing existing capacity within neighbourhoods and families to provide support; addressing people’s needs at an earlier stage and before the need for formal services; and through the provision of high-quality state support based on clear national entitlements. Care and support will be more effectively joined up and will seek to remove traditional

boundaries between statutory, private and third-sector organisations.

These policy changes should also come alongside a new care and support bill aimed at overhauling the current complex mass of social care legislation and regulation. Whether this is accompanied by a new funding settlement is the least certain part of the equation – at this stage we can but hope.

This is all set in the context of adapting services to meet the needs of a growing older population, the changing profile of health and well-being in later life, and the on-going crisis in social care funding. The scale of the challenge that local authorities and their partners face in turning principles and aspirations into consistent meaningful action should not be underestimated.

Clearly there is a huge agenda for the local system to get to grips with. Therefore it is important to start by taking a step back to think about where HWBs can add the most value; in particular, by looking at what is missing in the current set-up and, crucially, what we can learn from the successes and failures of forerunner partnership bodies.

Most areas have engaged in the past with various partnership arrangements and joint commissioning, so integration and collaborative working arrangement are not new. The question, therefore, has to be why it has not worked well before – in particular, whether the theory is correct that integrated working would ultimately improve outcomes for local residents and reduce duplication and waste across statutory agencies.

For those working in statutory and voluntary-sector agencies at a local level, there is very little about the way HWBs have been established that will bring a fresh approach. There is no real leverage to force change across the health and social care system, and with each main agency being a statutory body in its own right, the same problems of cost-shunting and push and pull across health and social care will exist. Without substantial new powers, it is critical to determine how to maximise the impact of HWBs and avoid their becoming talking shops.

The first lesson we might usefully draw from past experience is the need for aims and goals that are targeted and achievable. HWBs will have to be clear about what they are best placed to drive directly and where theirs should be a co-ordinating role.

Endlessly reinventing the wheel or duplicating existing roles and functions is naturally to be avoided. However, there is still a real debate to be had about the positioning of HWBs as strategic leaders or commissioners. There is a real risk that becoming a commissioning body

will undermine some of a board's wider potential impact, especially if it means excluding key bodies from among its representatives.

In a social care context this will be vital. Successful delivery of social care reform will, for example, require a clear response from the local provider market and workforce. Reforms will also probably seek to change the behaviour of service users – both self-funders and local authority-funded – as well as carers and people with low-level needs. It is hard to see how boards will function truly strategically if private-sector providers and third-sector representative bodies (because of their dual provider role) are sidelined in these important discussions.

Nonetheless, there may still be a case for HWBs to take a more direct role in some parts of service provision that either cut across or do not fit within constituent parts of the system. Both local authorities and the NHS have joint, but not necessarily collective, responsibility for many residents who have long-term conditions, including enduring mental illness, dementia and disability, in particular the vulnerable and frail. Most will have arrangements that jointly commission services for these individuals. With a growing, ageing population there is a great opportunity to build on this work through HWBs to drive a truly collaborative approach that is person-centred, open and transparent. Often these people will be unable to navigate a complex system and therefore go without the care and support that is available to them. The aim of HWBs should be to ensure the provision of integrated, cost-effective services for those most in need.

Taking the lead on new services

The social care white paper includes new pledges around universal services such as information and advice, low-level support services and intelligence-led services such as case finding and co-ordination services. HWBs could be in an ideal position to lead on development, if not direct commissioning, of these new or enhanced service offerings.

The danger of duplication does not just exist in relation to commissioning or service roles. The dynamic of clinicians and local politicians both being key players on the HWBs is interesting, and in practice there is a possibility that HWBs could feel and operate like overview and scrutiny committees instead of a strategic partnership. Ensuring clarity around purpose, roles and responsibilities from the outset is perhaps the second lesson we should apply to HWBs.

The overview and scrutiny function is locally effective and supports democratic legitimacy, but it cannot properly challenge social care in the same way as it does health because of local authorities' dual role as the statutory commissioner of social care. If we assume,

as many of us do, that reform of both health and social care will mean moving services and funding across care settings – in particular moving care out of the acute sector into community and social care functions – this inevitably will mean decommissioning and visible service closures. How local politicians manage these changes alongside statutory service commissions may prove a challenge. The role of HWBs in this debate is crucial – balancing up its role providing critical challenge as well as strategic leadership is key, as is resisting the temptation to recreate the role of overview and scrutiny.

Last but not least, building consensus across the system around goals will probably need to be an essential part of HWBs' work. Part of the challenge will be to avoid creating a structure that feels like a distraction from the real issues for professionals involved. However, consensus building should not be restricted to professionals. The social care system is facing up to enormous changes; it will be vital that commissioners, providers and the public receive consistent messages about direction of travel. HWBs have a clear role to play in engaging all players in that discussion.

The real potential of HWBs

So where does this leave HWBs, particularly in relation to social care? We would argue that the strength and true potential of HWBs would seem to lie in their capacity to provide joined-up strategic leadership.

Playing an instrumental role in developing and communicating a local vision for holistic well-being

Regardless of the intent and membership of HWBs, people can have very fixed perceptions of what health and well-being is. Many people and professionals will think only of NHS and healthcare, or at the very least will see it at the top of a hierarchy. This is not surprising – for the general public, the need for support will typically arrive with a health concern and a visit to the GP or hospital. The reality of social care and public health measures are not a part of the majority of people's daily experience.

Bringing sectors together in one place will not address these issues by itself. There are some deeply entrenched cultural differences around the way different organisations and professionals groups think. Indeed these differences have frequently been cited as a key barrier to the delivery of co-ordinated care.

Changing culture and ways of working is never easy and will not happen overnight. However, we know that successful examples of change in complex systems have always begun with a clear and compelling vision of the future.

HWBs have an opportunity to seize the initiative and involve stakeholders across the local system, in particular service users and the public, in developing a vision and setting goals that are meaningful.

Promoting common culture and values across health and care services

Culture is a word that comes up frequently in debates around both health and social care reform, in two important ways.

First, there is, rightly, a focus on our culture of care. We are all aware that many vulnerable people in need of care and support are not always treated in ways we find acceptable. The challenge for HWBs is to promote a common culture that spans all local services. In the current debate of health and care reform, culture change is often applied to a single or limited number of organisations – a ward, a hospital, sometimes a commissioner. However, a person's experience is not isolated, so a positive culture linked with their NHS care can be entirely undermined by negative culture linked with their social care or vice versa.

Second, there is a question of professional and organisational views of their role and their objectives. These are big issues for integration across sectors in particular, but we should not be blind either to the cultural differences that exist within sectors. Delivering innovation in social care is likely to require organisations to think differently about the services they commission and deliver. It will also mean new partnerships, new players in the market and new professional roles. HWBs need to focus on establishing common principles and a more consistent culture in order for innovation to succeed.

Assessing impact and effectiveness across service areas, acting as a broker and source of challenge where necessary

Assessing impact and effectiveness across services is not easy, but it should be adopted as central to the HWBs' purpose. Too often services are assessed in isolation against narrow objectives. However, there would be great value in looking across the range of services to assess their overall impact against a broader set of goals. This would mean generating performance measures that are not isolated to single interventions but also relate to the consequences of different types of local activity.

For example, road blocks in social care are estimated to account for a third of delayed discharges from hospital. Anecdotal evidence suggests that some social care teams actively delay the setting up of care packages in order to spread costs. In the meantime, a person may deteriorate or fail to recover when they are back home. Such an episode could amount to two isolated interventions that have achieved narrow objectives, but the result for the individual is that they are less independent and less mobile. That – the outcome for the

individual – is the outcome against which the system should be measured, and HWBs should be both helping to develop and championing cross-agency assessments.

Providing a “people and community” check on decision making, providing real leadership in public and service user participation

With key challenges around a growing, ageing population and substantial reform on the horizon, it is important from the beginning to articulate the role HWBs will play in ensuring that services are right. This will require boards to be clear how they will engage older people in the future design and development of services. Currently there is no requirement for older people to be represented on HWBs, even though most, if not all areas, will cite an ageing population in the context of the current financial backdrop as the main challenge facing them in future years.

There are also opportunities for HWBs to be innovative about how they engage and represent with older people and hard-to-reach groups. For example, employing techniques such as “Mrs Smith” can provide valuable insight into services, especially if they are undertaken as part of experience events that help board members really understand the realities of age and ageing.

Developing deep understanding on present and future population

It is now a well-understood fact that we have an ageing population. However, it is less clear that the implications of an ageing society for services are equally well understood. HWBs will have to take the lead in unravelling their local population and piecing together the whole picture that emerges from the data. The joint strategic needs assessment is an excellent start, but HWBs will need to go further in understanding the attitudes and aspirations of the older population, particularly in relation to care and support.

Stimulating system innovation

HWBs should be the place where local thought leadership takes place: looking and planning ahead. It is also a body that could provide consistency and long-term strategy. Technology, for example, is likely to revolutionise the way care is delivered. However, it will fulfil its potential only if providers are able to invest in innovative solutions and if services adapt to using technology effectively. This requires more certainty around strategy than most elected politicians can give.

HWBs will need to embrace the inevitable and begin to stimulate the design of services and solutions fit for future generations, at the same time ensuring that innovative solutions do not exclude the most vulnerable in communities and increase inequalities.

Ultimately, however, if we learn from past experiences HWBs will need to be informed by genuine pragmatism and a realistic assessment of strengths and weaknesses in each local area. We live in challenging times, and how successfully we line up complex systems to respond effectively will be the biggest test.

Chapter 6

Early intervention

Barbara Herts, Consultant and Commissioning Programme Manager
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Early intervention

This paper argues that health and well-being boards (HWBs) provide considerable potential for improved outcomes for children, young people and families and opportunities for greater integrated and accountable joined-up health and well-being services. However, meeting children's needs in a fully joined-up way will require partners to look beyond the framework of the Health & Social Care Act 2012.

Inadequate services and a lack of co-ordinated care can be a particular challenge for children with complex health needs, such as disabled children, children on the edge of care, looked-after children, young people in custody and those living with or affected by HIV. What is more, children and young people often struggle to have their voices heard when decisions are made about health services or their own care.

Making sure the new HWBs can deliver better outcomes for children, young people and families

Building good physical and mental health in early life is key to securing wellness and resilience in later life. Multiple government-commissioned reports have highlighted the importance of giving children the right start in life. Sir Ian Kennedy's independent review in 2010, however, raised concerns about the lack of relative priority given to children and young people in the health service. There is a real imperative to focus on getting it right for children and young people in the health system.¹

Sir Ian Kennedy identified a number of persisting barriers to integrated working, especially as our knowledge of "what works" increases. For example, barriers such as information sharing, pooled budgets, a lack of congruence in the form and delivery of outcome measures, a lack of transition planning from services for children to services for adults and cultural barriers to co-operation. The HWB must tackle these barriers if health services for children are to improve.

According to Graham Allen MP in his 2008 report for the Centre for Social Justice,² the philosophy of early intervention goes much further than prevention. Early intervention is about breaking the cycle of underachievement in many of our communities and enabling communities over time to heal themselves.

1 Kennedy, I *Getting it Right for Children & Young People: Overcoming Cultural Barriers in the NHS So as to Meet Their Needs* (Department of Health, 2010)

2 Allen, G and Duncan Smith, I *Early Intervention: Good Parents, Great Kids, Better Citizens* (Centre for Social Justice/Smith Institute, 2008)

In Essex, the HWB brings together key partners for the development and implementation of a strategy to improve health and well-being for the communities of Essex.

The vision for better health and well-being in Essex

By 2018 residents and local communities in Essex will have greater choice, control and responsibility for health and well-being services. Life expectancy overall will have increased and the inequalities within and between our communities will have reduced. Every child and adult will be given more opportunities to enjoy better health and well-being.

Our approach to health and well-being takes the perspective of the "whole life course", improving outcomes for Essex residents by focusing on prevention and better outcomes for every individual and family throughout their lives and at the end of life – bringing together investment carer support, continuing care and palliative care. This strategy reflects the Marmot review findings that action is needed across the social determinants of health.

