Healthy Places
Councils leading on public health
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New Local Government Network (NLGN) is an independent think tank that seeks to transform public services, revitalise local political leadership and empower local communities. NLGN is publishing this report as part of its programme of research and innovative policy projects, which we hope will be of use to policy makers and practitioners. The views expressed are however those of the authors and not necessarily those of NLGN.

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Executive summary

Local government is once again a major player in the health arena. With a new public health duty and a leading role to play in the new Health and Wellbeing Boards (HWBs), councils have an opportunity to generate much greater efficiency and effectiveness. Moreover, as this is the first time clinicians, politicians and local government officers have come together, there is a once in a lifetime opportunity to rethink and redefine preventative health interventions to radically improve the health outcomes of the local population.

We wanted to map out how local government could take up the role of the 'health improving council' implied by the recent reforms. Our research included a survey completed by key figures in local government, as well as over 25 interviews with HWB members. As the agenda moves on a daily basis the findings from the research are meant to serve as a guide rather than a definitive conclusion on the success or failure of emerging arrangements: Health and Wellbeing Boards, currently in their shadow form, will not be formally established until April 2013.

Local government has gained responsibility over health but little power and few resources. This report argues that we need a new generation of 'health improving councils', capable of driving preventative healthcare into the work of the planning department as much as children's services, even when those delivery bodies do not always recognise their role. Local authorities will also need to go beyond the town hall to engage with a wide variety of external stakeholders, which they can influence only indirectly. Experience with previous partnerships shows that developing bonded networks, with real sharing of risk and reward, not just information, will be most fruitful. HWBs will be one of the key tools to creating this network of influence

The new arrangements will certainly create opportunities, and there are reasons for optimism: among those involved in the agenda, our research reveals a relatively high degree of confidence (3.85 out of 5) in the new structures. However, it is already evident that creating stronger relationships across an increasingly complex health and social care sector will not be without

its challenges. There are dangers of organisational divisions and territorialism in decision-making and budget-setting, not least where hard choices have to be made to divert limited resources from existing services to new priorities.

These organisational divisions are perhaps the most significant potential barrier to the success of HWBs: 66 per cent of survey respondents selected organisational differences as the most significant factor which might limit the effectiveness of the HWB in their council. Strong leadership from local authorities will be needed to mobilise action across organisations and departments around clear goals and to ensure commissioning choices reflect these.

Working across organisational boundaries will be particularly challenging in two tier areas where counties hold both the resources and the responsibility, but where many local government services are delivered at district level. There is a danger that the perception of counties as distant to local communities and the separation of functions across the tiers will lead to a disconnection between strategic decisions and local action. Counties and districts in two tier areas will need to combine resources to create sustainable and flexible systems of polycentric health governance and engagement.

The effectiveness of HWBs will depend on their ability to engage local stakeholders. However as local government only has soft powers at their disposal, there is a danger of public health not being prioritised by other local agencies. For example, thousands of pupils might risk losing access to health services if academies and 'free schools' choose not to co-operate. Incentives to promote joint ownership over public health outcomes will need to be encouraged through local leadership and national legislation.

At the heart of the changes lies an opportunity for a new era of public involvement in health services and prevention. By engaging residents, particularly 'hard to reach' groups, HWBs will be able to design interventions that meet immediate needs but also reduce demand in the long term. With a new democratic mandate over health and wellbeing, local authorities can enable citizens to become active co-producers of the health of their own communities.

Our research found that budget pooling is seen as the most effective tool available to ensure effectiveness of HWBs, particularly during a time of

tightening budgets. However 94 per cent of respondents felt that central government has provided insufficient incentives for integrated working. If local authorities are to succeed in reducing demand for acute services, they will need to shift resources to prioritise preventative measures. However there is often a lack of preparedness to use budgets differently and additional incentives will be needed to promote pooling of budgets between HWB members.

This report sets out to describe the 'health improving council' and its place in the new public health system. We also touch on some of the emerging challenges in the new system and illustrate the various approaches taken by local authorities to tackle them. The report begins with the current policy landscape and the new tools at the disposal of local authorities. The second section highlights some of the challenges facing local authorities and emerging best practice.

The paper concludes with a vision for what a health improving council could achieve and the opportunities created by the reforms. Each locality faces distinct public health challenges and each local authority will need to take a different approach. It will be ever more important to learn from best practice around the country and to find new ways to collaborate with partners and allies. But the prize is the opportunity to bring about a step change in our nation's health.

Recommendations

Within this landscape councils will need to take a proactive role in embedding health improvement and health protection locally. At the same time, central government will need to play its part in creating and aligning the incentives for the diverse stakeholders within the system. To achieve this, we make the following recommendations:

1. Health and Wellbeing Boards should publish an explicit strategy for public involvement in their work. This strategy should also set out the short, medium and long term outcomes the public should expect to hold the HWBs to account.

2. HWBs should have a 'right to challenge' the decisions of the NHS

Commissioning Board (NCB), where they can demonstrate a particular deleterious impact on the locality, to which the NCB should have a duty to respond.

Governance and membership

3. Health and Wellbeing Provider Panels should be established in parallel to HWBs and should be open to all local providers. The HWB chair should work with the Provider Panels to link them in to the design and delivery of the Joint Health and Wellbeing Strategy.

4. Two tier areas must find an appropriate way to engage district councils in the health and wellbeing agenda. We suggest at the minimum that district councils within a county should work together to produce an annual scrutiny report of the county HWB.

5. To share best practice and facilitate coordination within local health economies, HWBs should nominate an external representative to attend meetings of the neighbouring HWBs.

Strategic planning

6. To encourage honesty in 'difficult conversations', HWBs should design a 'prenuptial agreement' illustrating the commitment and contribution each board member is prepared to make to the board.

7. As part of 'Health and Wellbeing Deals', the government should encourage a small number of HWBs to bring forward plans for pooling their budgets to support the Joint Health and Wellbeing Strategy. Where the HWBs identify specific regulatory or legal barriers to pooling, the Secretary of State for health should lead the process of removing those barriers. The Department of Health and Department for Communities and Local Government could also consider providing a top up for pooled budgets as part of a service redesign process.

Coordinating delivery

8. Public bodies (for example, free schools) should have a 'duty to cooperate' with HWBs, similar to that in the Localism Act 2011. Such a

duty would require public bodies to demonstrate a consideration for the JHWS and contribution to achieving the public health outcomes.

9. The HWB chair should have a 'call in' power to local authority departments commissioning services (for example in relation to the use of CIL) to ensure local authority delivery takes the JHWS into account. In two tier areas the 'call in' power should apply to directorates within district councils. There should also be a Health and Wellbeing representative within each directorate to lead on the agenda shift.

10. In recognition of the synergies between economic growth and health, LEPs should establish mechanisms to 'health proof' decisions. This would involve the HWB chair reviewing the health impact of the LEP strategy and making suggestions where options for health improvement could be considered.

1 Towards a health improving council

Public health is returning to local authorities after 38 years. Each upper tier and unitary local authority in England will take on a new duty to improve the health of the people in its area. To achieve this, councils will have two key levers at their disposal: the public health budget and their position as lead agencies within the new Health and Wellbeing Boards. However these tools will not provide local authorities with any hard powers, simply an opportunity to use soft governance to influence existing service provision. Local authorities will need to make full use of both the budget and the boards if they are to prioritise upstream services and co-ordinate their efforts with other key stakeholders to become 'health improving councils'.

These opportunities need to be set against the crisis in health and social care budgets. Demand for expensive care is increasing and long term conditions are putting huge pressure on care budgets. The Department of Health's best estimate is that long term conditions account for 69 per cent of the total health and social care spend in England. Total expenditure on long term care by 2022 is predicted to rise to £15.9 billion However there is an increasing body of evidence that health care services play a smaller role in health outcomes than generally assumed (see figure 1).

The transfer of public health to local authorities represents a key opportunity to focus on the wider determinants of health as well as to 'join up' health and social care provision to prevent conditions deteriorating. A study commissioned by London Councils found that the integration of commissioning support for health and wellbeing, children's services, adult social care and public health with the work of Clinical Commissioning Groups (CCGs) could result in a shared resource of up to £50 per head, as compared with the £25 per head stand alone resource that is currently available to CCGs. These resources will be needed to drive innovation in the current 'age of austerity'.[1]

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[1] London Councils (2011) Improving health and social care in London: supporting integrated commissioning

Figure 1 Estimated impact of determinants on health status of the population
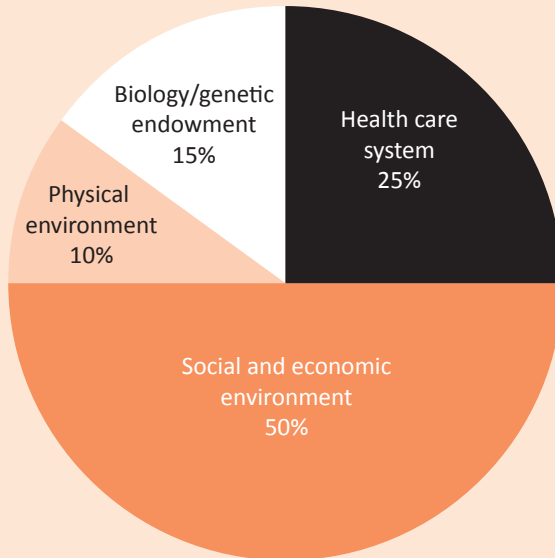
Source: Canadian Institute for Advanced Research, Health Canada, Population and Public Health Branch AB/NWT 2002

The new structure

Local authorities are now required to employ a Director of Public Health (DPH), to be supported by a new ring-fenced budget. The Health and Social Care Bill further requires DPHs to publish an annual report that can chart local progress. To ensure the DPH is able to challenge the local authority, any authority that wishes to dismiss a DPH will be obliged under statute to consult the Secretary of State. However there is no requirement for the DPH to be appointed at the 2nd tier with direct access to the council Chief Executive, Cabinet and elected members. In 42 per cent of authorities, the newly appointed DPH in a local authority will be a subordinate to the

Director of Adult Social Services or reporting to a 'super-director'.[2] This will put additional pressures on the DPH to use soft, rather than hard, power to influence service delivery within wider local government.

Although there are still decisions to be made with regards to the full range of new responsibilities to be devolved, the main public health duties will vary from smoking cessation services to workplace health (full list in appendix 4). Local authorities will need to work with CCGs and other stakeholders to commission these initiatives and create an integrated package of services.[3]

Health and Wellbeing Boards are the second new tool available to local authorities to improve the health of the local population. Boards have been operating in shadow form since April 2012 and will become fully operational, with statutory duties, from April 2013. Before April 2012, there have been more than a 130 'early implementers' and experience of these is the subject of the research. They will lead within the system by collaborating on Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies (JHWS). JSNAs are intended to assess the needs of the population and the strategies will need to make recommendations on how these needs can be addressed. It will be a statutory duty for commissioners to have regard to the JHWS when developing commissioning plans. JSNAs and JHWSs will be crucial in understanding inequalities in the local area and the factors that influence them such as poor housing, worklessness or crime.

The majority of the statutory members of HWBs are from local authorities and the leadership of the Board most commonly sits with a local authority representative. Typically the Board is led by the cabinet member for health, adult social care or children's services or by the leader of the council.[4]

Our own survey of local authority officers shows that the majority are either confident or extremely confident in the potential effectiveness of Health and Wellbeing Boards.

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2 ADPH (2011), English transition update survey – results
3 Department of Health (2012) Local Government and Public Health
4 Humphries et al (2012) Health and Wellbeing Boards, System leaders or talking shops

Figure 2 On a scale 1-5, how confident are you about the effectiveness of your HWB over the next 1-2 years?

Level of responses

	30					
	25					
	20					
	15					
	10					
	5					
	0					

1
Not at all confident

2

3

4

5
Extremely confident

n=64
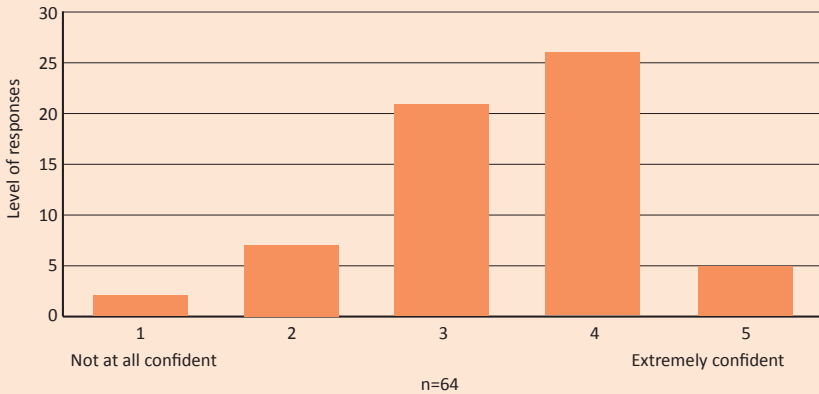
The level of confidence does not vary greatly regionally (See figure 3).