HWBs provide a great opportunity to embed evidence-based practice at all levels and to involve children, young people and families in establishing "what works", not only to ensure that solutions are appropriate, consistent with need and effective, but to ensure ownership within communities. The new HWBs have the potential to oversee integrated early intervention approaches and secure priority for children's health within the health system – giving every child the best start in life. There are a number of Quality, Innovation, Productivity & Prevention programmes in health that focus on this.

Essex County Council, as one of several community budget pilots, is taking a "triple-track" approach to:

- deliver better outcomes for families with complex needs and troubled families through Essex Family Solutions;
- shift mainstream systems to deliver more effective early intervention for children and families; and
- grow and embed across the county a culture of democratic, innovative, responsive and cost-effective public services.

HWBs and early prevention

The HWB must ensure a focused strand of activity for children and young people to make sure their needs do not get sidelined or lost, and this is being taken forward

nationally in many different ways. In Essex, starting and developing well – ensuring every child has the best start in life – is a key priority area. This covers:

- reducing teenage pregnancies;
- increasing immunisation take-up, including MMR;
- improving preschool and educational attainment;
- improving outcomes for children with special educational needs;
- reducing risk-taking behaviours;
- designing new interventions to focus on families with complex needs;
- integration so that transition from children to adult services is more effective; and
- reducing childhood obesity levels by increasing physical activity.

HWBs and the development of joint health and well-being strategies (JHWSs) have great potential to drive forward integration and integrated commissioning approaches. However, achieving the working relationships required to meet children's needs in an integrated way will require local partners to look beyond the framework set out in the Health & Social Care Act.

In the past, planning strategically through children's trusts has been of great benefit for local children and families, primarily because partnerships and commissioning have come together and have been focused on improving the lives and experiences of children and young people in their local areas. However, children's trusts are no longer required and in many parts of the country local partnership arrangements for children are being reviewed.

A key task for the HWBs and local authorities is to make sure a children's partnership dedicated to children and young people exists with join-up to the safeguarding children's boards. The commissioning of all NHS services for children and young people must sit alongside commissioning of all services for children.

Engaging schools

Schools are a key example of a health-related service that HWBs should engage, but some key questions remain nationally. For example, how best to engage with all schools and how best to engage with academies?

There is, however, a duty on a wider range of partners, including all types of publicly funded schools, to co-operate to promote the well-being of children.

Schools, colleges and youth services will need to be key partners in reducing obesity

and smoking rates and increasing uptake of physical activity.

Their contribution would include educating and providing information on healthy lifestyles through the curriculum and helping to ensure that all children have appropriate access to physical activity opportunities. Co-ordination with health services will be important for ensuring that information and personal, social and health education programmes are up to date, can signpost to the right local support, and encourage uptake of health services by, for example, providing face-to-face contact with those providing this support. A key to the success of this will be to see HWBs steering the new direction for school health.

For HWBs to succeed in promoting the children's agenda, supporting local partnership structures based around the needs of the whole local community will be vital.

Close working between local partners is particularly important for children with complex needs, such as disabled or looked-after children, who need *co-ordinated* interventions from a range of services. A recent report from the Every Disabled Child Matters campaign found that families of disabled children often reported experiences of fragmented service delivery and of being caught between services that did not communicate well.

A focus on early intervention

In Essex we are reviewing all our partnership governance structures to ensure that the children's early intervention strategy, the all-age approach to commissioning, clinical commissioning groups (CCGs) and the safeguarding children board join up effectively and are cohesive. For example, we are making sure that the HWB ensures that early help and support are made available to families with complex needs, as recommended by the Munro report into children's safeguarding.

There is great opportunity to improve outcomes by joining up the ways in which services are commissioned, and getting the governance right will be crucial. Much can be learned from examples of pooling and aligning budgets under the children's trust and ensuring that the commissioning of NHS services for children and young people sits alongside the commissioning of all services.

Ensuring expertise exists where it is needed

Ensuring the availability and use of expertise in meeting children's needs in the NHS will be vital. There are a number of potential challenges to securing this.

The Association of Directors of Children's Services has raised concerns that safeguarding must be a standing item on every HWB agenda. It has also suggested that the chair of the local safeguarding children board must be a member, in addition to the director of children's services and lead member.

A recent survey by the association in conjunction with the National College for Leadership of Schools & Children's Services³ found that it can no longer be taken for granted that local authorities will have a director of children's services who is primarily concerned with education and children's social care, with 33% of local authorities reporting that they have either had alternative arrangements in place for some time, or have recently moved in the direction of an alternative structure. The statutory director of children's services role can therefore not always be relied upon to champion children's needs within the HWB.

In terms of postcode lottery, there will be more CCGs covering smaller populations than there have been primary care trusts, potentially spreading local expertise more thinly. It will be the duty of the HWB to ensure consistency of commissioning based on need and shared joint agency priorities, for example to sign off all CCG commissioning plans.

Listening to the voice of children, young people and families

The benefits of involving children and young people when designing and commissioning health services are already evidenced through the You're Welcome quality standards developed by the Department of Health and through the Young Inspectors used by some local health providers. In Essex, the NHS has in place a participation strategy through the You're Welcome standards.

As set out in the Children & Young People's Health Outcomes Forum report,⁴ there are considerable opportunities to improve outcomes by adopting a child-friendly approach, encouraging child and family participation in individual decision making, service improvement and policy priority setting.

Concluding remarks

Much has been written nationally about the likely consequences of devolving so much of health provision to CCGs, local providers and councils and the potential increase in inconsistency and postcode lottery across the country.

³ Association of Directors of Children's Services and National College for Leadership of Schools & Children's Services *New Futures: What Is Happening to Children's Services?* (2011)

⁴ Lewis, I and Lenehan, C *Report of the Children & Young People's Health Outcome Forum* (Department of Health, July 2012)

For children, the number of teenage pregnancies or children with special educational needs statements (for example) varies considerably in different areas. The test will be whether the joint strategic needs assessments will work well enough to inform the HWBs about the full range of children's needs. There is much that HWBs will need to do in bringing together the NHS and wider children's services; for example, safeguarding, early intervention work with families, the troubled families agenda, children's mental health and families with complex needs.

The HWBs must build on the lessons learned through partnership working and commissioning with children's trusts, specifically on areas such as Early Intervention work, the Munro review and upcoming legislation on special educational needs in the Children & Family Bill – all of which will have an impact on the general health and well-being of children, young people and their families.

Integrated services with aligned outcome frameworks, pooled or integrated budgets and clear lines of accountability can lead to better services for children, young people and families, but this will happen only if HWBs actively champion the interests of children, young people and families.

The HWBs should not become an additional requirement for local authorities, but should have a clear place and role in local arrangements. Local councils already have in place health scrutiny committees, and it will be important to understand the relationship between these committees and the HWB.

There are real concerns about the range of reasons for which families and young people may not access routine healthcare. In this respect, it is essential that the expertise and knowledge of GPs is used as part of the joint strategic needs assessment.

There is the potential for the new HWBs to proactively listen to the views of children, young people and families and to build on specific innovative and creative approaches and techniques, rather than developing satisfaction questionnaires and surveys. Working with children and young people to develop local services and support, especially around sexual health and substance misuse, has ensured that those services reach vulnerable young people who may not ordinarily access services.

Chapter 7

Children's services

Debbie Jones, Executive Director for Children's and Young People's Services at Lambeth Council and President of the Association of Directors of Children's Services

Children's services

The new health and well-being boards (HWBs) bring tremendous potential – to connect schools, the environment, housing, health and safeguarding services, all to improve outcomes for children and young people. However, with potential comes responsibility, and it is incumbent on all HWB members to advocate on behalf of children and young people.

HWBs are a means of helping to integrate the commissioning of health, adult, children's and wider services. Children's services have a rich experience of partnership working and aligning commissioning, through the development of children's trust boards (CTBs) over a number of years. The CTBs' duty to co-operate to improve the lives of children, young people and families remains in force, with considerable flexibility in how local partners can implement it. The lessons learned from the journey from establishment to maturity of the CTBs will be useful for informing the development of HWBs. Essential features of successful CTBs include having a child-centred, outcome-led vision, integrated front-line delivery, integrated strategy and inter-agency governance. This is a useful framework for the development of HWBs.

Another lesson is the need to get the relationships right. The successful CTBs have been those in which participants understand each other, are honest and face up to the really difficult issues. Unsuccessful ones did not achieve this. Some CTBs (and many other partnerships) spent a lot of time trying to get the structure exactly right when establishing themselves, losing time and energy for focusing on outcomes for children and young people. The truth is that partnership structures need to be flexible to respond to continuing change. A key lesson is: do not get bogged down in structures and governance – rather focus on outcomes.

Speaking from the experience of my own local authority, Lambeth Children's Trust Board – which has been in existence since 2004 – has delivered real benefit to partnership working and improving outcomes for children, young people and families in this inner London authority. The Lambeth experience has been that the CTB provides effective and ambitious leadership to promote the welfare of children across services, with strength and stability of leadership within the CTB and the clear vision, ambition and priorities articulated through the Children and Young People's Plan driving sustained improvements. Inspections have consistently highlighted the vision, drive and benefit of the CTB in Lambeth.

Practical examples include:

- the promotion of early help through successful embedding of the use of common assessment framework and multi-agency team approach; and
- the Family Nurse Partnership, a preventive programme for young first-time mothers and fathers, offering intensive and structured home visiting by specially trained nurses (family nurses), from early pregnancy until the child is two years old; and
- parenting programmes and intensive parenting intervention – multi-agency staff have been trained to deliver parenting programmes in schools, children's centres and health clinics across Lambeth;
- co-locating practitioners, for example police, children's nurses and health visitors, in social work teams; and
- joint commissioning of child and adolescent mental health services provision in Lambeth – joint contract performance arrangements and the collaborative approach taken in successfully negotiating the changing fiscal environment. Working successfully with partners has allowed continued delivery of patient and client services.

The commitment of Lambeth CTB to integrating service delivery, sustaining partnership working, raising achievement, safeguarding children and young people, and developing the children's services' workforce has undoubtedly contributed to closer partnership working at all levels. It is also gratifying that partners in Lambeth valued the CTB and its achievements, concluding that it should continue and articulate our shared aspirations through a refreshed Children's and Young People's Plan.

The new statutory HWBs can build on the successes of CTBs. A key subject for discussion within both Lambeth's CTB and the shadow HWB is how the two boards link to each other, how their strategic and commissioning priorities are aligned, and what the respective roles and remits of the two boards are. We have been exploring these issues through joint workshops and on-going discussions, which have helped shape how the HWB has been established. In Lambeth the lead member for children and families and the chair of the CTB is the vice-chair of the HWB, which demonstrates the commitment to the children's services agenda. There are numerous examples of how other authorities have approached such issues.¹

Safeguarding of children

Another issue to consider is how the local safeguarding children's board (LSCB) links

¹ National Learning Network of Emerging HWBs Across England *Children & Young People & Health & Well-being Boards – Putting Policies into Practice* (2012); Easton, C, Hetherington, M, Smith, R, Wade, P, Aston, H and Gee, G *Local Authorities' Approaches to Children's Trust Arrangements* (2012)

with the new HWB. In Lambeth, the CTB and LSCB together adopted a protocol to clarify the arrangements to enable effective scrutiny of the safeguarding of children. Consideration will need to be given at a local level to developing such protocols.

In Lambeth, the HWB is placing strong commitment on its role and responsibility for engaging with the public, including children, young people and families. Meetings are held in public with opportunities for local residents to ask questions of the board members. The board has made involvement one of its core purposes and has agreed principles to support this. One starting point is a commitment to work with Lambeth Youth Council (the representative forum for Lambeth children and young people) to understand its members' perspectives on how health and well-being can best be improved in Lambeth. Although this is not revolutionary, it is an important starting point to ensure that the voice of children and young people is heard by the HWB.

The HWB emphasis on public engagement reflects the wider development of the "co-operative council" in Lambeth. The CTB is at the forefront of the co-operative council approach of meaningful partnership and co-operation. In practice, this means partnership working with citizens to design and deliver services that meet their specific local needs, providing incentives for citizens to play a more active role in their local community, and more co-operation with a wide range of service providers to deliver tailored services in different areas.