Figure 3 On a scale 1-5, how confident are you about the effectiveness of your HWB over the next 1-2 years? - Regional divide

Score out of 5

5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0

Yorkshire and Humber   London   South West   West Midlands   North West   East of England   South East

n=64
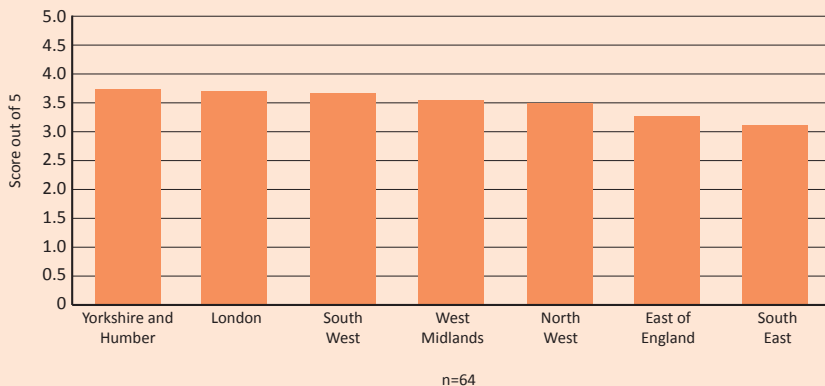
Local authorities' new functions will not be limited to their participation in HWBs, nor even to employing the DPH: *"most of the decisions won't be*

made at the HWB meeting, but rather through the networks the Boards have facilitated".[5] Both will only be effective if they are seen as nodes in a network of stakeholders engaged in health improvement. Much of this network of stakeholders exists outside the direct control of a council, susceptible at best to local government influence.

Getting the HWB right will be essential to bringing together all the key players locally. As the duties passed on to HWBs and its members are not necessarily accompanied by additional powers (see appendix 5 for full list of duties and powers), a creative approach to implementing the agenda will be needed. The levers available to local authorities will range from direct control over a department, to softer powers of influence and persuasion. Some of these levers are outlined in figure 4:

Figure 4 Levers available to local government representatives on HWB.

Hard power   Soft Power

- Financial
  - Direct financial Incentives
  - Procurement contracts
- Scrutiny
- Planning policy
- Tax policy (For e.g upcoming business rate legislation)

- Understanding of joint purpose
- Democratic statute/reputation
- Indirect financial benefits
- Leading by example
- Information provision
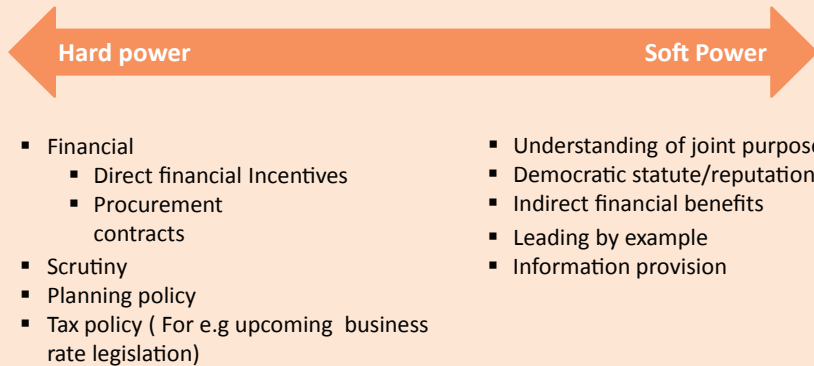
National context

Local authorities will need to work within an increasingly complex system and will need to develop relationships with national structures such as NHS Commissioning Board (NCB), Public Health England (PHE) and National Institute for Health Clinical Excellence (NICE).

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5 Interview

The NCB will be an independent statutory body accountable to the Secretary of State for NHS outcomes via an annual mandate. The NCB will commission all primary care, dentistry and pharmacy services, as well as specialised services and national screening and immunisation programmes, with guidance from PHE and DPHs. As it will be responsible for more than £20 billion of the total NHS budget, there may be tensions between local priorities and national commissioning. Less one in five HWB members think they will influence the NCB.[6] However a channel of influence will be needed if HWBs are to take ownership over local outcomes. As an interview told us *"we are beginning to understand how NCB will hold local partners to account but not how HWBs will hold the commissioning Board to account".* Another HWB member said *"Our big concern is that the NHS Commissioning Board is going to tell us what to do. We still don't know how much money we are going to get nor what is going to be dictated by them. If we are really about responding to local needs and services, then we need to make those decisions locally"*

RECOMMENDATION: *Health and Wellbeing Boards should have a 'right to challenge' the decisions of the NCB, where they can demonstrate a particular deleterious impact on the locality. The NCB should have a duty to respond to those concerns, justifying or amending the decision.*

Local authorities will also need to work with PHE to achieve public health outcomes. PHE will be in a shadow year of operation during 2012/13, before becoming a statutory executive agency, accountable to the Secretary of State, from 2013. PHE will work with partners to provide evidence and analysis to enable local government, the NHS, voluntary and other sectors to invest in prevention, health promotion and protection. For the time being, the nature of the relationship between DPHs and PHE remains uncertain. However, it is clear that PHE will play a coordination role in health protection, particularly for more controversial services that need national consistency and during a time of public health emergencies.

The new role for local government in public health has potential to transform the way local authorities work with their partners. Local authorities often report that in the past there were 'missed opportunities', where initiatives could have

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6 Humphries et al (2012), Health and Wellbeing Boards. System Leaders or Talking Shops? Kings Fund

led to improved outcomes or could have been more effective if other partners had been involved from the earliest stages.[7] The opportunity is now there, but will only be realised if local authorities take up the role of system leadership, working in a new collaboration with the NHS and other partners.

Lessons from previous arrangements

In the past decade there has been a myriad of efforts to improve wellbeing and coordinate services with local partners. These have had mixed results and therefore, it is important to understand the pitfalls encountered to avoid them as HWBs undergo their development journey.

One of the most extensive evaluations of previous partnership arrangements has been the evaluation of Local Children Safeguarding Boards (LCSBs).[8] Some key findings include:

- **Membership and governance:** Governance remained weak after years in operation. A lack of continuity of Board membership made it difficult to maintain a shared vision and to sustain progress. The size of the LCSBs was also a crucial factor in their effectiveness. Small Boards lacked enough members to be able to invest sufficient time to meet the LSCB role and remit, while large boards became unwieldy and impersonal. The most effective size was found to be 20-25 members.

- **Accountability:** A lack of clarity about accountability hindered the effectiveness of LCSBs. The implications of non-compliance with Board recommendations were often not clarified and systems should have been put in place to support the resolution of differences of opinion.

- **Stakeholder engagement:** Clearly linking up channels of communication between the representatives on the LCSB and those in charge of operations was important. Evaluation findings suggest that work to address public understanding of the work of LSCB remained weak and was often inhibited by lack of resources. Engagement and consultation

7 Health and Wellbeing Board member
8 France et al (2010), The Evaluation of Arrangements for Effective Operation of the New Local Safeguarding Children Boards in England - Final Report, Department of Education

with children and young people was also found to be underdeveloped. Although they may have been informed about the work of the Boards it was unusual for them to be actively involved or for their views and opinions to influence LSCB business and priorities.

Local strategic partnerships are another key initiative that had a similar remit and structure to HWBs. LSPs suffered from a low profile amongst the local electorate, despite their role in coordinating the efforts of key service delivery partners.[9] An Audit Commission evaluation of partnership working highlighted a number of key lessons relevant to HWBs.[10]

- **Lack of clarity in LSP role:** LSPs were found to work at three layers: (1) strategic: oversight, vision, and direction-setting; (2) executive: resource allocation and performance management; and (3) operational: service management and delivery. However local partners and central government did not always understand how these layers worked and their principal role was.

- **Performance management**: Too few LSPs took an area-wide approach to performance and resource management. In a survey of LSPs 75 per cent of partners agreed that an LSP should challenge their performance against locally agreed outcomes; however, only 41 per cent said their LSP does.

- **Resource allocation:** Fewer than half of the respondents to the 2008 survey could identify budgets their organisations had aligned with LAA or LSP priorities and only 14 per cent of the single-tier and county LSPs mapped resources in their areas. An underdeveloped approach to resource allocation was thought to be a key obstacle to partnership effectiveness. Although there was agreement about the need for honest and challenging discussion about money, financial challenge occurred in only a quarter of LSPs.

- **Accountability:** Accountability to different government departments was seen as a further obstacle to closer integration of performance systems.

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9 OPM (2009) Should Local Strategic Partnerships (LSPs) be elected?
10 Audit Commission (2009) Working Together Better

- **Joint working:** There was often a lack of clarity in the costs and benefits of joint working. This left LSP partners without an important source of information for assessing risks and choosing between alternative approaches to collaboration.

Furthermore, interview respondents thought that LSPs often struggled with not having any tangible power to influence.

Case Study

Partnership working in Blackburn with Darwen (BwD)

Blackburn with Darwen Council has a long history of partnership working. Effective partnerships have not just been limited to health and social care but have spanned the wider public and voluntary sector: BwD received 'an outstanding' for partnership working in a 2010 OFSTED inspection. As BwD is the 17th most deprived council in Britain, in the last decade the council has made it a key priority to tackle inequalities and improve population health. A survey sent to council officers in BwD indicated that the council has been very joined up around health improvement in the past, with joint management arrangements, good working relationships and a strong drive to improve joint outcome indicators as key facilitators in this partnership approach.

In 2009 BwD became the first place in the country to drop charges for swimming, sport and fitness activities. The LSP, including the Council and the PCT jointly invested £6 million over three years to offer free leisure to anyone who lives, works, is in full-time education or whose GP practice is in Blackburn or Darwen, branded as 're:fresh'. The decision to implement 're:fresh' stemmed from a recognition of "the need to be radical in helping citizens to recognise their own responsibilities in creating better conditions and also intervene earlier to the issues before they become acute". Due to the improved levels of physical activity across the Borough, the PCT and council has continued to support this initiative.

The LSP also commissioned a resource-mapping exercise to provide a body of evidence on how public sector resources were being spent in the area. Key partners' expenditure was mapped against wards and the priorities identified in the community strategy with the aim of driving better coordination of resources and needs. [11] *The results were crucial in informing work on neighbourhood budgets.*

In April 2010 health and social care commissioning was integrated with the establishment of a Care Trust Plus. The shared commissioning and service delivery model was key in making decisions regarding service reductions. A 'report card structure' allowed the Care Trust to focus on evidence of impact and jointly agreed outcomes.

The council has worked to avoid making quick and uncoordinated disinvestments which would leave gaps in services. To promote public engagement in the difficult but necessary spending decisions, the wider community was asked to highlight the most important issues through the "Your Call Campaign". Further, to engage young people in the agenda, BwD has been increasing the use of tools such as Facebook and other media instruments.

Key lessons taken from the establishment of the Care Trust Plus were about communication and leadership. Communication across organisational boundaries had to be developed before partnerships were really effective. Strong leadership was needed to communicate a shared vision and an agenda for the future to get buy in from all partners.

HWB members are enthusiastic about building on previous arrangements to establish their Board. As one HWB member put it " ...the value added of the [HWB] boards will be their democratic mandate, structure for strategic planning, influence over resource allocation and an interface with commissioners as well as providers".

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11 Audit Commission (2009), Working better together case studies: Neighbourhood working in Blackburn with Darwen Strategic Partnership

However there will be a number of challenges as the development of the HWB is underway. One of these challenges is the impact of organisational discontinuity on recent partnership working: "It's a massive agenda with changes on a daily basis. Keeping the momentum and interface between all members will be quite a challenge". HWB members will need to maintain a focus on joint outcomes to overcome the system flux. Another key issue highlighted through interviews was concern about prioritisation and that members will view "everything as a priority". Moving forward, BwD will be using the strong history of partnership working to prevent turning into a "talking shop" and "proactively make decisions that will positively impact citizens".

There is relevant experience from overseas. New Zealand, with a similar local government structure to England's underwent a period of health reforms in the last ten years aimed at bringing health services closer to the values of practitioners and the local population. The 2000 NZ Public Health Strategy led to the establishment of 20 District Health Boards which were given a clear mandate to assess local need, deliver services and ensure national health objectives were achieved.

In response to concerns about spill-over effects, in 2009, a statutory framework was put in place for DHBs to collaborate and address other shortcomings through the use of technology, more integrative care and innovative use of the private sector.

Despite the reforms, some additional shortcomings were highlighted. There was some fragmentation within DHBs and weakness in terms of necessary skills or know-how. Additionally there were concerns that production of Needs Health Assessments (NHAs) did not facilitate a robust prioritisation process.

NHA's main goal was to influence District Strategic Plans and create a coherent picture of the "current state of local health". This was often undermined by a lack of resources, skills and time within the Voluntary and Community Sector (VCS), a key channel of information. As a result, the NHA has marginal impact on the planning process and implementation, ultimately

portraying NHAs as a mere 'information-generating' mechanism'[12] There is a danger of parallels with JSNAs and further thought is needed on what input will be needed to ensure the JHWS is value added.

The lessons from these previous arrangements here and overseas are reflected in the comments of HWB members we spoke to:

"Strong relationships will be needed to tackle organisational differences and truly collaborate around outcomes. Previous arrangements have often underestimated different cultural and organisation methods of working/language"

"Complex reporting mechanisms do not help but distort and make the situation so opaque that it is impossible to improve"

"The purpose of the Boards should not be about producing plans, but identifying and clarifying priorities"

"If those partnerships are going to work, everybody has to see what they contribute and what is the part they play"

"It has to be able to have measurable, specific tasks and purposes, and that is why the tasks we are going to engage on can't be over-aspirational"

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12 Coster. C, Mays. N, Scott. C and Cummings. J (2009),The impact of health needs assessment and prioritisation on District Health Board planning in New Zealand, international journal of health planning and management, Vol 24: 276–289.

2 *Emerging practice, emerging challenges*

Although it is early days, our interviews and survey reveal that a number of key issues are emerging as being potential barriers to the impact and effectiveness of HWBs. The initial challenge for the 'early implementers' has been to establish the right membership which includes those with influence over service areas. Many areas have chosen to 'top up' the statutory membership arrangements with appropriate local representatives. If they are to be workable, HWBs cannot include everyone with a potential stake in promoting public health; however there remain tensions of linking up districts and providers to the strategic direction and delivery of health improvement. As the membership arrangements are put in place, representatives from different professions will need to overcome organisational differences and pull out of their own 'vertical accountabilities' if they are to deliver services that meet local needs.

Health and Wellbeing Boards will have a three-fold role: strategic planning, resource allocation and coordination of delivery. HWBs have begun to fill the strategic role. The latter two roles are less well understood and many are not yet in a position to align commissioning processes or where appropriate to pool budgets around chosen priorities. HWB members will need to influence and engage wider partners in local government and in the local community to change the way services are delivered.

In particular, a new strategy of public involvement will be crucial for HWBs to have an impact on people's health. If local government is to lead the way in reducing health inequalities, it will need to engage with 'hard to reach' groups co-producing solutions to some of the most pressing health problems. The representatives on HWBs will have a unique opportunity to redesign the new citizen offer in order to deliver what citizens want and need.

In this section we assess the challenges and opportunities facing local authorities in becoming health improving councils, especially in relation to the establishment of HWBs.

Governance and membership

A common issue in our research has been the dilemma of HWB membership. Balancing the breadth of representation implied by a holistic approach with the need to build a Board that is sufficiently streamlined presents problems. This is particularly evident in two tier areas, where district councils have no duties or powers in relation to health and wellbeing. Even though there is emerging best practice in making these arrangements work, additional incentives will be needed to overcome this challenge in areas where cross-tier partnership working is less established.

A number of Boards have had unstable membership in the first year while settling into a more permanent structure. Even though there has been a lot of interest from stakeholders to be directly involved, HWBs have had to keep a limit on Board membership to prevent it from becoming unwieldy. A large proportion of the Boards have settled for 13-20 members with shire counties likely to have more members due to district representation.[13] Also securing senior members is seen as important: *"Putting high-level people and key-influence makers in their organisations and county, bringing them together is a powerful statement".*[14] For the most part seventy per cent of authorities think the core membership contains the right mix of people for effective functioning. While the core membership remains small, HWB members are already in the process of establishing links with other existing partnership arrangements to avoid duplication and ensure buy in for the emerging priorities.

The exact membership arrangements are varied across the country (see figure below). There is usually an even split between local government officers, politicians, NHS representatives and members of the public to make sure decision making is balanced and a range of views is represented.[15] Some HWBs have involved other representatives such as head teachers and police commissioners[16] demonstrating the way in which HWBs are adapting their strategic direction to local needs. Other councils such as Cornwall have

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13 Humphries et al (2012), Health and Wellbeing Boards. System Leaders or Talking Shops? Kings Fund
14 Health and Wellbeing Board member
15 Humphries et al (2012)
16 NLGN analysis of Early Implementers TORs

established a stakeholder group parallel to the HWB with a much wider membership (NHS trusts, schools, user led organisations etc) to be chaired by the HWB Chair.[17]

Figure 5 Who is represented on the Board?

Sample size: 48

Are the following represented on your board?   Yes ■   No ■
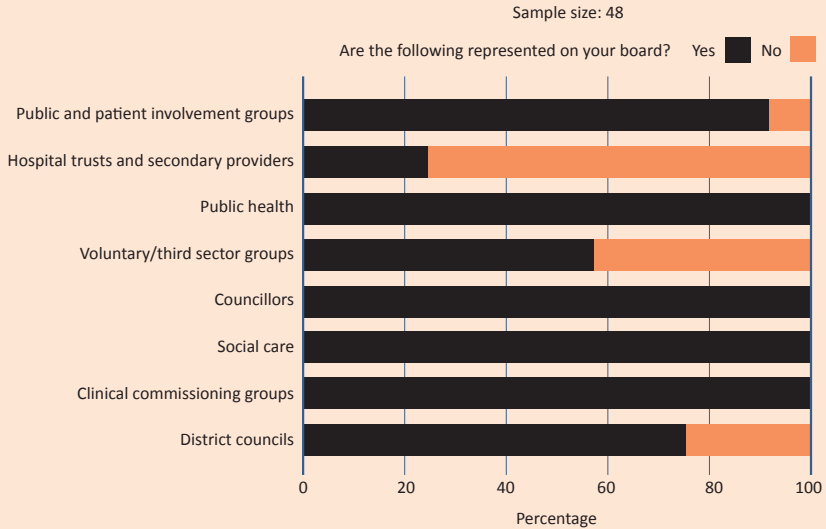
Source: Humphries et al (2012), Health and Wellbeing Boards. System Leaders or Talking Shops? Kings Fund

Administrative boundaries often do not represent local health economies and HWBs will need to work with other HWBs in deciding on priorities and changing ways of service delivery. The New Zealand District Health Boards highlight the importance of coordination across areas. In places such as Greater London, joint working and city wide action is necessary. HWBs have already begun coordinating with neighbouring HWBs and contributing to the London Health Improvement Board, funded by a three per cent top slice from local authority funding for health improvement.[18]

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17 Minutes of the Cornwall Health and Wellbeing Board Meetings 2012
18 NHS London (2012), The London Health and Wellbeing Challenge Events Report, Capgemini Consulting,

Even though HWBs are each on a unique development journey, there are important lessons to learn from one another and cross representation in other parts of the country should be encouraged.

RECOMMENDATION: *To share best practice and facilitate coordination within local health economies, HWBs should nominate an external representative to attend meetings of the neighbouring HWBs.*

Two tier areas

The division of functions and leadership between districts and county councils can exacerbate the difficulties in establishing an inclusive but workable Board membership. The failure to acknowledge the vital role of districts in improving wellbeing has potential to undermine the agenda. In a survey conducted by the District Council Network, 36 per cent of respondents did not feel they had "an inclusive and mutually beneficial relationship with county colleagues" regarding HWBs.

The mismatch between administrative boundaries and the real boundaries of service use by residents in two tier areas might become even more pronounced after the reforms. For instance, one of the district councils interviewed indicated the CCG in their district might be a part of a different HWB. Multiple layers of overlapping governance are not a problem per se, however there needs to be proper co-ordination.

A number of different approaches are being taken by two tier areas to develop the adaptive and flexible channels through which district councils can be involved in the agenda. For example, a district councillor and a housing department officer are elected by the various district councils in the county on the Northamptonshire HWB. Other county HWBs have chosen a system of rotation for district council representatives. In this system each district has biennial representation on the Board. Both of these styles of involvement rely on well-established channels linking all the district councils with one another to make sure they're able access the given representative on that Board.

Case Study

Strategic partnership working – Leicestershire District Councils

In order to deliver effective partnership working on strategic priorities Leicestershire District Councils use the following methods:

1. *Have clear priorities.*

2. *Have lead Chief Executives/Members representing the voice of Districts on priority areas and priority partnerships. Where Members take the lead role they are supported by a lead Chief Executive, not necessarily their own Chief Executive.*

3. *Use networks of Managers/Officers in each district council to support and work with the lead Chief Executive and support local Member Champions in their own councils.*

The method works because of:

- *Forward planning (e.g early distribution of agendas and papers so that the lead Chief Executive can get a steer if necessary from colleagues in other councils).*
- *Excellent communication.*
- *Awareness of differences in localities.*
- *Recognition of individual sovereignty of district councils (lead Chief Executive/Cabinet Member does not have a mandate to make decisions which are binding on other councils).*

Furthermore, in relation to health the following structures exist:

County Health and Wellbeing Board

- *Chaired by a county council cabinet member (who also serves as a district council leader.*
- *Two district council members*

- *District council members supposed by a lead CE.*
- *Lead CE is part of the HWB Steering Group which organises agendas, development sessions and supports the smooth working of the Board.*

Virtual Public Health Networks:

- *Lead CE meets quarterly with DPH and Director of Adult Social Services to develop shared approaches and strong networks.*
- *Senior Public Health specialist co-located with district council staff for part of each week to develop strategic and operational approaches to health improvement.*
- *District Member Health Champions in each district which meet periodically with the HWB Chair, CCG senior managers and Director of Public Health to build understanding of the potential of the new system, develop skills and knowledge and look at locality priorities and delivery.*
- *District senior manager Champions and senior Public Health staff meet periodically to share opportunities and lead a new way of working.*

A key requirement for district council involvement will be the development of a joint understanding of the levers and tools district councils have at their disposal. A mechanism to do so is to undertake a mapping exercise detailing the roles of district councils that relate to health improvement; the resources allocated to that area of work; and the key officer lead. Such an approach was taken on by St Edmundsbury Borough Council and was found to be effective in moving forward conversations with county HWB members, who regard assessing the current service delivery landscape across all tiers as a key step in Board development: "*before we can decide on what we'll be doing, it's important to understand what is already out there".*[19] Understanding the range of district contributions to health and wellbeing minimises the risk of duplication and could inform the development of the JHWS.

An asset mapping approach can be extended to all local partners, not just district councils. Since many of the solutions to health improvement need to

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[19] Interview

rooted in local circumstances, it is important to recognise the assets individuals, organisations and other key stakeholders will bring to the table (see figure 6).

Figure 6 Asset mapping

20 I&DeA A Glass half-full:how an asset approach can improve community health and wellbeing.
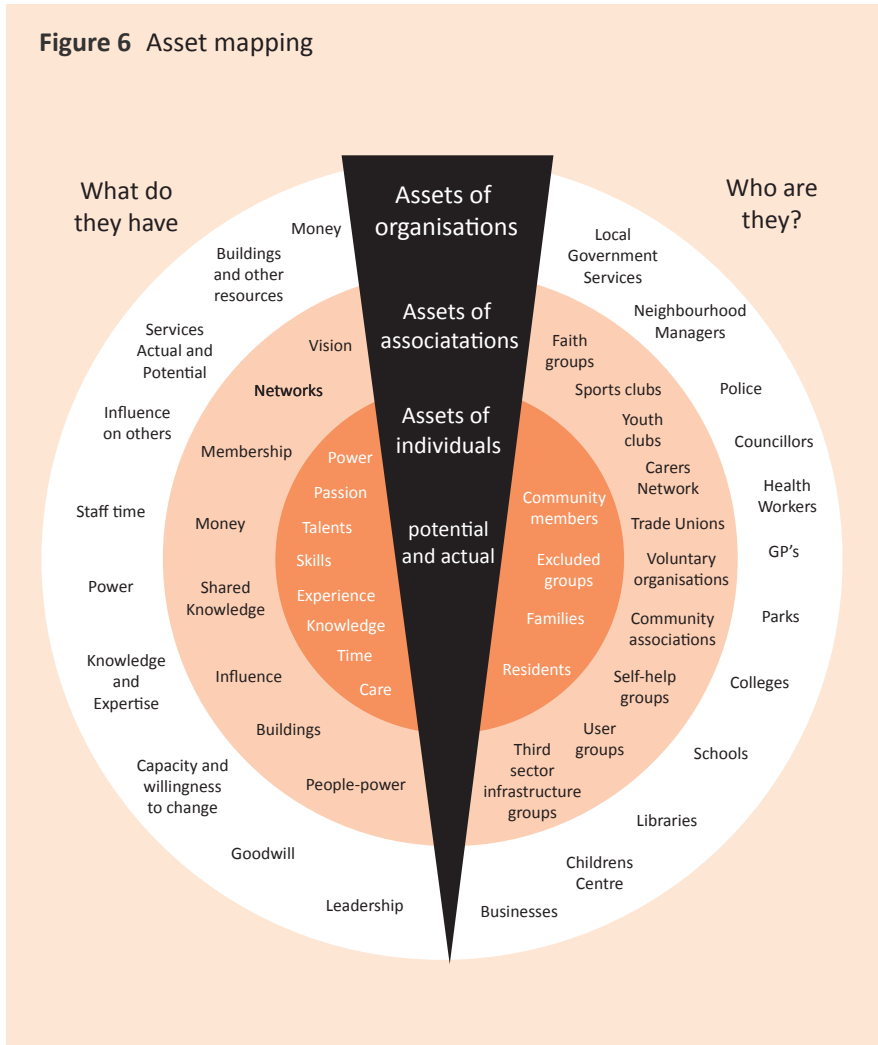
Some district councils have gone a step further and set up their own health and wellbeing partnerships, as in St Albans, where local knowledge and local connection with stakeholders has been important in deciding priorities for the Joint Health and Wellbeing Strategy.