Youth services are one of Lambeth council's early-adopter projects to demonstrate the co-operative council model in action. A new Young Lambeth Trust has been created, which young people, local residents and community groups are being encouraged to join. Lambeth is transferring the £3 million budget that the council currently spends on youth and play services to the trust, so it will have a significant budget to commission services in line with young people's priorities. Lambeth is transferring responsibility for running its seven adventure playgrounds, which have higher costs than those run by the voluntary sector, to the trust.

Children and young people will have a much greater say in how money is spent and how services are delivered, building on the success of the Lambeth youth mayor, Lambeth youth parliament and the corporate parenting board in engaging young people. The council will have places on the new trust board, and will continue to have statutory responsibilities towards vulnerable young people involved in the criminal justice system, those who are on the child protection register and looked-after children. The trust model is one of the council working in partnership with residents to design and deliver public services, rather than simply outsourcing a set of services. In Lambeth,

partnerships such as the HWB will be key players in contributing to and shaping the co-operative council approach, as well as ensuring that the communities/citizen/resident voice shapes service design and improvement.

Risk of marginalisation

Within the children's services community there is a concern that the children and young people's agenda may get subsumed within the adult health and care agenda, with its larger budgets. Another concern is that developments on health and well-being lack a whole child focus, with a risk that children's issues become marginalised into "children's health" with a narrow focus on "well-being" or child protection.

The Association of Directors of Children Services is receiving feedback from directors of children's services across the country about the development of HWBs. Broadly speaking, with the exception of public health campaigns on reducing the rates of teenage pregnancy, obesity and sexually transmitted infections, children's health and well-being issues are not yet getting much traction in HWBs, and HWBs are not yet effective drivers of change around preventative and early help agendas.

It is early days in the development and maturation of HWBs, with many boards just starting to define their priorities. However, ensuring that prevention and early help is at the forefront of strategic and commissioning priorities will be immensely productive. There is an opportunity, with the development of the compact being drawn up between the Local Government Association and the NHS Commissioning Board (due to be published later this year), to emphasise the value of focusing on early help for children, young people and adults.

The litmus test will be the publication of local joint health and well-being strategies (JHWSs). It is imperative that sufficient focus is placed on outcomes for children to demonstrate HWB commitment to the children's agenda. The JHWS and joint strategic needs assessments (JSNAs, which underpin the JHWSs) will need explicit coverage of children and young people's health and well-being, either throughout these documents or through dedicated sections.

Determining and implementing joint commissioning priorities will be the fulcrum on which the words of the HWBs become tangible actions and benefits for children, young people and families. It will be particularly important to ensure that a holistic, whole-life approach is taken in relation to the commissioning of services for children and young people – those with special educational needs and complex health needs in particular – to mitigate against the risks associated with the fragmentation of

commissioning responsibilities.

There is the danger of a fragmented approach to the commissioning of health and public health services for children and young people, particularly for those with special educational and/or complex health needs; at present services are commissioned in six different parts of the health economy alone – local authorities, clinical commissioning groups (CCGs), CCG clusters, local NHS commissioning boards, the national NHS Commissioning Board and the Department of Health. The Association of Directors of Children Services has concerns that the new system will fragment commissioning even more. Appointing joint strategic commissioning posts across health, adult services and children's services locally will assist in identifying duplication and plugging gaps in commissioning across the partnership, as has been the experience in my local authority.

Two recent reports² provide insightful reading on the development of HWBs and improving children and young people's health outcomes. Particularly pertinent are the issues around:

- the broad remit of HWB, meaning there will be a need to engage with a wide range of stakeholders as well as local people and communities, and the need to find imaginative ways of engaging stakeholders, including social media – this includes evolving the way HWBs engage with children, young people and families;
- the important role of Healthwatch England and Local Healthwatch in ensuring that children's and young people's voices are at the core of their work; and
- the responsibility and role of CCGs and GPs to ensure that the health and welfare needs of children and young people are addressed.

Importance of leadership development

Leadership development will be key to the successes of HWBs. Leaders from children's services, adult services and health, councillors and Healthwatch will be responsible for discharging statutory duties and ensuring that HWBs work effectively. Partners previously unfamiliar with working together will need to quickly understand and appreciate each other's perspectives, whether they are from public services or local communities. Partnerships are all about people, and if there is a common understanding of purpose and vision then enormous progress can be made. To this end, it is essential

² Humphries, R, Galea, A, Sonola, L and Mundle, P *Health & Well-being Boards: System Leaders or Talking Shops?* (King's Fund, 2012); Lewis, I and Lenehan, C *Report of the Children & Young People's Health Outcome Forum* (Department of Health, 2012)

that there is a support and training mechanism in place to aid the development of HWBs and the leaders representing their organisations on the board.

In children's services there are well-established arrangements for sector-led support and improvement, the framework for which is overseen by the Association of Directors of Children Services children's improvement board. Leadership support and development are provided through the NHS Leadership Academy, the LGA's local government self-regulation and sector-led improvement bodies, the work of the Children's Improvement Board in children's services, the leadership programmes for serving and aspiring directors of children's services, the HWB leadership programme and the NHS's Top Leaders and Learning through Transition programmes. The quality of leaders on HWBs will be a determinant of the effectiveness and ultimate impact of these partnerships; these development programmes will assist in nurturing the leaders needed for the future.

Understanding and developing the workforce across the local authorities, health bodies and partner organisations will be key to implementation at the local level. An example from my local authority is where the Lambeth CTB has been committed to developing the children's workforce through multi-agency training. For example, Healthy Weight – Healthy Lives for Lambeth Children is a multidisciplinary programme developed to address childhood obesity, and Mental Health First Aid is a training programme that teaches practitioners to recognise the symptoms of mental health problems, to provide initial help and guide a person towards professional help, where appropriate.

The HWB will play an important role in driving forward joint training across adults, children's and health partners. Multi-agency training harnesses an increased understanding and joint approach across partners, which can only benefit children, young people and families.

The requirement is to facilitate and promote shared system learning and leadership at all levels in the health and well-being system. HWBs need to be driven locally to address local circumstances. However, developing relationships at the national level – between Healthwatch, Public Health England, national representatives of CCGs and other national bodies of key stakeholders, including the Association of Directors of Children's Services, the Association of Directors of Adult Social Services and the Association of Directors of Public Health – is essential to drive the successful implementation of HWBs and aligning with the children's services agenda.

The establishment of HWBs is a positive move with a localist basis. The key for me is for children's services, health and adult services leaders to engage in the new HWBs

and work together to champion the voice of the child. This is an exciting time to harness the skills, drive and ambition of all partners involved in improving outcomes for children, young people and families.

What will be the test of the success of HWBs? If we can see that HWBs commission services according to local need, broker relationships and partnership working with local people as equal partners to achieve improvements, and ensure that there is a range of high-quality services for children, young people and families to choose from, we will be in an advantageous position.

Chapter 8

Public health

Dr Yvonne Doyle, Director of Public Health for NHS South of England

Public health

Public health and councils – context

"The health of the people is the highest law." This quote from Cicero (part of the *Twelve Tables of Roman Law*, 451–450BC) was placed above the door of a south London building that provided public health services from the local council in 1937. The presence of public health in these locations represents a traditional link between health and local government that commenced over 160 years ago. In an age when local communities had few links to central government, enterprising towns took it into their own hands to form a collective approach and make improvements to the quality of people's lives.

It was soon clear that there were significant problems of poor health. These problems began to be measured. What was measured became knowledge, and that knowledge became the subject of advocacy. Examples include the state of the worst living and working conditions and the connection of these conditions with deaths in an area. There was also a crucial recognition of the differentials in health between the affluent and the poor in these areas.

The consequences of this were more than noting local variations in deaths. Such data and the advocacy that followed eventually had profound effects on the planning of towns and the engineering systems of the larger cities. Despite considerable opposition in some quarters, the advocacy also led to changes in the laws of Britain. For instance, the Public Health Act 1848 was a piece of legislation that attempted to deal with pressing health problems such as outbreaks of infectious disease. Interestingly this law was rooted in local democracy.

The 1848 Act established a central Board of Health and allowed local boards of health to be set up if more than 10% of the population petitioned for one. No central inspection was required for authorities that had boards of health outside the legislation. Towns where the death rate exceeded 23 per 1,000 population were obliged to set up a board of health.¹

These were urban developments, and the issues of rural misfortune did not receive the same level of detailed attention at that time. To a large extent, utilitarian needs drove an interest in public health. Even the early advocates felt compelled to protect society from miasma (or bad odour), which was wrongly associated with spread of disease and which emanated from the poor. When the nature of infectious disease was better

¹ By comparison, in recent years, total annual death rates are between 4.5 per 1,000 for females and 6.4 per 1,000 for males.

understood, fear of the spread of TB and other lethal infections drove the instigation of national screening and treatment programmes. The needs of the armed forces in the South African War of 1899-1902 drove national action on the poor physical state of recruits, many of whom had to be rejected for service.

That said, members of local boards of health played a vital role in developing the early public health system. For instance, they:

- provided leadership and action throughout acute health threats;
- helped public representatives understand the scale of the problem and instigated early forms of disease surveillance;
- established an understanding of using evidence to guide planning;
- united fragmented means of delivery, which often required co-operation between local systems; and
- advocated for social justice in health.

The boards established a focus of knowledgeable leadership for health which has developed forward to this day in the role of the director of public health, a unique role. The early heritage of understanding the wider determinants of health and their influence on health inequalities has also carried through to Britain's contemporary international leadership in this arena. An example is the chairmanship of the World Health Organisation's Commission on Social Determinants of Health, which reported in 2008.

What does public health mean for councils? How can an HWB operate effectively for public health?

Public health as a function has grown since those early days and its infrastructure is a success of the modern British state. Some of the best population information and surveillance in the western world comes from Britain. The population is protected in a systematic and highly professional manner by an infrastructure of services dealing with prevention and control of communicable disease and environmental hazards.

The evidence based on research – much of it conducted in Britain – has led to organised programmes of screening to prevent common long-term conditions and vaccinations for preventable diseases. Health improvement has offered the population support for a range of personal risk factors. Local, regional and national programmes provide wider support on tobacco control, drug and alcohol reduction, maternal and child health.

Those who already co-operate on these matters are part of the NHS, local government,

the voluntary sector, and some national government departments. The NHS has played its part particularly through the preventive services offered within the community and general practitioner services and will continue to do so.

The local leadership for contemporary public health in England rests with the directors of public health and their teams. These include trained topic specialists from a range of clinical, scientific and other graduate backgrounds, analysts, and practitioners working with local communities. After a generation of embedding this leadership mainly in the NHS, the teams are now moving to councils where their leadership will complement and marshal the wider determinants in contemporary society that are mainly within the purview of local government. The specialist function of protecting the population from communicable and other hazards has been handled jointly from the NHS and local government.

In future, the clinical and scientific specialist elements of protection will be part of Public Health England, a new national body. This will be distributed locally to align with local government. However, the NHS remains a very significant partner in this new arrangement.

All these elements will need to work together as a collaborating public health system.

The move of a function that has not been formally within local government for over a generation will require learning for the new entrants and for their receivers. The point here is that directors of public health, with chief officer status under the Health & Social Care Act 2012, will need to work across the whole council if the dividend of such a major move is to be realised for the benefit of local people. But councils will also need to evolve in ways that will find expression through the health and well-being board (HWB).

Councils are now charged formally with improving health in a manner that will be explicit through the measurement of outcomes. While many areas of England have already experienced joint appointments of the director of public health between the NHS and local government, the leadership for health via the professional function, and the leadership for democracy via the elected function from within the same organisation will require understanding by both parties.

The director of public health must work with the subsidiarity of council business to the role of the elected members, build a constructive working relationship with lead members and appreciate the role of colleague directors who may become champions

for health through their own work.

Members and officers need to appreciate the long-standing role of the director of public health (and their predecessors) in acting as the advocate for health, expressed for instance in the independent report of the director of public health on local health issues. This report should be published annually by the council without fear or favour. Experience has shown that these reports are a big asset, not least for raising an informed debate about health, and have been well aired in council chambers. An obvious additional forum for such discussion is the new HWB.