Case Study

St Albans Health and Wellbeing Partnership

St Albans has had a long term interest in health and has been working to bring people together across organisations to scrutinise local health issues. In the past it had two partnership arrangements: a council committee on community health where health issues of local concern were scrutinised and a district level LSP which was chaired by the PCT to bring together key local stakeholders. These two partnerships facilitated the establishment of a district Health and Wellbeing Partnership which combines existing high level representation from the council with other local partners such as the local hospital, parishes and local community groups and organisations. The Board aims to promote a joined up district approach around health issues.

The district level Health and Wellbeing Partnership has taken on both an "informing role" and a "delivery role". A number of factors have allowed it to take on this role: first it has strong links to community concerns and insight into local issues. Secondly, the cabinet members have good relationships with relevant health providers and commissioners giving the partnership additional levers over local decision making. For example, a number of instances were cited where data was reinterpreted in a more meaningful way due to the local knowledge accessed by district councils and where members were able to change delivery mechanisms with the connections they had on the ground.

The district health and wellbeing partnership has strong links with the county HWB and the Chair sits on the district board. The analysis that led to the prioritisation was done jointly and there has been continuous dialogue between the two structures. The priorities that overlap between the two strategies will be tackled jointly but the district partnership still plans to proceed with tackling St. Albans specific issues.

Although it has only been underway for 6 months, there is already evidence of new means of service delivery and detailed action plans are being developed for chosen priorities. The action plans will identify what is already happening, if the initiatives are joined up, what the evidence for their effectiveness is and whether there needs to be a reassessment of those initiatives.

While not every district can be formally represented on the HWB, it is important for them to be establishing clear links between all districts to coordinate input into the HWB. District councils should be further encouraged to pursue local priorities in health improvement alongside the implementation of the JHWS.

The House of Commons Health Select Committee, in its report on public health pointed out concerns about the involvement of lower-tier authorities. In response, the Department of Health indicated that they will not prescribe how this should happen in practice. Local areas will have the flexibility to develop the arrangements that work for them and fit best with local circumstances. However in areas with less established cross tier partnership arrangements additional incentives might be needed to encourage collaboration: *"Although policy and guidance talks about involvement of lower tier authorities there is insufficient incentive to make this happen."*[21]

RECOMMENDATION: *Two tier areas must find an appropriate way to engage district councils in the health and wellbeing agenda. We suggest at the minimum that district councils within a county should work together to produce an annual scrutiny report of the county HWB.*

Engaging providers

Another key issue in emerging membership arrangements has been the lack of links with local providers of health and social care services.[22] At the moment only a minority of HWBs have provider representation which

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21 Survey respondent
22 NLGN Survey

could prove to be a hurdle in changing service delivery.[23] HWB members with commissioning responsibilities have to tread a fine line between using selective commissioners to drive innovation and quality improvement, and developing long-term relationships with providers to deliver effective services: engaging providers in the design and scope of contracts produces more responsive and sustainable solutions.[24] Even though provider-commissioner discussions will occur within their respective commissioning directorates, there is value to be gained from having those discussions at an integrated level. Furthermore, better coordination between primary and secondary providers (for example, CCGs and acute care providers) has the potential to reduce the costs of treating long term conditions.[25]

A recent initiative in the United States highlights the potential value of provider involvement in service improvement and cost reduction.

Case Study

Accountable care organisations in the United States

The Accountable Care Organisation (ACO) has been one of the models used for health care reform in the United States which has put ownership upon providers for the quality and cost of care provision to a defined population.' One of the goals is for ACOs to increase care coordination and in doing so reduce duplication of medical care, reduce use of acute services and improve overall outcomes. The implementation of ACOs could lead to an estimated median savings of $470 million from 2012-2015.[26]

The organisational model is still relatively new and untested with mixed results of preliminary evaluations. Nevertheless there is still

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23 Humphries R, Galea A, Sonola L and Mundle C (2012), Health and Wellbeing Boards. System Leaders or Talking Shops? Kings Fund

24 Sampson, F, O'Cathain, A, Strong, M, Pickin, M and Esmonde L (2012) 'Commissioning processes in primary care trusts: a repeated cross-sectional survey of health care commissioners in England' in J Health Serv Res Policy January 2012 17:31—39

25 Humphries R, Curry N (2011) Integrating health and social care: where next? London: The King's Fund.

26 Department of Health and Human Services, Centers for Medicare & Medicaid Services (November 2, 2011). Medicare Shared Savings Program: Accountable Care Organisations; Proposed Rules. 76. Fed. Reg. 67

optimism about the positive impact of these collaborative structures. The incentive structures of ACOs will help shift the focus to keeping people healthy: "It's a system where physicians lead not only in the care of patients with acute and chronic illnesses, but also with people who are perfectly well and need the tools to stay that way,"[27]

There are, of course, potential conflicts of interest in granting direct membership to providers in the area as well as a danger of limiting the market to existing providers. However, other means could be used to involve providers in priority setting and in discussions around strategic commissioning. Bringing providers together around shared goals will help HWBs manage the conflicts of interest associated with granting large providers membership with receiving input into the implementation of the JHWS.

RECOMMENDATION: *Health and Wellbeing Provider Panels should be established in parallel to HWBs and should be open to all local providers. The HWB chair should work with the Provider Panels to link them in to the design and delivery of the Joint the Health and Wellbeing Strategy.*

Organisational differences

"The most effective way of dealing with partners is based on nurtured and strong relationships" [28]

As local authorities work ever more closely with health providers, the often stark cultural and organisational differences between them will become more apparent. Indeed, our survey findings showed that organisational differences were thought to be the most significant factor which might impede the success of HWBs (see figure 7). As the NHS and Local Authorities work ever more closely together on public health, it will be important to better understand their differences and take steps to overcome them. As an interviewee told us: *"our first challenge is to develop relationships between GPs and local government. This will require seeing them in their practices and fully understanding the pressures they're under"*

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27 President and CEO of Iowa health system
28 Health and Wellbeing Board member

Figure 7 What are the three most significant factors which might limit the effectiveness of the HWB in your council?

n=54
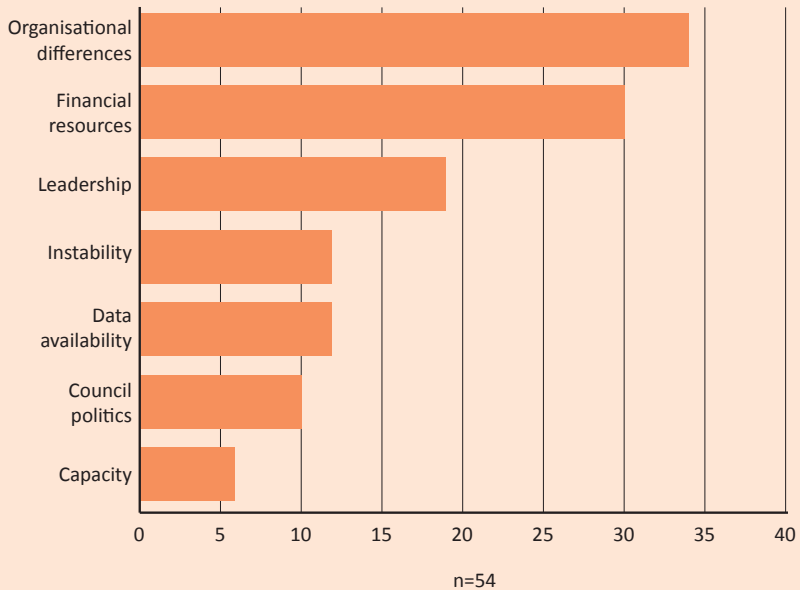
Appreciating the differences and similarities between the represented professions will be important. All partnerships face such cultural differences, of course, such as those between the public, private and voluntary sectors. But there are particular distinctions between the health service and local government, that we identified through our interviews:

Organisational structure	Local government has a direct accountability to the local electorate whilst decisions in the NHS are mainly driven from the centre.
View of public health	Public health is often viewed by NHS representatives as a combination of clinical interventions whilst local authorities have a wider view rooted in the social determinants of health.
Relationship to patient/citizen	In the NHS residents are viewed as patients with a clinical condition whereas LAs are more inclined to take a holistic view and see people as citizens, service users and community members.
Commissioning procedures and types of providers	The size and type of organisations involved in care provision commissioned by the NHS and local government is varied. Similarly commissioning procedures and timescales are two key differences in how these two organisational structures operate.
Definition of place	Although catchment areas have been scrapped, GPs tend to view places in the form of neighbourhoods whilst local government views place with a larger radius.
Language	The jargon and language used by HWB members is often sector specific. An interviewee described the challenge as: *"Encouraging people to drop some of the barriers we tend to put as professionals and ask questions.... Not assuming that when we use the same words, we mean the same thing"* [26]

These differences should be set against the common goal of improving the health of the local population. As a participant at a seminar put it: "*I work*

for the local area rather than the LA or the NHS" – being accountable to, and relating to the place rather than institution. This is the corollary of focusing on interpersonal relationships rather than structures.

Our research found that a range of approaches is being pursued by councils seeking to break down these organisational differences and build honest and productive relationships.

Figure 8 Measures taken by councils to facilitate good working relationships between different HWB members
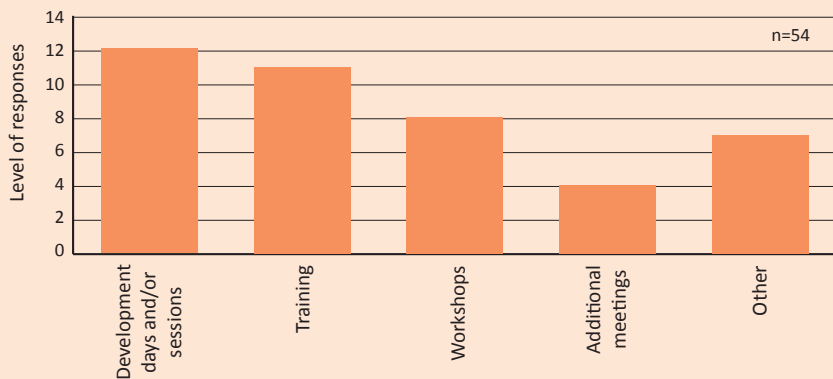
Some councils have gone further in fostering relationships at middle levels of the organisation to facilitate not only collaboration in decision making but in delivery as well.

Even with an active approach to establishing and improving relationships with the HWB and wider stakeholder groups, there are concerns these relationships could be undermined by the ongoing organisational flux.[30] Constant changes in institutional structures have often led to people turning inwards and being less open to forging new relationships.[31] Accountability mechanisms and incentives will need to be established in a way that facilitates rather than hinders partnership working since reforms to health and social care are likely to continue.

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[30] Interview
[31] Interview

Politics and accountability

One of the most important fault lines running through HWBs relates to the structures of accountability and legitimacy underpinning the partners, especially within the dominant sectors of health and local government. In short, this is a question of politics: local government is closer to it, because of the direct accountability to local voters through elected members, while in the health sector the lines of accountability are stretched all the way back to the Secretary of State. Along with the impact that politics has on the organisational culture of the partners decision-making, distinct lines of accountability could yet affect the cohesion of HWBs.

'Accountability' is concept with a number of different meanings but has most often been described as the process of 'being called to account to some authority for one's actions'. Although there have been various attempts to define types of accountability,[32] this is beyond the scope of this report. However Figure 9 begins to outline some of the new accountability structures within the system which vary from the scrutiny over the action of HWBs to the contractual accountability that the NCB will have over CCGs:

Figure 9 Accountability stuctures within the new system
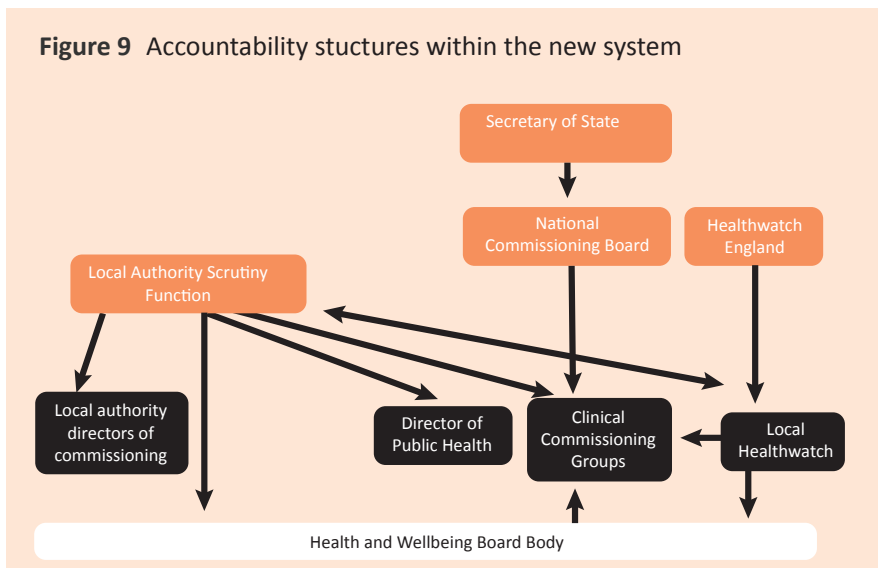
HWB members will of course retain their formal lines of accountability to different parts of the system, but they will also have to develop a shared responsibility for developing and contributing to the delivery of the JHWS. There is a danger that partnership working will be undermined when individuals are primarily accountable to their home organisation. It will therefore be important to clarify accountability structures within a local area and emphasise accountability to the place and local population within which HWBs will function. As one interviewee put it: *"central government talks about integration but NHS bureaucracy gets in the way of what we want to do at a local level"* [33]

The majority of respondents to the NLGN survey do not yet have plans in place to assess performance in achieving public health outcomes or in improving service delivery. Through the interviews HWB members report there is often a lack of clear responsibility for the identified outcomes. The weak statutory duties placed upon HWBs in the Health and Social Care Bill further emphasise a need for internal mechanisms to hold members to account.

One of the key obstacles to clear understanding of accountability is that some Boards have yet to understand their primary task,[34] their level of authority and how they will measure performance on the possible roles they might take on such as strategic planning, resource allocation and delivery coordination. As a HWB member put it *"there is a danger we are trying to do too much too quickly without understanding why or where we are trying to get to".*

A delicate balance of short term wins and long term system changes will be needed. Quick improvements in outcome indicators will help to establish the trust and confidence in new ways of working within the Board[35] while the real test of partnership working will be the longer term outcome improvements for the local population. Developing a clear plan for expected short term and long term outcomes, as well as dependencies, will help HWBs manage internal and external expectations.

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[33] Survey respondent
[34] NHS London (2012) London Councils Challenge Event Summary
[35] Interview

One of the solutions to the confusion over accountability structures is the establishment of clear accountability to the local population. Local authorities already have strong mechanisms in place, through direct election: elected members are the strongest channel through which such a democratic accountability for health outcomes can be established.

Although there is a nervousness within the NHS about the politicisation of health, our survey reveals a positive attitude to political representation on HWBs (see figure 10). Nevertheless as the public health reforms are set in place, mechanisms will be needed to ensure access to vital health protection services do not become unnecessarily politicised.

Figure 10   HWBs have locally elected representatives bringing a new element of politics into health care. Please indicate whether you agree or disagree with the following statements (n=49)

Political representatives will make public health more accountable to local citizens

Political representatives will make no difference to health outcomes

Political representatives will lead to an unhelpful polsarisation of decision making in health

100%   Disagree   0%   Agree   100%
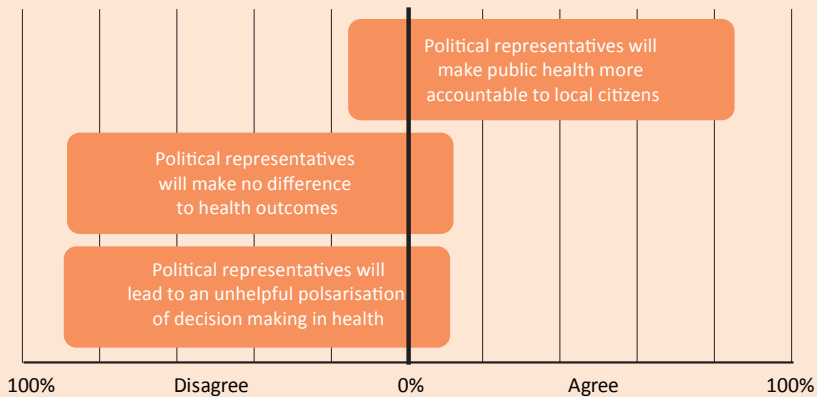
Other boards have taken steps to hold themselves accountable as a body through an independent chair or an independent evaluator. Local Children Safeguarding Boards provided a good testing ground as 40 per cent of LCSB areas decided to appoint Independent Chairs.[36] From the evaluation of LCSBs

36 France et al (2009), Effectiveness of the new local safeguarding children boards in England: interim report

and from our interviews we found a number of benefits and drawbacks of independent representatives:

Benefits	Drawbacks
• Independent Chairs were seen as bringing something new to the role	• Difficult for the chair to become fully embedded in the local context and existing structures
• Effective in challenging the activities of outside agencies and board members, particularly for politically sensitive issues	• Resource requirement to support sufficient chair time dedicated to the Board
• Could work across organisational boundaries	• Potential loss of democratic accountability associated with an elected member chairing the board

Taking those benefits and drawbacks into account, local authorities should consider an independent representative who will hold the HWBs to account for criteria decided on internally.

Strategic Planning

The strategic and executive role of HWBs will involve deciding priorities, aligning commissioning plans between HWB members and reallocating resources to where they are most needed. This will require "difficult conversations" about deciding whether something is not a priority or making disinvestments. Without a shared willingness of board members to use resources differently and additional incentives on the part of central government to facilitate integration, there is a danger that the Boards will become 'talking shops'.

Priority setting

The majority of HWBs have completed their JSNAs and are currently deciding on strategic priorities for their local population. Although a September

2011 survey found that 15-20 per cent of JSNAs refer to issues but have no recommendations in place to tackle those issues, substantial progress has been made in developing action plans going forward. The HWBs we spoke to are in the process of putting together their Joint Health and Wellbeing Strategy and aim to publish it in Autumn 2012. However, one of the difficulties reported by interview respondents is priorities will require deprioritising existing services. As an interviewee put it: *"The main problem is everything is a priority".*

Some councils such as Kirklees are developing a comprehensive framework for both investment and disinvestment decisions.

Key criteria considered by HWBs in putting together Joint Health and Wellbeing Strategies include:

- The severity of the problem
- The proportion of the local population affected
- The potential value added the board could bring to tackling the problem
- Available guidance on how the problem could be solved
- Feasibility of proposals
- Public support for proposal
- Political implications

Resource allocation

"Main worry is that in time of famine: people will retreat into silos and just focus on their core duties"[37]

For new priorities to displace existing priorities, resources will need to be shifted away from existing reactive services into upstream services: *"we need to accept that there won't be any extra money and we'll have to use what we have better."*[38] For example, coordination amongst HWB members could facilitate a shift of resources from acute care for the elderly to improved transport services which increase access to universal services. Similarly, impact on local population health should be a consideration for

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37 Health And Wellbeing Board member
38 Interview

disinvestment decisions across the local authority. There is general optimism about the possibility of money being used better through the joined up working. Seventy three per cent of survey respondents indicated some form of efficiency savings could be made through the collaboration (see figure 11).

Figure 11 To what extent do you believe that efficiency savings could be made through the HWB collaboration (n=50)
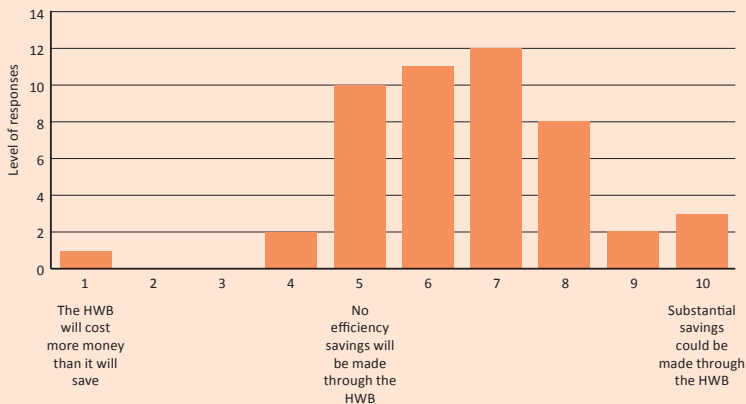
The survey also found that pooled budgets were thought to be most promising in increasing the effectiveness of the HWBs. Pooled budgets, or sometimes referred to as Section 31 agreements, are a mechanism by which partners to the agreement bring money to form a discrete "fund". The purpose and scope of the fund is agreed at the outset and then used to pay for the services and activities for the relevant client group.[39]

[39] CIPFA (2001) Pooled Budgets: A practical guide for local and health authorities

Figure 12 Mechanisms that will increase the effectiveness of the HWB in your council
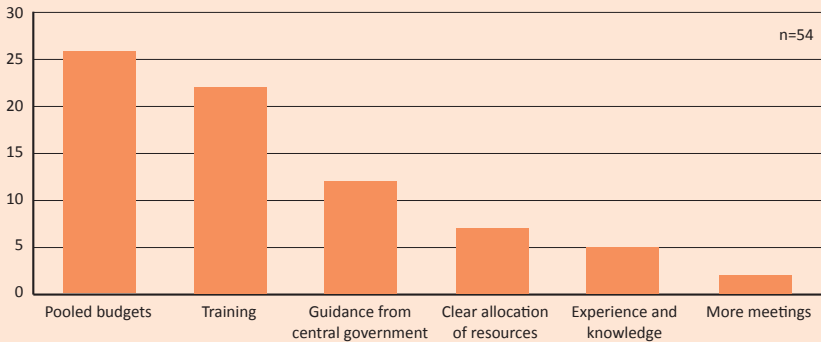
However, pooling budgets and using resources differently will be difficult in a time where the NHS and local authorities are facing significant cuts. Interviewees reported that HWBs needed to get a clear grip on what resources would be available in a locality and that work needed to be done to address diminishing resources. This would need to be combined with an understanding of how each HWB member organisation deploys their budgets and how resources could be shared. One of the lessons from LSPs was a need to facilitate challenging conversations about money and ensure there is a good understanding of members' respective business processes.

RECOMMENDATION: *To encourage honesty in 'difficult conversations', HWB should design a 'prenuptial agreement' illustrating the commitment and contribution each board member is prepared to make to the board.*

However, in addition to potential 'territorialism' over budgets, there are a number of barriers to pooling such as different VAT rules, legal accounting of pooled resources and others. Hence HWBs might need to consider aligned budgets which are simpler to implement. Slightly different from a pooled budget, an aligned budget involves two or more partners working to jointly consider their budgets and align their activities to deliver agreed aims and outcomes, while retaining complete accountability and responsibility for their own resources.[40] A careful cost-benefit analysis will be needed in

40 DCLG (2010) Guidance to local areas on pooling and aligning budgets

deciding to pool budgets and that decision will need to be made on a case by case basis. Guidance provided to LSPs on pooling and aligning budgets would be useful to HWBs going forward:

Aligning and pooling

Aligning is more suitable when:	Pooling is more suitable when:
LSP objectives are better supported by organisations redirecting their mainstream activity rather than by funding a discrete service or activity.	There is a clear, discrete service or activity that one organisation can deliver most effectively.
There are significant differences between the contributions made by different members (and some members may not make financial contributions).	All parties to the arrangement make proportionate financial contributions.
The arrangements includes private sector and third sector members of LSP.	The arrangement includes only statutory members of an LSP.
Arrangements need to keep a high degree of overall flexibility.	Arrangements need to keep a high degree of service responsiveness.
Parties to the arrangement continue to provide seperate frontline services.	The host will provide frontline services for the members.
Performance monitoring and review systems in the member organisations can provide enough confidence that LSP objectives will be achieved.	The host's financial performance monitoring and review arrangements can provide confidence that LSP objectives will be achieved.
The administration and other costs of pooling would exceed the benefits.	The benefits of pooling the administrative and other costs of setting up and maintaining pool.
Legal or other constraints make pooling difficult or impossible.	There are no legal constraints to pooling.

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41 Audit Commission (2009) Working Together Better

RECOMMENDATION: *The government should encourage a small number of Health and Wellbeing Boards to bring forward plans for pooling their budgets to support the Joint Health and Wellbeing Strategy. Where the HWBs identify specific regulatory or legal barriers to pooling, the Secretary of State for health should lead the process of removing those barriers. The DH and DCLG could also consider providing a top up for pooled budgets as part of a service redesign process.*

Furthermore, given the system flux, HWBs are finding it difficult to discuss resource allocation going forward as there is still uncertainty in the coming funding arrangements.[42] An interview respondent stated *"As the funding has not been fully allocated yet to both CCGs and public health funding, it is proving to be a continuing distraction. Once this is sorted out both service providers and commissioning groups will be able to understand the flexibility, freedom and opportunities available to move/pool resources."*

For resources to be shifted away from reactive services to preventative services, local authorities and the NHS will need to work together to work out decommissioning priorities, a transition plan and a clear message to the public about the benefits of the decision. These priorities will need to extend beyond the remit of HWB members and into the wider local authority commissioning powers.

If HWBs are to work and make efficiency savings disinvestments will need to be considered: *"Conversations about disinvestment will be the crunch point of our Health and Wellbeing Board".*[43] It is often easier to focus on new developments, with processes for identifying areas for disinvestment not well established. HWB members report a perceived and real difficulty in implementing disinvestment policies, especially in relation to secondary care, a poor evidence base around disinvestment and a fear of stakeholder response to disinvestment decisions.[44] As an interviewee told us: *"we have a difficult debate ahead of us in what has to be disinvested, what works and what has the highest evidenced-based impact".*

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42 NHS London (2012)
43 Interview
44 Interview

To support local authorities in developing this evidence base, NICE and Public Health England will be producing guidance and advice:

NICE Public Health Briefings

NICE will be producing briefings to HWBs about effective and cost-effective public health activities. The briefings will focus on a broad array of topics, populations and services across the range of arenas where local government will play a public health role. The first batch of briefings will be on tobacco, physical activity and health and work. These will be followed by Briefings on alcohol, population health and the wider determinants and health inequalities, return on investment, behaviour change, obesity, contraceptive services, health equity and partnership working.