In due course, such reports may be used to express outcomes from local health strategies that the board has agreed on behalf of its population. There will be a mix of officers, members, clinicians, commissioners, local leaders and possibly providers contributing to an HWB. They will need collectively to contribute the following skills towards making progress on particular health ambitions:

- understanding populations while delivering to individuals – *effective practitioners*;
- understanding individual motivations and circumstances while meeting the needs of populations – *effective commissioners of health programmes*;
- acting on the impact of factors beyond people's personal behaviours that affect their health – *effective leader advocates on social justice and wider determinants of health*; and
- perceiving the future and acting as guardian for the longer term – *effective shapers of local policy*.

Expectations are high that this move of public health into local government opens new doors on some of the most pressing problems in health. A high priority might be the health disparity between parts of every local population and the remainder, even in the most affluent geographies. These "health inequalities" are evident in every country in the world, but stubbornly persist even in developed economies. Reversing their persistence has been termed the major health challenge of our time.

The health element of health inequalities is a consequence of complex issues of disadvantage that occur from birth. Those who have researched the evidence pose that resolution of health inequalities goes beyond individual behaviour. Furthermore, the emphasis in putting the situation to rights should be on the earliest years of a child's life. Imagine the opportunities a council could offer towards making a dent in local health inequalities if it contributed new actions on every element within its purview.

If it works well, the HWB will be taking on such challenges. This means that the business of the board will not be diverted unduly by divisive agendas, such as local NHS disputes about reconfigurations. The majority of these issues have little or no influence on major health challenges and the needs of the local population. Those leading HWBs will need great resolve and wisdom to avoid this trap from what amounts to vested interests.

How will the chair of an HWB judge whether the board is making progress in delivering value to local people? Most would know if the board were seen as a hot spot, with constant competition for places at the table. That is, the interests and/or organisations that have a high impact on local people's health should be using the board, its strategies led by needs assessments, and its leadership, to make progress on the pressing identified problems.

This is not all within the gift of the council, and therefore other partners need to come to the table and do business for health. So, the board informed by a good joint strategic needs assessment may take the view that it will address a recalcitrant problem with adverse measures relative to other areas of England. It is up to each council to choose which health problems are most pressing. The director of public health is likely to be thinking along these lines too, and may have worked for several years on the problem. Very few obvious health problems are virgin territory for public health. The issue now is: can the HWB make progress that could not be made before?

To measure progress, the Public Health Outcomes Framework will offer councils a range of indicators from which they can choose. Useful information will be provided by Public Health England on these measures, which can show the local board what is happening within a stated period.

Suppose the priority identified by the council is to improve the perinatal health of babies (their survival and health from 28 days before birth up to one week after birth, a high risk period of the life cycle). The HWB can be used as the vehicle for making a commitment to local people that baby health is receiving attention and that the council will account for progress on addressing poor outcomes from this period of life. Published results will be comprehensible and will explain what is being done to reduce the problem.

This is a big ambition and will take much endeavour to achieve. Why? Because the HWB members are making a public commitment to the people of their area that they intend to do something that will require the co-operation and collaboration of several major

parties. Furthermore, people can hold the council to account for this. It is the only accountability built into the new public health system at a local level, and it could be much more harsh than the old style of performance management.

So it will take a passion for public health to ensure that it is delivered in a way that does make sense to local people while also tackling the issue. To do this, the challenge cannot be tackled by the experts – including those sitting on the board itself. Local help will be needed, and the elected members involved in this endeavour may seek all the evidence of who can make the biggest contributions outside the council itself.

For instance, perinatal deaths may be driven by too many babies born to mothers who smoke, or who leave seeking antenatal help too late – a problem that is well known among certain groups – or who have conditions that are poorly controlled, such as diabetes. Who has leverage with these women? How can they be helped to quit smoking? What quality of commissioned care can lead to a control of diabetes in pregnancy? Are some of these mothers abusing drugs and alcohol, and who can access them to provide help during pregnancy? Above all, what has already been achieved with some groups and what new difference can the council with its connections make? And if these babies are born in good health, how can their chances in life develop better with good parenting, early skills and a sound first education?

The HWB will want to know who is going to be held accountable for which elements of this, who needs to be brought on board, who needs to invest, in what way and how much. It also needs to consider what should be done if the approaches are not working. It might ask whether any other council has a similar problem, and whether and how another HWB has attempted to tackle it.

Learning from experience elsewhere

There is help in this respect. Health and local government organisations have been co-operating for the past 18 months to provide tools, networks and best practice from around England for HWBs in preparation for 2013.² This endeavour has been funded by the Department of Health, supported by the Local Government Association, the NHS Confederation and the Institute for Innovation & Learning, and continues to provide support. There is now a wide range of organisations collaborating nationally for public health. The challenge for HWBs is to build on this and to oversee new opportunities for health locally.

² For instance, see: *A New Development Tool for Health & Well-being Boards* (Local Government Association, July 2012) (www.local.gov.uk) and *Health Impact Assessment: A Useful Tool for Health & Well-Being Boards* (NHS Confederation et al) (www.nhsconfed.org/HWB)

In conclusion, the HWB can act as the touchstone of an effective and collaborating local public health system. Such a system will harness champions for health who:

- know the changing nature of the local population;
- commission support to enhance people's own efforts to mitigate damaging lifestyles;
- secure access to appropriate care, including access to technological advances; and
- ensure all this make sense to local people.

Chapter 9

Engagement with the voluntary sector

Sir Stephen Bubb, Chief Executive of the Association of Chief Executives of Voluntary Organisations

Engagement with the voluntary sector

For voluntary organisations in the field of health and social care, this is both an exciting and a nervous time. As the implementation of the reforms of the Health & Social Care Act 2012 gathers pace, the sense in the sector is that the future holds both great opportunities and great challenges. The act sets out a vision in which the third sector plays an ever greater role in an increasingly diverse and open healthcare arena, which offers patients much greater choice and control over the care and treatment they receive, and in which services are more closely aligned to local needs and priorities.

At the same time, the scale of the changes planned for NHS structures makes obsolete many of the established relationships between voluntary organisations and decision makers in primary care trusts and local authorities. Consequently the sector faces a significant degree of uncertainty, as primary care trusts (PCTs) are disbanded and clinical commissioning groups (CCGs) assume their new responsibilities.

One of the chief purposes of the Health & Social Care Act is to put commissioning responsibility in the hands of those who are better placed to understand patients' needs – GPs, rather than bureaucrats. However, even GPs cannot have an in-depth understanding of the full range of needs across a local community; disadvantaged or vulnerable groups, in particular, are likely to be more disengaged from GPs than other groups. For this reason commissioners are required to work with community partners, to ensure that all local citizens can have a voice in shaping and designing their local services.

GPs will need to work closely with local voluntary-sector partners, in their capacity as advocates and representatives as well as providers, in order to make sure that the diverse needs of the local community are understood and met. How can it be ensured that close and constructive engagement between voluntary organisations and healthcare commissioners is maintained under the emerging structures? Part of the answer to this question lies in the role of health and well-being boards (HWBs).

Roles of voluntary organisations

It is important to note that voluntary organisations carry out a wide range of essential roles in the field of health and social care. Most obviously, they directly provide an ever-growing number of services, from hospices to disease-specific interventions. Voluntary-sector provision is characterised by its capacity for innovation and, in many cases, by its focus on the medical benefits of social and community support instead of (or alongside) traditional clinical approaches. The sector has long championed the

improvement of health outcomes through better management of complex or long-term conditions, and the value of taking a holistic approach to improving the health and well-being of patients.¹ As commissioning responsibilities pass to clinically trained GPs, it is vital that they are aware of what the voluntary sector has to offer them and their patients.

The voluntary sector's role in health and care, however, also extends well beyond direct service provision. It is a particularly important source of advice and guidance for people requiring support to understand their condition and their options for treatment, through charities such as Diabetes UK, Asthma UK, the MS Society and many more. Not only do voluntary organisations such as these provide invaluable information and support, educating people about their conditions, helping them to make best use of personal budgets, and explaining their treatment options; they also act as advocates, giving voice to patients' concerns and representing them to decision makers at both the local and national level.

By their nature, third-sector bodies are deeply rooted in the communities that they serve; their understanding of the needs and circumstances of these communities enables them to act as a powerful collective voice. Whether they are helping to shape local services around the specific needs of a local community, or calling for national action to address an overarching issue, charities perform an essential representative function, most especially for vulnerable communities who might otherwise struggle to make their voices heard and their needs understood – for example, homeless people, or people facing economic disadvantage and marginalisation.

In this context, the role of HWBs in supporting meaningful engagement between commissioners and the voluntary sector becomes ever more significant. The Department of Health describes the ambition behind the establishment of HWBs as being “to build strong and effective partnerships, which improve the commissioning and delivery of services across NHS and local government, leading in turn to improved health and well-being for local people”.² To fulfil this ambition, these partnerships must include strong working relationships with the voluntary sector.

A key function of HWBs is to lead the formulation of joint strategic needs assessments (JSNAs) for local areas, and to develop a strategy for addressing an area's health and care needs, including through strategic commissioning of services. This will be done in

1 Curry, N, Mundle, C, Sheil, F and Weaks, L, *The Voluntary & Community Sector in Health* (King's Fund, 2011)

2 *The General Duties & Powers Relating to Health and Well-Being Boards* (Department of Health) (<https://www.wp.dh.gov.uk/publications/files/2012/07/General-health-and-wellbeing-board-duties-and-powers.pdf>)

part through the contribution of Local Healthwatch, the newly formed bodies which are charged with representing citizens in the needs assessment and commissioning processes, and which have a seat on each local HWB. However, no single body can have the same level of understanding of people's needs as a diverse local voluntary sector, with its close connections to a range of different beneficiary groups, especially in relation to specialist conditions or disadvantaged communities.

Importance of collaboration

In order to be successful, therefore, the process of understanding and meeting a community's health needs must be undertaken in close collaboration with the local voluntary and community bodies. For example, the process of understanding and mapping out the needs of a local population in relation to mental healthcare should not be attempted without close engagement with mental health charities. Such charities have strong relationships with their beneficiaries and a detailed understanding of their needs, and frequently benefit from the support of volunteers and staff who themselves have had experience of coping with mental health issues or supporting others that do.

Consequently, local HWBs should prioritise voluntary-sector engagement throughout the needs assessment and strategic commissioning process, so that the sector's insights can help to shape and design local services around local needs. HWBs have a degree of freedom to decide how best to engage with the sector, and early indications are that a range of models of engagement are developing: in some cases a voluntary sector representative is chosen to sit on the board alongside a Healthwatch representative, and in others the sector representative is elected and supported by a constituency of local voluntary organisations. Other HWBs intend to engage with the sector solely through the Healthwatch representative.³

While these arrangements will no doubt be refined and modified over time, it is important to acknowledge that a single representative or intermediary will not be able to reflect the full breadth and depth of the sector's expertise. HWBs must ensure that they have a comprehensive strategy in place so that they can benefit from the input of the full range of local voluntary health and care organisations. I would argue that many HWBs would find that they benefit from a dedicated sector representative on the board, but this should be supported by a broader plan for sector-wide engagement across a local area.

³ *Engagement with Health & Well-Being Boards* (Regional Voices) (<http://www.regionalvoices.net/stronger-connections-for-better-health/stories-from-the-front-line/engagement/healthandwellbeing-boards/>)

Challenges and conflicts

Of course, engagement with the voluntary sector poses challenges as well as offering benefits. By its nature, the sector is diverse and plural, which can make full and comprehensive engagement a lengthy process. In addition, where voluntary organisations have a role as providers as well as advocates and advisers, concerns sometimes arise around the possibility of conflicts of interest. While HWBs should be aware of these issues, they should also be aware that they are not insurmountable, and that solutions exist.

For example, voluntary-sector organisations have already begun to form collaborative initiatives aimed at simplifying communication with commissioners. These can be formed around a local area or around particular conditions, especially those which call for specialist knowledge and understanding that GPs may not have. One example is Neurological Commissioning Support, a joint project between the Motor Neurone Disease Association, the MS Society and Parkinson's UK, established to advise those who are commissioning care for people with chronic neurological conditions. HWBs may find that a small degree of support for collaborative initiatives of this kind between local voluntary organisations could go a long way to easing the process of engagement with the sector. Similarly, issues around conflicts of interest can be managed through the development of a transparent and open process of engagement, with clarity around the roles and responsibilities of all participants.