The briefings will not be in the form of 'must dos' for local authorities but rather consist of a menu of cost effective and evidence based actions which local could be used depending on the local priorities and on the needs of local communities. The approach provides clear and concise information about 'what good looks like' i.e what works, how it can be achieved and how to demonstrate progress

Past successful experiences of decommissioning in both local authorities and health services have identified the following considerations in going ahead with disinvestments:[45]

- Necessary to invest managerial effort to overcome resistance in changing the status quo.

- Sound knowledge in terms of the process management, expert know-how (national and local) and the expected trends for service demand.

- Good understanding of service provision on the ground by both consumers and providers.

45 Airoldi et al (2011), Healthcare prioritisation at the local level: a socio-technical approach, Working Paper no.7, Priorities for Population Health, LSE and National Audit Organisation (2010), Good principles for successful decommissioning

- A sufficiently long timescale allowed for the decommissioning process including the time given for consultation with third parties and stakeholders

- Understanding the short term and long term impact in the redesign of services.

- Ensuring there is monitoring and evaluation of the decommissioning process in order to avoid perverse outcomes.

The National Audit Office (NAO) recommends a series of six decommissioning questions that should be taken into account when disinvestments in services are considered:

Six decommissioning questions

Do we need to do this?	The activity can be a frontline service or an internet administrative or support activity. The evidence of need must be clear.
Does the activity support our objectives?	Any activity that does not support current LAA or organisational objectives should be candidate for decommissioning.
Do we need to do the activity this way?	There might be a more efficient, cash-releasing way to do it.
Do we need to do this amount of activity?	Review the volume of activity to identify waste or unsuitable use of public funds.
What is the likely impact on partners?	Will other local public bodies have to increase spending as a result? How can the LSP mitigate risks to other partners and to service users?
Is there an altenative?	The same, or equivalent, service could be available from other providers. If decommissioning is a response to poor performance there should be enough time to commission alternatives.

Integration

The language of integration, if not integration itself, is well established in the health sector. Yet the word has different meanings to different people. Its June 2011 summary report, the NHS Future Forum stated: "we need to move beyond arguing for integration to making it happen". There are a number of different forms of integration[46] but the two most often referred to are horizontal integration (between health care, social care and housing) and vertical integration (between community, primary and secondary care).This section will focus on health and social care integration."

A survey by NHS Networks showed that more joined up services had the most potential to improve quality of care.

Figure 13   What would make the biggest difference to quality of care?

Category	Percentage
More money	3.1%
Better management	16.0%
Better clinical decsions	6.6%
More joined-up services	53.2%
Better information	3.6%
Other	17.4%

n=669
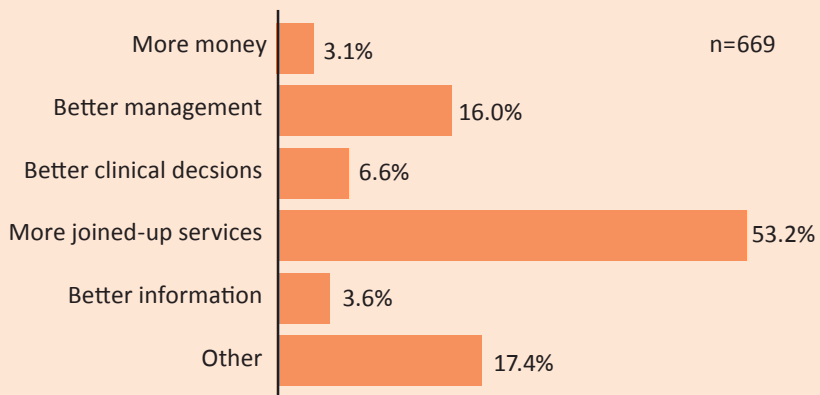
As figure 14 demonstrates, the majority of respondents to the NLGN survey believe that incentives are insufficient for integrated working from central government so HWBs will need to put in additional efforts to work "against

46 Goodwin N, and Smith J (2011), Evidence Base for Integrated Care: Slide pack, Kings Fund

the grain" to integrate services. They will also have a key role in voicing their concerns about the extent to which policy barriers impact upon their effectiveness to deliver better care.

Figure 14 To what extent has central government provided sufficient incentives to facilitate integrated working? (n=53)
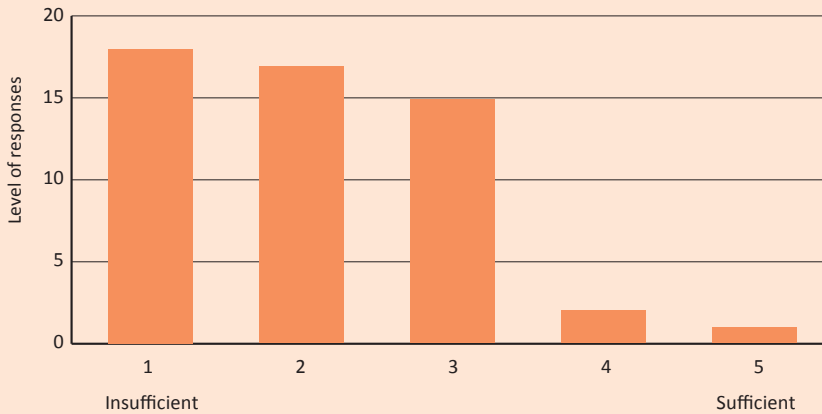
For example, the current payment by results structure is primarily designed to pay for episodes of activity rather than incentivise integrated care provision along an individual's care pathway. Furthermore, the current regulatory system does not place enough emphasis on the regulation of organisations as part of local systems of care and on the experience of patients across the whole care pathway.[47]

Health and Wellbeing Boards are well placed to integrate service. The table below lists the key organisational, management and policy barriers to integration identified by King's Fund. Those highlighted in orange are those that the new HWB structure has potential to influence while those in black are largely out of their control.

[47] Ham C, Smith J, (2010) Removing the policy barriers to integrated care in England. London: The Nuffield Trust

Key organisational, management and policy barriers to integration

Bringing together primary medical services and community health providers around the needs of individual patients	Payment policy that encourages acute providers to expand activity within hospitals (rather than across the care continuum)
Addressing an unsustainable acute sector	Payment policy that is about episodes of care in a particular institution (rather than payment to incentivise integration, such as payments for care pathways and other forms of payment bundling)
Developing capacity in primary care to take on new services	Under-developed commissioning that often lacks real clinical engagement and leadership
Managing demand and developing new care models	Policy on choice and competition
Establishing effective clinical leadership for change	Lack of political will to support changes to local care, including conversion or closure of hospitals
Overcoming professional tribalism and turf wars	Regulation that focuses on episodic or single-organisational care
Addressing the lack of good data and IT to drive integration, eg, in targeting the right people to receive it	Involving the public and creating a narrative about new models of care
Learning from elsewhere in the UK and overseas	Establishing new forms of organisation and governance (where these are needed)

Health and Wellbeing Boards will have influence over integration of commissioning as well as integration of delivery. In integrating commissioning (including decisions as to where the money goes), HWBs are planning to:

- Design joint principles
- Follow priorities decided in the JHWS
- Pool budgets around chosen priorities and care pathways
- Reduce service duplication
- Align commissioning cycles
- Identify gaps in existing service availability
- Jointly develop and manage the provider market

To ensure delivery of services around the individual, HWBs will be able to:

- Promote joint awareness of existing services
- Design and implement integrated care pathways
- Encourage better integration of primary and secondary care

Coordinating Delivery

Engaging all parts of local government

If councils are to become health improving councils rather than keeping "public health" as a siloed department, all parts of the council will need to take into account their impact on population wellbeing and health. As the cost of conditions such as diabetes are predicted to consume £16.9 billion of the NHS budget by 2035, 4/5 of which might be preventable,[48] the focus on wider determinants of such conditions is evermore important. The areas highlighted in this chapter are only a selection of public sector bodies that should be further integrated into the agenda.

A number of local authorities have already begun working in this way , but in the future this approach will need to be scaled up. For example Kirklees council has been using the well-known 'rainbow' of the factors contributing to specific health issues to illustrate to directorates the value added of their involvement (see example for diabetes below).

48 York Health Economics Consortium (2012) Impact Diabetes Report

Figure 15 Kirklees Council annotated rainbow

Lack or awareness of risk factors for diabetes

Unable to work due to disability and poor health

Low income - perception that healthy eating and exercise is expensive

Work

Learning

Income

Physical environment

Housing

Not attending routine screening

Family, social and community networks, safety, inclusion

Poor access to transport to don't attend appointments

Transport

Personal behaviours

Access to services

Services not culturally appropriate

Physical and mental ill health

Poor understanding of risks among certain BME groups

Resillience, coping and control

Poor diet

Age, gender and ethicity

Obesity

Increased risk of CVD

Poor self skills

Physical inactivity

Poor Control of Diabetes

Newcastle City Council has taken a slightly different approach and uses 'a tripod' of action to illustrate the power of the health and wellbeing partnership to reach out to wider local government (See figure 16).

Figure 16 Newcastle's three areas of action for their health and wellbeing partnership

Addressing the social determinants of health

Core elements

Governance and partners

Strategic processes, capacity and capability

Making sure people get high quality services they need

Releasing the capacity of communities to identify and act on issues that impact on their own, and others, wellbeing and health
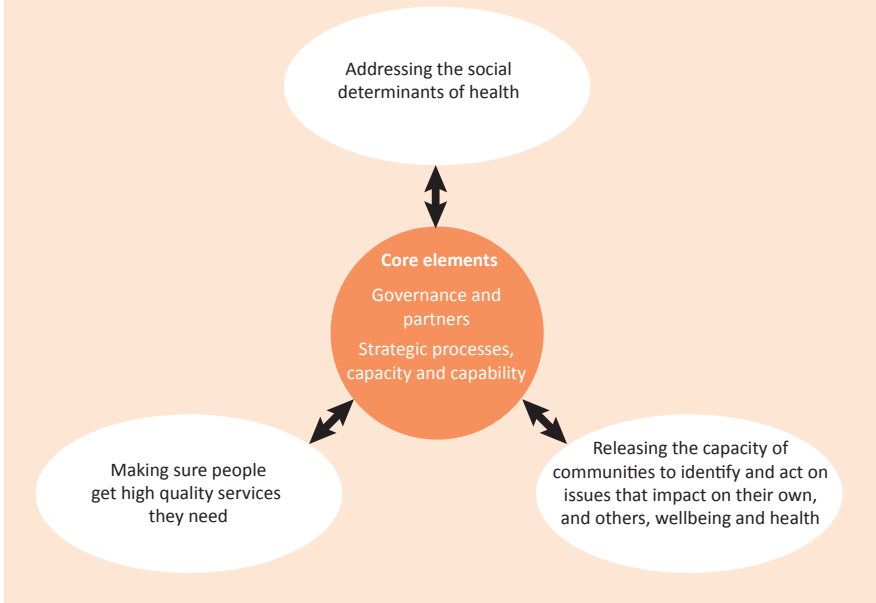
With the development of the new collaborative arrangements, local authorities are already reporting changes in the way services are provided.

One of the key recommendations in the Marmot Review of Health Inequalities in England, *Fair Society, Healthy Lives*, is to: 'fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality'. The new duties of local authorities have created a number of opportunities to create these links and system synergies. By involving wider local government functions such as housing, planning, economic development and others improving health can be re-established as a fundamental to local government's purpose.

Housing

Housing is considered to be one of the key areas connected to public health. Linking housing and health is not a new idea. Florence Nightingale said *"The*

connection between health and the dwelling of the population is one of the most important that exists".[49] However in the UK and in other western countries housing, health, and environment have often become separate and unrelated disciplines.[50]

Annually, poor housing conditions are implicated in up to 50,000 deaths (over 36,000 excess winter deaths in 2008/09 in England and Wales); cause 0.5 million injuries and illnesses that require medical attention; and contribute to increased risk of cardiovascular diseases, respiratory diseases and depression and anxiety. Furthermore the UK has the highest rate of illnesses caused by water systems, dampness and mould, ventilation and conditioning in the European Union.[51] The estimated costs to the NHS in England each year to treat the health impacts of poor housing stand at £600 million and the full costs to society of poor housing at some £1.5 billion per year.[52] The potential of targeted investments to reduce those costs particularly for the vulnerable population are well-documented.[53]

As housing deficits top the list of priorities for local and national government, it is important to take the opportunity to join up housing initiatives with considerations about health improvement. Only some HWBs have housing representatives on the board increasing the importance of creating strong links with housing representatives as the Joint Health and Wellbeing Strategy is developed.

Schools

These changes to the public health system are taking place at the same time as 'the academisation' of education. To lead the agenda, local authorities will need to change current ways of working: *"especially through the changes in schools and education landscape, where schools are becoming much more autonomous and the local authority control is diminishing. We need to be much more creative"*[54]

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49 Lowry (1991), Housing and Health, British Medical Journal; 303:838-840

50   HUD (April 1999), The Healthy Homes Initiative: A Preliminary Plan, Full Report, U.S. Department of Housing and Urban Development, Krieger J, Higgins D (2002), Housing and Health: Time Again for Public Health. American Journal for Public Health; 92(5): 758–768 and Lowry (1991)

51 http://www.keepthecityout.co.uk/2011/10/post-3/

52 BRE 2011 The Real Cost of Poor Housing

53 HCA 2010 Frontier Economics, Financial benefits of investment in specialist housing for vulnerable and older people

54 Interviewee

Although local authorities will have a duty to commission school nurse services, one area of concern is that there is not a duty on autonomous schools to take these services up. There are concerns students will not necessarily have access to essential public health services at school such as vaccinations, vaccination checks and confidential health advice.

However a body of evidence suggests that immunisation uptake is higher in schools-based programmes. A survey sent to Health Protection Units showed that 76 per cent of respondents indicated that schools were the preferred place to deliver routine vaccines.[55]

More than 2750 pupils will be starting in free schools in 2012[56] and will risk losing easy access to these essential health services. This is in addition to more than a million currently in academies and free schools.

The area of particular concern is administration of HPV vaccines. Since September 2008 there has been a national programme to vaccinate girls aged 12 to 13 against the human papilloma virus (HPV). This programme has mainly taken place in schools. The HPV vaccine protects against cervical cancer which is the second most common cancer in women under the age of 35. Yet the vaccine has been linked with some controversy about teenage sexual health and therefore might not be universally demanded by schools.

Furthermore if new vaccinations are to be introduced in the future, for example against bacterial meningitis, there is concern these vaccination programmes would not be taken up by autonomous schools putting thousands of children at risk.

Other health services provided at school might also be at risk if they are not seen as a necessary part of education. These include those aimed at reducing teenage pregnancy, childhood obesity and substance abuse, all indicators outlined by the Public Health Outcomes Framework. Although children and young people are entitled to the universal offer of public health, it is up to the school whether the universal offer is available through schools.

55 Health Protection Agency Survey of Primary Care Trust teenage vaccination programmes
56 NLGN calculation based on Department for Education approved list of free schools for 2012

There are several reasons for schools not to engage with public health initiatives. First of all, certain religious schools might find initiatives such as sexual health advice contrary to their beliefs. Second, some schools might not consider health as the key priority of their establishment and do not directly reap the benefits from such initiatives. Some governing bodies would like minimum distractions to the schools day have the space available.

Planning

Planning is another key function of local authorities that has historically been badly linked with health improvement and social care. The way in which new developments are structured impacts on the everyday experience of residents though travel patterns, access to community services and open spaces or the standard of buildings.[57] Some of these impacts planning decisions have on health are outlined below:

Links between planning and health[60, 61]

- Open space that is safe and easy to get to increases exercise, and moderate exercise improves health outcomes
- Reducing traffic reduces air pollution
- Green spaces improve mental health
- Green space improves rates of physical activity
- Better insulation and heating improves health
- Traffic interventions reduce accidents and/or increase physical activity
- Design of neighborhoods and community cohesion
- Local access to healthy foods may improve diets

[58] [59]

When asked how engaged the following stakeholders were in HWB priority setting, planning emerged as the area within local government with the largest gap between current involvement and ambition for future involvement (See figure 17).

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[57] TCPA (2010) Spatial Planning for Health: A guide to embedding the Joint Strategic Needs Assessment in spatial planning
[58] Ross (2011) Plugging health into planning: evidence and practice A guide to help practitioners integrate health and spatial planning
[59] Boyle and Patel (2009), Allen, et al (2011), The Marmot Review: implications for spatial planning. London: NICE

Figure 17 Difference between ambition for level of engagement and current level of engagement of key stakeholders
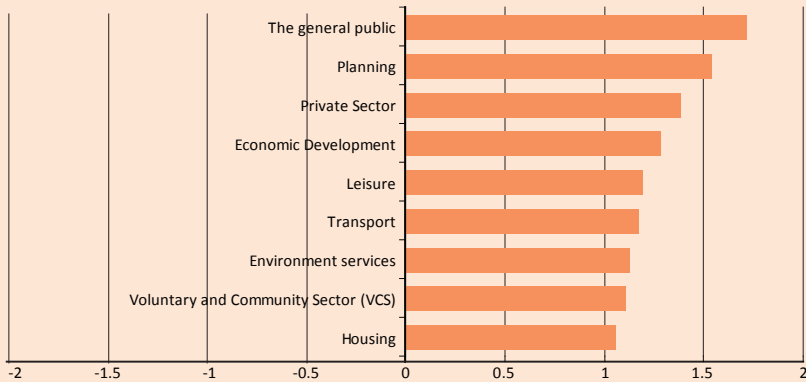
Survey question: How engaged are the following stakeholders in setting priorities for the Board with 1 being disengaged and 4 being actively engaged. A) Currently B) Ambition for the future

However as local authorities take a role in health improvement, they will need to find new ways of engaging with planning departments to embed health outcomes into planning decision making. The Healthy Urban Development Unit established in London provides a good example of how planning and health can be integrated into a coherent strategy for a place.

Case Study

The Healthy Urban Development Unit (HUDU)

The Healthy Urban Development Unit (HUDU) was launched in 2004 across five different London boroughs to enable the alignment of NHS priorities with planning mechanisms. Through the S106 agreement in the Town and Country Planning, the NHS was able to integrate health within the core strategy of Local Development Frameworks, as well as improve engagement and enhance social infrastructure.

One of HUDU's most significant successes has been the reduction in language barriers and the creation of toolkits to assess and measure the soundness of health plans. Such an approach has been particularly relevant for regeneration programmes such as the Thames Gateway Social Infrastructure Framework, which aims to address inequalities within London.

Although the integration of health and planning has initially been successful, a tension between the long term impacts of planning against the short term needs of the population has been observed. HWBs will have a key role mitigating this tension going forward.

Another key goal for HUDU in the coming year is to improve the health impact assessment. Although, some environmental impact assessments have addressed health, the potential of these processes has not been fully realised. In the future, effective health impact assessments will need to include pre-application discussions, a high level of community engagement and robust monitoring and review arrangements.

Engaging planning with public health will require further evidence to forecast the health outcomes associated with developments and put in place requirements to mitigate adverse health impacts. At the moment, there is often a lack of clarity in desired outcomes of developments and the health impact of new settlements.[60] As planning authorities are under a number of pressures to take into account other council priorities such as economic growth and environmental sustainability, strong leadership and a sound evidence base will be needed to guide planning decisions.

The National Planning Policy Framework (NPPF) and the Localism Act give local discretion to develop policies that address local health concerns such as the concentration of fast food outlets. Additionally financial resources such as the Community Infrastructure Levy (CIL) will provide an opportunity to ensure new developments are health neutral or health positive.

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[60] TCPA (2010) Spatial Planning for Health: A guide to embedding the Joint Strategic Needs Assessment in spatial planning

A number of councils have already begun to consider how CIL could be used for investing in health improvement. Since CIL is intended to compensate communities for the impact of developments, a strategy to involve communities will be needed. For example, Shropshire council has passed down CIL and New Homes Bonus to local parishes/and neighbourhoods with the aim of creating "resilient local communities" who can take their future in their own hands. To ensure there are no missed opportunities in creating health improving spaces, local authorities should communicate the importance and benefits of incorporating health outcomes into contractual or commissioning arrangements.

RECOMMENDATION: *The HWB chair should have a "call in" power to local authority departments commissioning services (for example in relation to the use of CIL) to ensure local authority delivery takes JHWS into account. In two tier areas the "call in" power should apply to directorates within district councils. There should also be a Health and Wellbeing representative within each directorate to lead on the agenda shift.*

Economic Growth

One of the key links for health improvement is that with economic growth. Good health may be considered as a form of human capital that has a beneficial effect on productivity. For example, coronary heart disease alone costs the UK £2.91 billion in lost productivity per annum.[61] Similarly, levels of income and income inequality have direct causal links with health outcomes.[62,63] However health policy and economic policy are usually siloed from each other.

As councils have an increasingly important role to play in both health and economic growth, there is an opportunity to create a synergistic process between the two with improvements resulting in escalating human development. Local Economic Partnership (LEP) will be a key forum through which economic growth policies are coordinated across areas and with

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61 Liu et al (2002), The economic burden of coronary heart disease in the UK. Heart, 88, 597-603.
62 Commission on Growth and Development (2008) Population Health and Economic Growth
63 Lynch et al (2004), Is Income Inequality a Determinant of Population Health? Part 1. A Systematic Review. The Milbank Quarterly, 82, 5-99.

stakeholders.[64] Since LEPs and HWBs are the two emerging structures for local governance, further links between the two will be needed. Whilst some HWBs have invited infrastructure and employment representatives to HWB meetings, the two partnership arrangements might remain disconnected.[65]

One of the ways of connecting LEPs and HWBs would be to introduce "health proofing". This would involve the HWB chair assessing the health impact of the LEP strategy and making suggestions where considerations for health improvement could be incorporated.

RECOMMENDATION: *In recognition of the synergies between economic growth and health, LEPs should establish mechanisms to "health proof" decisions.*

Other local bodies

Local authorities will also need to work with agencies outside the public sector to coordinate and improve service delivery. In Leicestershire a new voluntary and community sector (VCS) Strategy Group has been established to co-ordinate and support the input of the sector into the Leicestershire Together (LT) Integrated Commissioning Framework. The Living Well Initiative in Lambeth is another example of a project which has brought together organisations involved in service delivery and where key stakeholders have jointly agreed on the optimal way forward to tackle upcoming challenges.

Case Study

Lambeth Living Well Collaborative

The LLWC is attempting to develop an improved offer through a process of co-production with the full range of partners (VCS, GPs, users etc). Over 800 people have participated in 9 major partnership / co-production events since July 2010 out of which a new improved service offer has been developed with the agreement of key partners.

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64 Manning J, and Kuznetsova D (2012), Grow your Own: Skills and Infrastructure for Local Economic Growth

65 Health and Wellbeing Board member

The work has been ongoing since January 2010 to put elements of the offer in place. This includes:

- *A new community options service*
- *A new primary care support / enabling service,*
- *A new information and resource hub service*
- *A new self directed payments recovery fund*
- *A new universal time banking service*
- *A new peer support service*
- *A more focused secondary care service*

During the work, it was recognised that these service developments on their own are not sufficient and that in order to achieve the scale of improvement in outcomes there needs to be a "citizen" friendly "easy in and easy out" operating system focused on recovery and personalised support. This includes.

- *A collaborative provider landscape*
- *Collaborative commissioning including a stronger user voice*
- *A single shared information data base*
- *One case load which is primary care and patient led*

Although this initiative began before the formation of the Health and Wellbeing Boards, it illustrates the benefits of engaging stakeholders in redesigning service delivery.

In working to embed health improvement into wider local government departments and other local public bodies such as free schools and social landlords, councils will need additional levers and soft powers. A "duty to cooperate", first introduced for Local Strategic Partnerships and more recently in the Localism Act 2011 in respect to planning places an expectation in a highly devolved system that local public agencies will engage with the priorities of others. Such a duty in the health field would give LAs a fighting chance to lead on health improvement.

RECOMMENDATION: *A "Duty to cooperate" with Health and Wellbeing Boards should be put in place for recipients of public money.*

Public engagement

The return of public health to local authorities and the development of Health and Wellbeing Boards brings a new imperative for health services to be accountable to local communities. Through this new democratic mandate over health, local authorities will be able to enable citizens to become active co-producers of health outcomes. Although there is widespread agreement that users should be kept at the centre of decision making about service delivery, the exact mechanisms of doing are so often less clear. At the same time, there is an anxiety that the establishment of national Healthwatch structures has lagged behind other items on the reform agenda.[66] The NLGN survey showed that actual engagement with the public lagged behind the ambition and that the best intentions are yet to be realised.

Health and Wellbeing Board members will need to work across organisational divisions to develop a joint strategy of public engagement. This will be difficult at times as there are some differences between models of patient involvement and public involvement. Patient involvement refers to patients and health professionals making joint decisions about a course of care while public involvement most often refers to the involvement of members of the public in strategic decisions about health services and policy.[67] Furthermore the relationship between residents and elected representatives adds an additional layer of complexity. Clearly all of these are not mutually exclusive in the context of health but it will be important to maintain a balance between citizen and patient involvement to ensure all perspectives are taken into account.

Although historically the public have had little input into what and how public health initiatives are rolled out, HWBs represent a unique opportunity to link up citizen representatives with decision makers. There are a number of tangible benefits to scaling up public involvement as set out below:

1. Democratic accountability: ensuring that decisions that are made, take into account community needs and that the public hold politicians to account for the impact they have on local health.

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66 Interview
67 Litva et al (2002) The public is too subjective': public involvement at different levels of health-care decision making

2. Local knowledge: helping to link quantitative information used for JSNAs with qualitative knowledge of local issues.

3. Quality improvement: patients can drive improvements in the healthcare system through co-design and informed choice.

4. Early intervention: by listening to residents rather than solely to current patients at GP surgeries, there is potential to gain a better understanding of how intervention can be shifted upstream.