By effectively engaging with the sector in this way, commissioners can support continued improvement in health outcomes through better understanding of their community's needs, particularly in the case of vulnerable groups and specialist conditions; better-designed care pathways, tailored around local circumstances; and better understanding of the range of options available for treatment and support of patients. In addition, it is important to note that the voluntary sector can provide new options for supporting improved health outcomes in more cost-effective ways.

It is no secret that the NHS budget is under strain from financial and demographic pressures created by the UK's ageing population, the increased prevalence of long-term conditions due to changing lifestyles, and the lack of extra funds to address the problem. Long-term conditions, which are most commonly treated in costly acute settings, now account for around 70% of total health and care costs.⁴ Put simply, the NHS as a whole must develop new ways of addressing these conditions, or its costs will become entirely unsustainable.

⁴ *Long-Term Conditions* (Department of Health, June 2011) (http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPPworkstreams/DH_115448)

In this context the "prevention" aspect of the NHS's Quality, Innovation, Productivity & Prevention programme becomes ever more important. Prevention in health is an area where voluntary-sector providers have led the way for a long time, both in "upstream" projects designed to inform the public about the risks of unhealthy behaviours such as smoking or overeating, and in work that helps people to better self-manage their long-term or age-related conditions, supporting them to stay healthy and avoid the need for expensive, acute clinical interventions.

Many of these non-traditional approaches may not be familiar to clinicians, and therefore HWBs can play a valuable role in mapping the provider options available in a local area, and making commissioners aware of their potential. Many such projects leverage non-clinical resources, such as the support of families and wider social networks, to develop innovative ways to help people stay healthy, often with accompanying social benefits.

For example, TCV's Green Gyms offer volunteers, most commonly older people, the opportunity to exercise and socialise while also improving and conserving their local environment. Projects might involve activities such as gardening, tree-planting and path-building in an outdoor environment, as part of a social group. Independent evaluations have found the projects to produce improvements in both physical and psychological health.⁵

The voluntary sector is replete with innovative projects of this kind that offer highly cost-effective ways to improve health outcomes, and which will continue to grow in scale as commissioners look to reduce pressure on acute services. HWBs should take on the role of supporting the entry of innovative service providers into the local marketplace, and ensuring that commissioners are aware of the options available to them when drawing up commissioning strategies.

Threats to voluntary providers

Voluntary- and community-sector providers have grown increasingly used to competing for contracts in recent times, as commissioning has become the dominant model for all types of public services. However, there remains some concern in the sector about the potential difficulties of entering local markets for health services alongside larger and better-capitalised providers from other sectors. If commissioners favour large, agglomerated contracts in the name of short-term cost-cutting, smaller providers may be crowded out, and their capacity to support long-term improvements in outcomes

⁵ Reynolds, V *Well-being Comes Naturally: An Evaluation of the BTCV Green Gym at Portslade* (Oxford Brookes University, 2002)

and efficiency will be wasted. HWBs should monitor the development of local markets and offer support for diverse, plural markets which foster innovation, and which offer the maximum possible choice for both commissioners and patients.

In addition, HWBs should ensure that commissioners are aware of the ongoing challenges faced by voluntary providers within a competitive market. Financial sustainability remains a significant concern across the sector, particularly in an environment where many charities are already coping with significant funding cuts. Voluntary providers cannot bear the same level of financial risk as their counterparts from other sectors, and if commissioners fail to appreciate these concerns, there is a danger that financial constraints will stifle innovation and inhibit the development of a plural, competitive marketplace.

HWBs can play a role in educating commissioners about these issues and supporting them in, for example, making use of grant funding to build local capacity, or designing contracts so that providers bear a manageable level of financial risk. As the NHS reforms drive progress towards a more market-oriented system, HWBs should be aware that they have a role to play, alongside commissioners, in developing and maintaining a healthy local provider market.

There is no doubt that the scale and scope of the NHS reforms pose enormous challenges to all those working within the system, including commissioners and providers alike. They also present the chance to progress towards a new model of healthcare delivery, one that is more responsive, more innovative, more efficient and more effective. To make it work, all elements of the system, from commissioners to providers, clinicians to patients, need to be ready to engage and collaborate with each other.

This is why the job of HWBs in drawing together stakeholders across communities is such an important one. For the full potential of the reforms to be realised, the voluntary sector must be closely involved, both as providers and as advocates and advisers. HWBs will play a central role in supporting this engagement and fostering effective, collaborative relationships between commissioners, voluntary organisations, and the beneficiaries and communities that they serve.

Chapter 10

Mental health

Kathy Roberts, Chief Executive of the Mental Health Providers Forum,
and Annie Whelan of the Mental Health Providers Forum

Mental health

The disbanding of the National Mental Health Development Unit in 2011 – as well as several other major changes in health and social care, such as the closing of the regional development centres for mental health – has created something of a void in the mental healthcare system. There is no longer a national government body to act directly as a strategic influencer or conduit between national policy makers and mental health service providers, or a guidance body for commissioners. This has happened as many mental health strategic and commissioning functions have merged with broader, more generic functions with less of a specialist focus on mental health. However, at the same time health and well-being boards (HWBs) have been formed.

Although we at the Mental Health Providers Forum (in conjunction with our members and alongside other forums and bodies, such as the NHS Confederation and the Centre for Mental Health) have done our part to address these huge changes, the inception of HWBs is to be welcomed. These locally organised forums will have statutory authority to consult, communicate, set local standards and influence commissioning frameworks. The possibility of a vehicle for closer collaboration and sharing of practice based across local health and social care providers offers potential benefits.

In this chapter we will bring together a range of views from our members (and from the Centre for Mental Health) on the possible impact that HWBs could have on services as well as mental health practice more widely.

A fair say across the country

Although there is the clear intention to invite mental health organisations to participate, this may not be considered essential by all of the new HWBs. It is vital that there should be a consistent approach to the make-up of these boards, and that specialist areas be appropriately positioned to create awareness and understanding. Sensitivity to local need and variances will necessitate differences. However, it is hoped that the intention contained within the guidance to share and roll out good practice nationally will be realised as HWBs get up and running.

With this in mind, one of the immediate challenges is maintaining a consistent approach across the country. Although development guidance is offered, this guidance could be enlarged. The very fact that the HWBs can be individualised and matched to local requirements could mean that there are fundamental differences between them. Historically, locally established bodies have varied quite widely in consistency and approach, particularly in relation to understanding and sensitivity to mental health

issues. The MHPF is concerned that not all HWBs will give equal weighting to mental health or have the same specialist understanding of it as a component of overall health and well-being.

All members and partners interviewed felt that it would be vital for there to be adequate representation from different parts and perspectives across the mental health sector. This could happen through mental health champions or perhaps by setting up subgroups to feed into the HWBs. The optimum solution would be recognition by the HWBs of the diversity and spectrum of the mental health sector through the involvement of a range of organisations in the central forums.

As members of the HWBs will all be given an equal voice, voluntary-sector partners (who provide an essential proportion of mental health support and care) should have the same say as statutory partners. However, in these early stages of implementation and consultation, several of our members report little or no early involvement. Most HWBs include some third- and voluntary-sector participation, but the voluntary sector stretches across a huge variety of interests and areas. In addition, the mental health third sector is incredibly diverse. As many areas have only one or two seats to represent the whole of the third/voluntary sector, and not necessarily those particularly specialist in mental health, we feel that local organisations are unlikely to be in a position to represent the full breadth of the interests of the mental health third sector adequately, unless mechanisms are established for wider review and feedback.

Our members do feel that if mental health specialism is included in the focus of HWBs across the country, then pressure to provide an appropriate strategic focus on mental health can be applied to clinical commissioning groups (CCGs). They also feel that there is certainly the potential for more cohesive and joined-up working across health and social care, with many areas of existing good practice that can be built upon. It is absolutely essential that involvement begins in a meaningful way, as the HWBs are being formed, so that our wider voice is a part of the early development and mental health needs are considered during their formation.

Mental health service users and carers also need to have a defined self-advocacy position within HWBs. Appropriate attention to service users and carers will place greater focus on personalisation, personal health budgets and personalised services. It will also ensure adequate initial investment in quality at the front end of services and in prevention, which should create savings for the whole system. Making service user views central to the process will allow for greater transparency and clearer lines of communication.

Pooling budgets and sharing information

One of the biggest challenges to progress in service development is the pooling of budgets and shared funding priorities. There are a great many lessons that can be learned from previous boards, forums and strategies. Historically there have been huge problems with service collaborations across health and social care statutory systems and a lack of collaboration around the sharing of funding and joint commissioning. There should be robust processes in place to manage the inherent difficulties around pooled budgets and joint commissioning. It is also important to acknowledge fully the tensions between third-sector organisations, despite their shared values and priorities. There is a huge pressure to collaborate to secure funding at a time when organisations are in stark competition with each other. This is a systemic problem that will impact on the fluidity of joint work and shared practice, unless joint commissioning addresses these challenges.

An additional concern is that HWBs will find their ability to influence commissioning difficult if they do not have some control of the monitoring or funding of services (directly or in a clearly defined process). As CCGs may be working with more than one HWB, differences in approach could create confusion.

As a national forum we endeavour to set an example by sharing issues across sectors and between organisations. We hope that the establishment of HWBs will allow often overlooked issues to be discussed openly, leading to greater collaboration. In particular, information and good practice should be shared, as well as shaping around safety planning and risk review processes in mental healthcare.

Patient safety is important in physical and mental healthcare and as a part of planning for overall well-being. However, greater attention is often given to patient experience and safety in relation to physical health than to mental health and well-being. We hope not only that HWBs will create an opportunity for parity between physical health and mental health, but that patient experience and perspective will create new emphasis and momentum.

Information and data recording has historically been poorer in mental health than in other areas of health. This lack of adequate information and data has influenced the positioning of mental health within the joint strategic needs assessment and has affected its overall status in the joint health and well-being strategy (JHWS). As a membership body and a strategic partner for the Department of Health, we want to see an improvement in the recording of data and management, and we will be pushing for this on behalf of the sector.

The government's strategy in *No Health without Mental Health*¹ addresses the stigma and places mental health firmly within the framework of "whole person" health. This is welcomed alongside the government's intention to support more people throughout recovery and provide for their well-being within outpatient and community-based settings. It is important that the HWBs do not just focus on the health and social care field, but look more widely at involving educational, employment and criminal justice partners, in order to gain more of an understanding of whole-person health and well-being, and reconnection with life and community.

Conclusion

There is also scope for a renewed recognition of the contribution that mental health third-sector providers can make to the whole well-being economy. The sector has built flexible skill sets across different service areas and is committed to developing services around individuals and embracing personalisation as the way forward in mental healthcare. Often statutory providers are involved more integrally in new service models and developments than the third sector. This sometimes means that the breadth of knowledge and capacity in the voluntary sector is poorly represented when it comes to making decisions about commissioning services.

Third-sector mental health services can play a crucial role – something that needs to be understood by the new HWBs. Time and investment needs to be made in creating collaborative vehicles for a broad range of stakeholders working cohesively in the development of new service models.

The Mental Health Providers Forum (www.mhpf.org.uk) is the national umbrella body of not-for-profit mental health organisations across England. Our members provide a broad range of mental health services covering inpatient, community-focused, personalised support, personal assistance, support brokerage, supported housing, day service, floating support, independent advocacy and forensic services throughout England. Our membership includes larger national mental health organisations, such as Mind, Turning Point and Rethink, as well as regional and local organisations of varying size, such as MCCH, Second Step, WPF Therapy and Community Options. In all we represent more than 55 mental health charities.

It also leads a strategic partnership of mental health organisations, which includes

¹ *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages* (Department of Health, 2011)

the Centre for Mental Health, Mental Health Foundation, Mind, Rethink Mental Illness, National Service User Network and Mental Health Helplines Partnership. The partnership was established as a collaborative vehicle for sharing information and opinion about policy and changes that affect the mental health third sector. As its lead, the Mental Health Providers Forum is in a position to work with other Department of Health third-sector strategic partners to advise and inform regarding key issues for mental health service providers, influencing positive change across health and social care policy and benefiting those who access and rely on mental health services.

Chapter 11

Scrutiny and accountability

Tim Gilling, Executive Director of the Centre for Public Scrutiny

Scrutiny and accountability

Getting out of the blocks

As part of the health reforms established by the Health & Social Care Act 2012, health and well-being boards (HWBs) are being set up by county and unitary councils across England in time to take on the co-ordination of health and social care services and health improvement activity from April 2013. But they are an innovative departure from traditional council committees, bringing together politicians, clinical commissioning groups (CCGs), directors of public health, directors of children's services, directors of adult services and Local Healthwatch. The NHS Commissioning Board will also have a role in local boards, in relation to commissioning of primary care and specialised services.

HWBs are a component of the health reforms that drew almost overwhelming support during the passage of the legislation through parliament. People can see the potential of boards to drive change – but how can they best develop as transparent, inclusive and accountable bodies?¹

The prescribed composition of boards set out in the legislation is a starting point to make sure that key people with a role to influence health, social care and health improvement strategy are visible around the table. But the best boards will use the minimum prescribed membership as a springboard to include other people in the local context – for example, district councils (which have responsibility for fundamental determinants of health, such as housing, leisure services, community safety and planning), along with the leaders of education and business.

It is clear that very large boards will risk having meetings become ineffective talking shops, but, similarly, boards that take a compliant attitude to meeting the duty for minimum membership risk failing to drive the change of culture necessary to tackle some of the most long-standing inequalities and challenges we face as a society.

It is also clear that not everything can be achieved through formal board meetings – boards will need good networks around them (as opposed to a big bureaucracy) to inform their work. So a key question boards need to answer is: are the right people around the table, and who do we need to hear from to help us make a difference? From this starting point, boards can begin to be transparent about how they work, helping to build trust and credibility with local communities, partly through the role of Local

¹ "Operating Principles for Health and Well-Being Boards" were published by the Department of Health, the NHS Confederation and the Local Government Association in 2011.

Healthwatch but not restricted to only one expression of the voice of people who use services and of the public.

The most effective boards will be visible to local people and groups and will support them to present their views about their experiences of health and social care services, the best ways to tackle inequalities and ideas for designing services for the future. A compliant attitude to transparency (for example, publishing only historical information) risks harming the reputation of boards. Opening up decision making, being clear about how people can influence their work and providing credible responses to what they hear will give boards a greater chance of success.

Concentrate on core business

The purpose of boards is to "advance the health and well-being of the local population and promote the integrated working of all those engaged in providing health and social care services locally". They will have a duty to develop and publish a joint strategic needs assessment (JSNA) and a joint health and well-being strategy (JHWS). The local authority and NHS commissioners will be required to have regard to these when they commission health and social care services. Bringing together key players across the health, local government and community sectors will help them to tackle some tricky challenges.

Boards will have to make difficult decisions about priorities and board members will need to work together to take collective responsibility through joint health and well-being strategies for how limited resources are used to address the needs outlined in joint strategic needs assessments.

The best boards will recognise that it is important not to confine priorities to health and social care services, but to tackle also the wider determinants of health – for example, by trying to align housing provision, educational attainment, skills and jobs with environmental factors such as transport, open space and recreation. It is likely that successful boards will comprise partners who do not seek to protect their budgets by withdrawing from joint working or attempting to shift costs to other partners. Good boards will find opportunities to consider how best to use collective spend across agencies to improve agreed outcomes.

Currently in shadow form, boards are necessarily spending time thinking about the processes they need to work well. These foundations need to be in place but boards will quickly need to turn their attention to the outcomes they want to achieve. Ultimately, boards will be judged on their ability to add value by doing things differently to get better results.

Providers of services have specialist knowledge which boards will need to take into account when considering joint strategic needs assessments and joint health and well-being strategies. Boards themselves will not necessarily be directly commissioning services, but they will lead on strategy and governance issues relating to delivery of the joint health and well-being strategy and will play a leading role, developing new integrated ways of working across the NHS, public health, social care and the whole of local government to improve local health and well-being outcomes. Boards will need to recognise and manage real and perceived conflicts of interests so that provider views can be incorporated into the improvement of services in ways that maintain equity of responsibilities.

Outcomes are everything

Outcomes linked to health and well-being priorities as identified in the joint health and well-being strategy should underpin the work of boards, in particular the commissioners of health, public health and social care. Boards should be focused on improving outcomes when assessing needs, setting strategies and reviewing whether outcomes have changed as a result of agreed action, taking into consideration the long-term nature of achieving many public health outcomes.

Boards need to be very inclusive when thinking about outcomes – a compliant attitude to inclusion (for example, only meeting legal duties to involve and consult) risks the perception that boards do not want to learn from the experiences of local people. The best boards will demonstrate shared decision making across the spectrum of their work, so that services are commissioned on the basis of people sharing decisions about their treatment and care and so that communities can collectively influence the future pattern of services.

It is important to recognise that there will be a web of accountability around boards, affecting different board members in different ways. Boards will have a shared responsibility for developing joint strategic needs assessments and contributing to the delivery of the joint health and well-being strategy. Because local elected councillors will be involved in boards, the actions that boards take to achieve these aims will have an element of democratic legitimacy – but this is not the same as accountability.

For example, the act sets a legal framework for the accountability of CCGs to come through assessment by the NHS Commissioning Board, the inclusion of lay people on CCG boards and duties to involve and consult and publish an annual report. Accountability of local authorities will come through council scrutiny functions and through Local Healthwatch (in respect of social care services). Local Healthwatch

itself will be accountable to councils. HWBs will be collectively accountable to council scrutiny and they will find themselves held to account in other, less formal ways; for example, through the press and social media.

The principles outlined here can be used as part of a self-assessment of the progress of boards. Self-regulation and improvement will be an important part of the governance and operational culture of boards – that is, how transparent, inclusive and accountable they are. Boards will need to adopt a learning approach to evaluate how well they operate, their collective impact on improving outcomes and a process for identifying the most effective ways of sharing what they do and learning from the practice of other boards.

So what might be some key questions about accountability? I think they fall into four broad themes.

Leadership

This is about providing collective clinical, political and community leadership to improve health and well-being for everyone in the area, so that shared decision making with patients and service users and co-production of needs assessments and strategies are the norm. What might successful leadership look like? Boards could begin by making some public commitments, for example:

- to work together in transparent, inclusive and accountable ways;
- to work with communities, people who use services, professionals and the private and voluntary sectors to develop and deliver a shared vision for improving health and well-being; and
- to learn lessons from local experience and the experiences of others and work together to find solutions to difficult issues and to support agreed actions.

To be successful, boards will need clear governance procedures and regularly evaluate them for effectiveness and outcomes. The leadership culture of boards will heavily influence success – a culture built on trust and respect between board members, people who use services, communities and their representatives can be a springboard for better outcomes. Boards that evolve an opaque, exclusive or defensive culture risk failing to achieve the kinds of changes needed. Boards need to be clear how commissioning plans will address the JSNA and achieve the outcomes of the JHWS.

They should be clear about how they work together with people who use services and communities to tackle difficult issues such as prescribing policies and service recon-

figuration. Are boards using lessons from local experience and the experiences of others to change the way the board works, and are they applying good practice to integrate health and local government services? The overarching accountability question about leadership is, does the leadership and outcomes of boards command the respect and support of the people who use the services and communities?

Democracy

Achieving democratic legitimacy and accountability, and empowering local people to take part in decision making, will be key demonstrators of credibility. Success might be achieved by making some public commitments, for example:

- to be transparent about information and decision making processes;
- to allow people who use services and communities, along with third-, public- and private-sector participants, to influence the work of the board;
- to help communities find their own solutions to improving health and well-being; and
- to demonstrate clinical and democratic legitimacy for decisions.

The Nolan principles of public life are fundamental for board members, but boards need go beyond the basics to demonstrate how they work creatively with others to achieve credible outcomes. Ways they can do this might include collaborating widely to develop the joint strategic needs assessment and the joint health and well-being strategy. Legal duties to involve local people are important but boards will also need to provide evidence that outcomes have been influenced. One way to do this might be to allow people who use services to generate measures of success for boards.

Seats for councillors on boards will inherently add some democratic legitimacy to decisions about the framework for local commissioning. But democracy could also be demonstrated through community development approaches – supporting people who use services and communities to find their own solutions to improve local health and well-being (bearing in mind that other agencies and central government have an impact on improving the public’s health). The approaches taken by boards to working with council scrutiny functions, Local Healthwatch, lay people and other community interest groups will be other important indicators.

Equity

Boards have potential to tackle health inequalities by shaping the framework for commissioning such that comprehensive, equitable health and local government services are planned and delivered in the area. A public commitment to publishing

realistic needs assessments and addressing the wider determinants of health by including, for example, education, housing, transport, employment and the environment in a creative health and well-being strategy will be a start.

Further commitments to collaborate and work in partnership to achieve shared outcomes and alongside other statutory bodies (for example, local safeguarding boards) and non-statutory bodies (for example, children's trusts) will demonstrate a bold vision. Boards must not forget the needs of unregistered patients or vulnerable groups and must focus on children and young people as well as adults.

Boards will need to present evidence that outcomes from their work are making a difference. Examples of questions boards can ask themselves are:

- What measurements are used to indicate that health and well-being are improving and that health inequalities are reducing?
- Are there examples where local government and NHS services have joined-up working arrangements?
- Do people who use services report experiences of seamless and continuous care?
- Are there clear links between the board and statutory/non-statutory bodies?
- How are the needs of unregistered patients, vulnerable groups and children as well as adults identified and met?
- Does the board have confidence and ambition to work beyond health and social care services and work with people who are not board members?

Priorities

Boards will ultimately be judged on the extent to which they identify credible priorities for commissioning health and local government services and develop clear plans for commissioners to make best use of combined resources to improve local health and well-being outcomes in the short, medium and long term. This might mean making a commitment to align commissioning plans to the agreed priorities in the joint health and well-being strategy, together with a commitment to make the joint strategic needs assessment a high-quality process and to treat the outputs as the evidence to develop the joint health and well-being strategy.

Demonstrating that decisions are based on research, public and patient input, and robust evidence will be important, along with collecting relevant data and information to help measure progress. A commitment to take action when indicators show plans or initiatives are not working will give local people confidence that boards can agree best use of resources effectively, fairly and sustainably. A key indicator to support con-

confidence will be how boards demonstrate capacity to assess risks and plan to adapt or respond to change, for example, changing demography or available resources. Demonstrating a shared understanding of resources that are available locally (such as cash and social capital), together with a consensus about how these resources can best be utilised to improve outcomes, are important indicators.

Breaking the tape

Back in 2010, our response to "Equity and Excellence" highlighted opportunities to redefine relationships and behaviours between professionals, patients and carers (for example, through shared decision making); commissioners and providers (for example, through shifting the balance of power and capacity to change the status quo); commissioners, providers and communities (for example, through involvement and influence); and commissioners, providers and councillors (for example, through political leadership and scrutiny). If politicians, clinicians, other professionals and Local Healthwatch commit to transparent, inclusive and accountable boards, this vision could be realised.

Chapter 12

Learnings from an early implementer

Sharon Cannaby, Head of Health Sector Policy at the Association of Chartered Certified Accountants

Learnings from an early implementer

The power of health and well-being boards will be built on mutual trust, shared understanding, shared vision and shared commitment to serve the health and wellbeing of the people we serve.

We think that there is a real synergy with the more data-driven epidemiological approach that public health brings with the understanding that local councillors have of place and of their community. We think that these two factors, taken together, are very powerful in terms of cementing leadership.

Dr Peter Marks, Director of Public Health for Leicestershire & Rutland

For many years attempts have been made to promote strategic partnerships between the NHS and local authorities, but none of these has been particularly successful. So will health and well-being boards (HWBs), the latest initiative designed to engender collaborative working, succeed where others have failed?

An early implementer tells its story

With a strong track record of high performance – it was named Council of the Year in 2009 and has a number of high-performing departments – it is perhaps not surprising that Leicestershire County Council took the decision to become an HWB early implementer.

The council was keen to become more closely engaged in the health agenda and recognised the potential for doing things even better through collaboration. It already had a history of successful partnerships, working both with the NHS and other agencies, and so the establishment of a shadow HWB at the earliest opportunity within the NHS transitional arrangements was a natural next step.

In 2009 Leicestershire County Council already had a joint change programme board operating at executive level between the council and local NHS. This comprised executives from the primary care trust and the council, as well as the leaders of the emerging GP clinical commissioning groups (CCGs).

Following the announcement of the NHS reforms programme, the terms of reference for this group were amended and its focus directed at overseeing the transition. The joint change programme board was responsible for four key strands of work:

- transition of public health services from the NHS to the council;
- development of Local Healthwatch;
- joint commissioning (now called integrated commissioning); and
- implementation of the shadow HWB.

Subgroups of the joint change programme board were created to oversee each of these work streams. A project implementation team was created to oversee the establishment of the shadow HWB.

TIP: Establishment of a joint change programme board at executive level helps move forward a complex change management programme in a structured way.

Implementation timetable for the shadow HWB

November 2010	Appointment of programme director (seconded from primary care trust)
	Appointment of project manager (seconded from council)
	Implementation plan developed
November 2010–April 2011	Identification of potential membership of shadow HWB members
	Identification of stakeholders
	Organisation and delivery of stakeholder engagement plan, including involvement of the media
	Consideration of governance and accountability arrangements, including substructure beneath the board
	Preparation of draft terms of reference
	Preparation of website, including frequently asked questions section, with content based on stakeholder engagement period
April 2011	Development meeting held for members of shadow HWB

April 2011	First formal shadow HWB meeting
May 2011	Stakeholder workshop, including engagement on board substructure and communications
June 2011	Shadow HWB agrees strategic priorities at second formal shadow HWB meeting
December 2011	Shadow HWB reviews alignment of organisational commissioning priorities for 2012/13 at development session
January-May 2012	Shadow HWB produces and publishes revised JSNA
October 2012	Draft health and well-being strategy presented to shadow HWB
April 2013	Board will meet as a statutory body for the first time

Establishing the shadow HWB

The primary purpose of HWBs is to:

- promote integration and partnership working between the NHS, social care, public health and other local services; and to
- improve local democratic accountability.

Keeping these two key points in mind, the project implementation team produced a work plan aimed at establishing the shadow HWB by April 2011.

A programme director, seconded for one year from the local primary care trust (PCT), led this work. She was supported by a programme manager seconded from the council – an officer from democratic services. Communications and engagement support was provided by the PCT and the council manager.

TIP: Having a project team comprising NHS and council officers will help smooth the transition process.

This small team was faced with a long to-do list, including: identification of all stakeholders; development and implementation of a stakeholder engagement plan,

including media relations; briefing and supporting the chair of the board to take on his new role; identification of potential members of the shadow HWB; drafting and agreeing terms of reference; and clarifying governance and accountability arrangements.

Being an early implementer meant that they could not readily access prior experiences of colleagues who had already implemented this approach in other areas – everything was developed from scratch using a bespoke project plan.

One of the first tasks the implementation team tackled was preparing an introductory workshop for the members of the shadow HWB to introduce them to each other, provide an overview of the terms of reference, and have the board shape their cultural development at an early stage.

From their initial discussions it was agreed that the shadow HWB would focus on three key themes:

- improving health outcomes;
- improving service integration; and
- improving efficiency and balancing the economy.

This work also reconfirmed that the joint change programme board would continue with its core role of overseeing all four elements of NHS/local authority transition (namely public health transition, development of Local Healthwatch, integrated commissioning and implementation of the HWB).

The second large task the implementation team for the HWB took on was development of a comprehensive stakeholder engagement plan. In summary, this covered identification of all potential stakeholders, establishing how they might wish to be engaged across the spectrum of information – from sharing to very active involvement – and then organisation of an engagement workshop to secure broad-based support.

Over 50 people attended the workshop, including representatives of Leicestershire County Council, members of the public, service users on county council boards, district councils, the voluntary sector, NHS trusts, and Leicestershire Local Involvement Network (LINK). The event aimed to encourage active stakeholder involvement in both establishing the shadow HWB and framing its initial priorities.

TIP: Don't underestimate the amount of work needed to produce a comprehensive stakeholder engagement plan.

The key messages from the workshop included:

The need for a strong communication strategy: Workshop delegates stressed the need for communication to be two-way. They said that care should be taken to ensure that publications are accessible to all – 60% of over those aged over 65, for example, do not use email, so dissemination of information should not be limited to the internet. They also suggested that, where appropriate, reports should be targeted at specific audiences.

The need to involve seldom-heard groups and users: It was suggested that groups such as the physical and sensory disability board and the prevention and early intervention programme board were invited to feed in their views through membership of a subgroup of the HWB.

The need for better understanding of the JSNA: Participants at the event said there should be greater clarity around which aspects of the joint strategic needs assessment (JSNA) worked well and which did not. A question was also raised about whether regularly updating the JSNA delivered any real benefits; it was thought that a longer-term approach might add more value.

The need for genuine engagement with local residents: It was suggested that the HWB aim to engage with a large range of people and organisations, including older people, families (not just children), voluntary hubs, the WRVS, local sport and health alliance, local champions, organisations such as Weight Watchers, and local business groups. In recognition of how difficult it can be to encourage engagement, it was proposed that a more proactive approach be taken, directly approaching people, for example, to request their support.

The need to add value: Workshop delegates said it was important that the new board added real value and did not just duplicate work that was already under way.

In parallel with the board's development workshop and stakeholder engagement workshop, the programme director began to build relationships with others, such as the Department of Health's HWB implementation team, and to share experiences with other early implementers regionally and nationally.

TIP: Don't go it alone. Make time to share experiences and lessons learned with other HWBs.

Particular efforts were made in the establishment of the HWB to develop a strong working relationship with local GPs. Meetings were held with the local medical committee and CCG leaders, and the outputs were then used to help shape thinking on joint working and integrated commissioning. Development sessions were also arranged to brief GPs about the role and statutory duties of the council so that they had a better understanding of the context of the HWB as they joined this board.

TIP: Stakeholders come from many different backgrounds, so make time in the engagement plan to explain the roles and perspectives of the various organisations and how they come together within the HWB.

A key task for the project implementation team was determining how the board would operate and reviewing governance and accountability arrangements. This included:

- considering the appropriate representation on the board and, as a result of feedback from the engagement workshop, adding another member from LINK;
- considering voting issues including balance of board members and deciding who should have the casting vote;
- drafting terms of reference for discussion with the shadow HWB;
- looking at governance arrangements to determine where the shadow board would best sit within the Leicestershire Together Partnership and the county council; and
- considering the substructure of the board, with the aim of keeping it lean but also being clear on the groups that would be needed to sit beneath the board that would deliver the board's mandate and priorities.

TIP: The positioning of the HWB is critical if it is to have influence to shape and direct the agenda.

With stakeholder engagement under way and clarity around how the board would operate, the project implementation team turned its attention to establishment of the shadow board. In April 2011 the proposed members of the shadow HWB were invited to attend the first in a series of board development workshops.

The initial event, facilitated by John Benington, professor in public management and policy at Warwick University, was focused very much on relationship building. Participants were invited to discuss the impact that the NHS reforms would have on their employing organisation, which gave everyone the opportunity to articulate their concerns and helped to increase understanding of each other's perspectives. The

session proved to be particularly successful and paved the way for the first formal board meeting.

The board initially comprised the following members:

- the cabinet lead member for health (chair);
- the cabinet lead member for adults and communities;
- the cabinet lead member for children and young people's services;
- two representatives from East Leicestershire & Rutland Clinical Commissioning Group (one GP and one manager);
- two representatives from West Leicestershire Clinical Commissioning Group (one GP and one manager);
- the director of public health;
- the director of adults and communities;
- the director of the children's and young people's services;
- two LINK representatives (to be replaced with Healthwatch representatives);
- the chief executive of the local PCT (to be replaced with the chief executive of the local NHS commissioning board);
- the local medical committee representative (a temporary appointment); and
- the district council representative.

An early decision was taken to give the HWB a commissioning focus, so membership of the board reflects this. Providers are, however, invited to attend board meetings to address specific items.

Membership of the board has since evolved. The local medical committee representation has ceased since the CCGs have been formed. Both CCGs are awaiting the outcome of their authorisation assessment in wave one of this process. A member of Leicestershire Constabulary has joined the board and, with effect from October 2012, the PCT chief executive was replaced by the chief executive of the local office of the NHS Commissioning Board.

The board benefits from regular development sessions: recent workshops, for example, have covered JSNA development, care pathways for frail and older people, the development of the joint health and well-being strategy (JHWS), and developing joint commissioning intentions. These sessions, and the appointment of a chair who brings both NHS and council experience, have helped develop a good rapport between board members. They are all fully engaged in the board's agenda and have shared accountability for its success.

Operational running costs of the board are kept low. The board is serviced by an existing council employee structure, and democratic services and development workshops are mostly organised in-house, with all materials produced by the project team.

Care is taken to ensure that papers prepared for meetings of the shadow HWB take account of the different backgrounds of members, and that they contain sufficient levels of information and minimal acronyms, so as not to alienate any particular member.

The first year

The board has held formal board meetings in public since April 2011.

At its second meeting, in June 2011, the shadow board agreed eight interim strategic priorities, based around the three themes identified at the early workshop, the existing JSNA and the existing priorities of partners:

- increasing life expectancy and reducing inequalities;
- reducing the prevalence of smoking;
- reducing the harm caused by alcohol and drugs;
- reducing the prevalence of obesity and physical inactivity;
- improving the care of older people with complex needs and enabling more older people to live independently;
- improving the care of adults and children with complex needs and their carers, including those with mental health needs or complex disability needs;
- shifting investment to prevention and early intervention; and
- making urgent care systems for adults and children work.

These eight strategic priorities formed the initial focus and work plan of the shadow HWB and, at the December 2011 board meeting, members considered the alignment of organisational commissioning plans to these priorities.

The second year

Mindful of the need to not duplicate existing services, the shadow HWB is taking a systematic approach to integrated commissioning, working closely with partners to improve integration of services.

The shadow HWB has set up five subgroups to help shape commissioning decisions and to support the delivery of more joined-up service provision. The staying healthy board, for example, is focusing on key areas of health improvement such as smoking

cessation and tackling obesity. Other subgroups include the substance misuse board, the integrated commissioning board, and the JSNA and JHWS working group. The subgroups comprise a wide range of users, providers, commissioners, professional advisers and other stakeholders, to help ensure that the shadow HWB's recommendations are well informed and that services are successfully designed and delivered.

The fifth group (the HWB steering group) is an officer/operational group that plans the forward work plan/agenda of the board, including its on-going development sessions. This has representation from all the shadow HWB member organisations, including LINK.

The board produced a JSNA in spring 2012 and then began working on development of a single health and well-being strategy. The previous JSNA had been produced in 2009. Since that time new data, both qualitative and quantitative, had become available which was used by the public health team to introduce new sections and revised areas of focus to the JSNA.

Some pooled budgets already exist to support the commissioning of integrated services, for example in learning disabilities. The social care allocation given to local authorities by the Department of Health is core business for the Integrated Commissioning Board and is where the NHS and council agree the investment plan in key areas of integrated commissioning such as dementia, intermediate care and re-ablement services.

The third year

In its first year as a statutory body the board will focus on three key areas:

- leadership;
- relationships; and
- transformation.

The three areas are closely interlinked, with success in any one area heavily dependent on the others.

Leadership pertains to a shared understanding of the community – both its needs and its assets. With its cross-organisational expertise, the board's priorities in its first year as a statutory body will include enhancing the integration of commissioning approaches, and funding and examining health system change proposals that are emerging across Leicester, Leicestershire and Rutland.

TIP: Take time to understand and explore different cultures.

Relationship building with a wide range of people and across a wide range of organisations will be essential if the HWB is to develop a proper understanding of local perspectives and needs. In 2013/14 the board will be particularly focused on building new working relationships with Healthwatch and with the NHS Commissioning Board.

TIP: Success will be dependent on well-developed personal relationships rather than from structural change.

Transformation (rather than transition) needs to be innovative but should be based on what is known to work. In the years ahead the board is committed to directing change by taking account of both data-driven epidemiological evidence and local community knowledge.

The board is also looking at the wider determinants of health and assessing the role that each plays on health. At the October 2012 meeting, for example, the role of libraries in improving health and well-being was considered.

Accountability

Initially the HWB has operated in shadow format as an advisory body to the county council's cabinet, the NHS Leicestershire County & Rutland PCT board and CCGs. Independent scrutiny of the performance, functions and outcomes of the shadow HWB will be provided by the adults, communities and health overview and scrutiny committee.

From April 2013, subject to legislation, the HWB will become a statutory body and will be a committee of the county council with executive powers. The board will then be held to account through the overview and scrutiny committee, Local Healthwatch and, since it is ultimately a part of the council, to Leicestershire County Council cabinet.

Conclusion

The establishment of statutory HWBs is intended to support improved integration of healthcare across a locality through the alignment of service planning and resources.

Leicestershire has made a positive start on this journey. The shadow HWB has been in place since April 2011 and has already made its mark with the production of a revised joint strategic needs assessment and draft joint health and well-being strategy. Members are fully engaged in the work of the board and have assumed joint responsibility

for making it a success. The structure beneath the board is also starting to mature.

Establishing the shadow board was not, however, without its difficulties. As an early implementer, Leicestershire County Council had to do all the necessary planning and development work from scratch. It was also working to very tight timescales, which occasionally challenged the project management skills of the project implementation team. Although there is still some work to be done, mainly around improved stakeholder communication and engagement, the deadlines were met and the journey to date has proved successful.

Chapter 13

Achieving cost-effectiveness for health and well-being boards

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Achieving cost-effectiveness for health and well-being boards

Becoming a cost-effective health and well-being board (HWB) will be a challenge. The starting position and organisational background is probably set against HWBs being effective, and even more so against cost-effectiveness. This section looks at some of the opportunities to try and redress this imbalance.

There are unavoidable costs to setting up and running an HWB. The initial approximate minimum cost of running an HWB is £150,000 a year, based on six meetings and 10 people, but could be over £300,000 for large boards who meet more frequently. The meetings are held in public, which means there are additional administration costs. This is just the basic expenditure incurred by councils, clinical commissioning groups (CCGs), patient representatives, NHS providers and others in meeting as an HWB. There is a possibility that a miscreant HWB could make CCGs, NHS and other providers incur significant additional costs through various checkpoints – extended public consultation, in-depth equality analysis etc. These extra costs are ignored in this chapter. It is a risk that if those running the HWB have any hidden agendas and want to prevent any change, they have the power to place onerous constraints on providers.

There is no evidence that integration by itself is cost-effective. The evidence from the study in 2012 by Ernst & Young, commissioned by the Department of Health, confirms previous reports that integration does not necessarily save money or create a more efficient service.¹ It is perhaps most surprising there is no evidence that joint working between the NHS and social services can save money or use resources more effectively.

The initial ideas for integration were introduced in 1976 with the Joint Finance Initiative. This was a financial mechanism that enabled NHS funds to be spent by council social services departments. It provided a financial incentive for joint planning of community services to promote community care and reduce dependence on long-stay hospitals. There have been numerous initiatives since then, with pooled budgets, joint appointments and various directions on sharing budgets. But, over the 36 years since then, there has been no evidence that integration is the answer to providing a more cost-effective solution.

There can sometimes be a culture of mistrust between the NHS and social services. There is evidence that having an effective joint-care, long-term conditions manager or care planner can shift costs to or from one body or the other. There are significant

¹ *National Evaluation of the Department of Health's Integrated Care Pilots* (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133126.pdf)

sums of money to be transferred, depending on the effectiveness of the team and their skills in understanding the grey area between health and social care provision. This practice is still widespread, judging by the written evidence from the NHS Confederation in 2011: "However this is still happening in some places, for example, members of our Mental Health Network already report growing numbers of local authorities withdrawing from integrated older people's and other adult services."²

Roles of HWBs

One of the main formal roles for the HWB is to produce the joint strategic needs assessment (JSNA). When the annual real growth for the NHS was 4% (in the 2007 spending review), having a public health plan to direct the investment appropriately was essential. There was generally some spare money for new schemes after the acute hospitals had claimed their share. But now, based on the latest comprehensive spending review, average growth in real terms is 0.2%; there are 200 private finance initiative commitments in the NHS, which increase the annual revenue liability by the retail price index each year; specialist hospitals are lobbying Number 10 for more money on the back of medical innovation; and acute hospital activity keeps increasing. Under these circumstances, a plan to spend money on public health-type initiatives may be just a waste of paper. The JSNAs I have seen all eloquently describe the local population: how it is different to average and requires investment in certain areas. It is easy, in a way, to say that the population is ageing, more diseases will need treating in future and there is a significant unmet demand for mental health services. In fact, directors of public health have been saying this in their public reports since 2006.

Following the JSNA, the joint health and well-being strategy (JHWS) will be produced to help health and social care services to be joined up with each other and link with other services, such as housing, local economy and environment. There is also an expectation that the HWB will lever in health benefit from other council spending. An often quoted example is that spending on improving substandard housing – to ensure cheap heating and to change the interior design for older people with less mobility and poorer vision, to reduce the risk of falls, and to make other general improvements – will have an impact on health. However, it is not clear, other than through the influence the representative councillors on the HWB have on other local authority departments, how this will be achieved.

An HWB must review the CCG commissioning plan, to ensure the plan has taken account of and is in line with the JHWS. The HWB will also be consulted when the

2 <http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1583/1583we19.htm>

CCG proposes significant changes to the commissioning plan. Finally an HWB must provide an opinion on the plan, and this will be included in the CCG's published commissioning plan.

Constraints and opportunities

The HWB members will have to tread carefully, taking the relevant organisations on a journey, but be radical in their approach if they want to move beyond being a talking shop and actually deliver measurable improvements in healthcare, and become cost-effective. The temptation to maintain the status quo should be resisted.

One area of opportunity is to support CCGs to make radical changes. Take, for example, changes in hospital configuration. It is generally accepted by academics and senior doctors that hospitals need to change; the old district general hospital model is flawed, as the local hospital cannot continue to do everything.

Many hospital wards need to be closed and whole departments moved elsewhere so that the NHS can improve care for the most seriously ill patients.³ However, hospitals have been described as the living embodiment of public services: "They are deeply symbolic, they're bigger even than the NHS, they are the public's symbol of public services and a safety net and that's really important to understand."⁴

One example of radical change that has produced measurable results is the improvement of stroke services in London to be the best in the country, by developing eight specialist units that carry out the initial intense treatment and then downgrading the other 20 hospitals to rehabilitation services. Mortality rates came down quite significantly in London compared with the rest of the country, with thrombolysis used in about 14% of stroke admissions, while in the rest of the country the rate is around 5-8%. There was some political pressure not to change the status of the local hospitals, but the clinical evidence for change was overwhelming and there were funds available for investment and to meet any additional costs. This movement towards large specialist hospitals – especially in cancer services, which are centrally commissioned – has been going on for some time.

There is some scepticism that the development of a locality agenda and more powerful scrutiny committees and HWBs would stop these radical changes. In this

3 According to Professor Terence Stephenson, chair of the Academy of Medical Royal Colleges, quoted in Denis Campbell "NHS Needs to Close Wards and Hospitals to Centralise Care, Says Doctors' Leader" in *The Guardian*, 24 July 2012 (<http://www.guardian.co.uk/society/2012/jul/24/nhs-hospitals-need-to-close>)

4 Professor Naomi Fulop, quoted in "Reconfiguring Hospital Services", briefing for the King's Fund (6 September 2011) (<http://www.kingsfund.org.uk/sites/files/kf/briefing-on-reconfiguring-hospital-services-candace-imison-kings-fund-september-2011.pdf>)

case HWBs would have to be focused on improvements to outcomes for patients to be able to accept that downgrading of the local hospital and concentration of resources in specialist units would be the right outcome.

There is a three-way tension which cannot be understated between the public, patients and health professionals. The public expects a local service that will continue, access to all the new drugs, care for the elderly as families move apart, and as can be seen in the rising tide of obesity, an expectation that the NHS will make them better even after ignoring all public health warnings. Patients expect the NHS to provide all the care they require without delay; they expect to get better, to have a good experience and the best outcomes possible. Health professionals generally want the status quo: it is time-consuming and challenging to change medical practice. For instance, day surgery was recognised as the safest procedure in the 1980s, but even in 2012 not all suitable operations are carried out as day surgery; Care in the Community started in the 1960s but it took an act of parliament in 1990 really to start to implement the change, and even now there are pockets of resistance. Managing this tension to make changes that will improve the quality of care for patients will be difficult, and HWBs will have to persevere to overcome resistance.

In principle HWBs should continually examine decisions to ensure that all resources improve the health of the population. Crucially, they should accept that reconfiguration or major changes may be viewed adversely by the population but may nevertheless have benefits and improve patient care. They must also accept that the NHS does not have a monopoly on providing services, and there may be other organisations that can develop innovative cost-effective approaches.

Meetings and managing change

HWBs should constantly check that they are making a difference by focusing on and measuring the outcomes of deliberations and decisions. Within a cash-constrained service, this can be done by looking at investment and disinvestment decisions and how they improve patient care. According to a recent survey of finance directors,⁵ the NHS has improved efficiency, eliminated all unnecessary spending and made all possible savings, and the next round of spending reduction will result in quality of or access to services being affected. This does mean that significant disinvestment decisions will impact on patients and the public, but if there are more cost-effective ways of using the resources then these difficult decisions should be made.

⁵ *How Is the NHS Performing?* (King's Fund, September 2012) (http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/how-is-the-nhs-performing-quarterly-monitoring-report-sept12.pdf)

This is a risk management process to which the HWB can bring resilience and support. With fixed resources, changing any service means stopping what was done previously and starting the new service from scratch. There is probably nothing more risky than to propose changes that affect medical staff and the location of services for a new model of provision, but if this is the best outcome for patients, then HWBs should support CCGs.

Being clear on acceptable outcomes that are defined, agreed and then performance managed is essential. Outcomes are the wider changes that are caused by the actions of HWBs working through CCGs, local authorities, providers and any organisation that can improve health. Outcomes may relate to patient experience, time, improvement in health, recovery, re-ablement and so on. For example, the outcome for dementia may be measurable improvements in the provision of services in the community that reduce the impact and delay the onset of patients going into full-time care.

HWBs may need to be resilient and not focused just on one year, or an election cycle, as outcomes relating to significant changes for people tend to be achieved over years, not months.

To be cost-effective HWBs must look and work differently from other statutory boards. One initial observation on how to make meetings more productive is that it would be helpful to change the culture whereby members feel they have to say something, even if not relevant, just to be in the minutes.

Effective meetings really boil down to four things:

- They achieve the meeting's objectives – HWBs must be clear on what they want to achieve.
- They take the minimum time, and do not require unnecessary information from others.
- They leave participants feeling that a sensible process has been followed, so that people and organisations are satisfied with the outcomes.
- The HWB achieves more by bringing organisations together than can be done by the separate organisations.

Ideas to develop a cost-effective approach:

- Spend as little as possible on running the board.
- Do not ask CCGs or providers (NHS, third-sector and private) to provide

additional analysis and reports that are not essential. Always question whether this additional information will change the decision, and then, whether the cost is worth the information.

- Make clear decisions quickly and follow through to make sure they are implemented.
- Develop clear principles about how to improve patient care, which are used to make the right decisions.
- Challenge CCGs to be radical in the development of commissioning plans, and then support them in implementation.
- Ensure commissioning plans are backed up by realistic financial projections and show disinvestment and investment.
- Use the HWB members to ensure that when radical changes are made there are no blocks or constraining factors which can be used to delay implementation.
- Leverage other departments, ensuring that their investment maximises the health gain.
- Conversely, use wider influence to stop other departments changing spending patterns that would reduce the health gain, or require additional investment from other organisations.
- Cast a wider net for ideas, encompassing the third sector, other providers and commercial companies.
- Stop cost shifting from one organisation to another.

Conclusions

It will be a challenge, but HWBs could make a real difference and show the way forward in integration and the provision of cost-effective healthcare. The other option is to be like so many organisations set up by the NHS that disappear after a short while – think of primary care groups, the Commission for Health Improvement, directorates of health and social care. It will depend on how well the members work together and understand their role.

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