5. Health economics: patients could reduce healthcare cost, for example by taking on tasks previously done by professionals or making different healthcare or lifestyle decisions.

Nevertheless our interviews demonstrated that challenges remain with widespread public involvement by HWBs:

1. The diversity of the population in many areas does not lend itself to a single representative voicing an opinion. Although Healthwatch will aim to represent the local population, there are concerns that this will often be insufficient in representing the full spectrum of viewpoints. This is particularly dangerous in the context of 'hard to reach' groups whose lack of input could lead to further inequalities within the system.

"We need to be careful when making decisions, as we cannot just include those who are most vocal but we need to ensure that all people are included. Similarly, we cannot just listen to the most extreme cases, we also need to pay attention to those that rest in the middle and do not have enough of a strong voice. We cannot afford to be tokenistic.'"

2. It is often reported by public representatives that the high level of discussions at the HWB meetings may not be easily accessible to people outside of the sector. Although the organisational differences between the NHS and local government are thought to be daunting to one another, both systems are often incomprehensible to external representatives. The language used by the NHS and local government is often disempowering to the public: *"I find it difficult to feed information back to the public, it is hard to understand the information itself and I*

cannot feed it back if I am not fully comfortable with it."[68] Additional efforts need to be made to ensure information is accessible and decisions are explained in a clear and coherent manner.

3. Although a number of boards are conducting consultation exercises, there are concerns that consultation will be insufficient and that greater emphasis should be placed on creating links for continuous involvement.

4. Co-production of public health outcomes is inherently difficult as there is not a clear message about the expectations on the citizen and his/her role in creating health outcomes.

5. Children are seldom if ever represented on HWBs. Although the Director of Children's Services is responsible for voicing the concern of children, HWBs often find it difficult to incorporate the work of other related forums and boards. However raising awareness of public health issues early on in life could have significant benefits for wellbeing and the financial sustainability of health and social care provision. National Healthwatch similarly has not clarified plans for young people representation or how Healthwatch will link to children's' forums.

"Mostly people that are part of LINks tend to be older people, it is very difficult to get hold of young and working people...we need to find different ways to approach them"

Case Study

Knowsley children engagement strategy

Knowsley has established a local involvement network for young people, 'LINked-Up' to ensure equity of engagement, in recognition that adult issues tend to dominate the health agenda, and young people are often not given the same opportunity to be heard. LINked-Up has been set up by young people and is part of a recognised children and young people's governance structure that feeds into the work of the Health and Wellbeing Board and supports continuous involvement, beyond consultation.

68 LINK representative

A member of LINked-Up has direct representation on the Health and Wellbeing Board. The young person is elected by their peers to represent the diverse voice and collective issues from a comprehensive network of young people's groups and fora. When young people identified social media as their preferred way of getting information LINked-Up responded and set up a Facebook group and website so young people who do not attend meetings can still gain information and get involved. LINked-Up and Young Advisors are directly involved in the strategic direction of the board, such as setting up the terms of reference, governance structure and democratic accountability.

Knowsley runs a successful Young Advisors programme. Young Advisors are local young people aged 16-21 who lead young person to young person engagement and broker relationships with adults, young people and council partners. Young Advisors are trained to help young people and adults gain greater understanding of information. They 'youth proof' documents and provide 'jargon busters' to ensure information is accessible in addition to delivering training to build confidence and capacity to enable young people to contribute and influence decision making. As a result, the engagement and retention of young people is very high.

LINked-Up is the only children and young people's LINk in England, led by young people who use different approaches to engage and involve other young people in thinking about their health and wellbeing. By listening to young people as community members, service users and patients allows for a greater understanding of experience and need, which can influence commissioning and support early intervention. Linked-Up complements the work of the adult Knowsley LINk, enabling shared issues to be tackled together while promoting equity for children's health outcomes. Developing and fostering feedback loops and widening the young people's network to the wider community has been key to involving and gathering views of young people. It is envisaged that this approach will support LINked-Up and LINks transition to Healthwatch.

Given these challenges, some authorities have adopted a comprehensive two way process of engagement with a focus on empowerment of residents to express views. For example, several authorities are putting in place surveys to understand the views of the local population. Kirklees council has conducted a large scale local population survey with a clear analysis of needs and has also gone out to do insight groups in a wide range of communities. Hertfordshire HWB has similarly embarked on a survey to understand the priorities of the local population and their views in regards to the prioritisation process the HWB plans to use for the JHWs. The key focus of these approaches has been to enable people to come in and have the dialogue.

Accessibility of information is also helpful facilitating public involvement. Newcastle is one of the few HWBs to have a dedicated website where information is clearly presented, and readers are effectively signposted to the Council's website to access papers and meeting information. The Board produces regular newsletters and the Chair writes a blog.

RECOMMENDATION: *Health and Wellbeing Boards should publish an explicit strategy for public involvement in their work. This strategy should also set out the short, medium and long term outcomes the public should expect to hold the Boards to account.*

At the same time, there are concerns in involving the general public before the infrastructure of HWBs is developed. As an interviewee told us: *"There is anxiety from all parties about whether they ought to include partners while ensuring that they are delivering tangible results. Another layer of difficulty is assessing how and where to start in terms of involving and including all relevant parties."*

The political and organisational cost of setting unrealistic expectations for the board publicly could be detrimental to its future. As the HWBs are still in the developmental phase, there is an argument for establishing the institutional architecture before the general public are involved. The "catch 22" is that an element of co-production in the initial stages is vital to ensure people do not feel they are "being told what has already been decided". Therefore, careful mechanisms of achieving that co-production, such as through intelligent VCS representation will be needed.

The VCS will be vital to securing public engagement and fostering channels through which the public can contribute to priority setting and delivery. In particular, they represent a key link to "hard to reach groups". Eighty nine per cent of respondents to the NLGN indicated that VCS engagement was the top priority in the future. Yet, currently a minority (29 per cent) of the boards surveyed by the Kings Fund had voluntary and third sector representatives.[69] This is often because HWBs are finding it difficult to select the correct VCS representation. This is particularly challenging in areas where there is not a representative body for smaller organisations.

If HWBs are to succeed, a more strategic approach to public involvement will be needed. Individuals need to be empowered to actively co-produce public health services and co design the public health message.

69 Humphries et al (2012) Health and Wellbeing Boards: System leaders or talking shops

3 *Conclusion*

Through their new public health duty and leading role in Health and Wellbeing Boards, local authorities have the tools they need to emerge as "health improving councils", shaping how existing services are delivered and, perhaps more importantly, forging a fresh, connected approach to improving the health of their communities. But the transition will not be straight forward. Protecting and improving health outcomes to once again be recognised and owned by council as central to their core purpose. And as our formative evaluation shows, councils will need to be creative and focused in how they work with a wide network of public bodies around public health, deciding on joint priorities and then directing resources towards those priorities. Coordinating delivery across a number of partners, including those at the edges of their sphere of influence will not be easy. However, local authorities are taking on this new role with enthusiasm and innovative approaches are emerging from around the country.

Health and Wellbeing Boards will be at the heart of this new role. By bringing together the key agencies in public health, the NHS and social care, HWBs can provide a platform for redesigning services from vaccination to domiciliary care in ways that promote prevention and join up services around the needs of citizens. However there is a danger of HWBs being seen as everything for everyone. They will need to be clear about their core purpose and establish corresponding governance and membership structures, which enable decisions to be made and voices to be heard. Organisational differences and territorialism over budgets risk destabilising the new system: the success of HWBs will depend on the ability of different professional groups to work with politicians to create innovative and tailored local services.

Although local authorities will be under a number of new duties, they will be given few additional powers to enact those duties. Health improving councils will need to be creative and display leadership across the public health agenda to mobilise action by a number of bodies around clear local priorities.

The new era of health improvement and protection can bring significant benefits to local communities but will need to engage the public early on

for those benefits to be co-produced. Local residents need to be aware of local government's new role and hold it accountable, changing the way that the public is involved in decisions about the health and wellbeing of their community.

Whilst local authorities already do much that has a positive impact on health, it has not been an explicit purpose for many years. Health improving councils, at the heart of key networks of agencies and actors, will need to make the creation of healthy places a reality by aligning everything they do with this objective.

Appendix 1 *Methodology*

A survey of leading figures involved in the set-up of shadow HWBs to assess the levels of confidence in the emerging arrangements, determine key priorities for 2013, and identifies emerging challenges for the new boards. There were 93 respondents to the survey with 53 complete responses. Survey questions are included in Appendix 2.

28 Semi-structured interviews with HWB representatives from 13 councils.

Desk based literature review to summarise the latest thinking on the new policy agenda, partnership working and integration.

Deep dive case study of a shadow board (Blackburn with Darwen) to analyse performance to date.

3 Research seminars bringing together councillors, social care staff and public health professionals to develop a shared vision for the potential of Health and Wellbeing Boards.

- The first research seminar focused on scenario planning for HWBs in 2020
- The second research seminar was centred on decommissioning and disinvestment for public health
- The third research seminar was focused on tackling organisational differences.

The research has been assisted by an expert advisory group of key local government and NHS practitioners to help ensure the rigour and practical applicability of the recommendations. Listed below are the advisory group members:

Sharon Fryer, Children and Families Partnership Director, *Knowsley Council*
Councillor Sue Anderson, *Birmingham City Council*
Meradin Peachey, Director of Public Health / **Andrew Scott-Smith**, Director of Health Improvement, *Kent County Council*
Sarah Taylor, Policy Services Manager, *Northern Housing Consortium*
Mike Kelly, Director, Centre of Public Health Excellence, *NICE*
Anne Ruglys, Associate Director, Government & Policy Affairs, *Sanofi Pasteur MSD*
Sandra Whiles, Chief Executive, *Blaby District Council*
Nicola Stevenson, Senior Research and Policy Officer, *NHS Confederation*
Mark Duman, Chair, *Patient Information Forum.*
Sola Afuape, Chair, *Afiya Trust*
Michael Sobanja, Chief Officer, *NHS Alliance*
Judith Hendley, Head of Health and Adult Services, *London Councils*
Daljit Lally, Director of Adult Services, *Northumberland County Council*
Prof. Richard Parish, Chief Executive, *Royal Society for Public Health*,
Ian Winter, Deputy Regional Director for Social Care and Lead, *Pan London HWB network*
Andy Hull, Director of Stakeholder Engagement, *Liverpool PCT*

Appendix 2 *Future of Local Government and Public Health Survey*

1. **Which of the following best describes your relationship with the Health and Wellbeing Board (HWB)? (circle one)**

    Irrelevant to my work
    Sometimes relevant to my work
    Often relevant to my work
    I am a member of the Board

2. **On a scale of 1 (not at all confident) to 5 (Extremely confident), how confident are you about the effectiveness of your HWB over the next 1-2 years?**

    1   2   3   4   5

3. **What are the 3 key priorities for the HWB in your council?**

	Priority 1	Priority 2	Priority 3
This year			
In five years			

4. **How will your HWB assess its performance in relation to**:

    a)   Tackling public health outcomes:
    b)   Improving service delivery:

5. **What are the three most significant factors which might impede the functionality of the HWB in your council?** (please rank)

Financial resources
Data availability
Leadership
Organisational differences
Council politics
If other, please specify

6. **What mechanisms do you think will increase the effectiveness of the HWB in your council? (circle all that apply)**

Pooled budgets
Training
Guidance from central government
More meetings
If other, please specify

7. **To what extent do you believe that efficiency savings could be made through HWB collaboration?**

1   2   3   4   5   6   7   8   9   10

1   The HWB will cost more money than it will save
2   No efficiency savings will be made through the HWB
3   Substantial savings could be made through the HWB

Additional comments:

8. **To what extent has central government provided sufficient incentives to facilitate integrated working?**

1 (Insufficient)   2   3   4   5 (Sufficient)

Additional comments:

9. **How engaged are the following stakeholders in setting priorities for the Board? (Please enter a score of 1-4)**

1   Disengaged
2   Sometimes engaged

3   Engaged
4   Actively engaged

	Currently	Ambition for the future
Housing		
Leisure		
Transport		
Environment		
Planning		
Economic Development		
Private sector		
Voluntary and Community Sector		
The general public		

10. **Do you think the membership of your Board contains the right mix of people for effective functioning?** (circle one)

Yes
No
I don't know

If not, what has prevented this?

11. **What measures have been taken in your council to facilitate good working relationships between different HWB members?** (e.g. training)

12. **Health and wellbeing boards have locally elected representatives bringing a new element of politics into healthcare. Please indicate whether you agree or disagree with the following statements:**

	Agree	Disagree	Don't know
Political representatives will make public health more accountable to local citizens			

Political representatives will make no difference to health outcomes			
Political representatives will lead to an unhelpful polarisation of decision making in health:			

Additional Comments:
Other

13. **Would you be prepared to take part in a telephone interview with an NLGN researcher to further explore your answers to these questions?**

14. **Would you be prepared to share your HWB strategy with NLGN?**

15. **Is there anything you would like to add?**

Appendix 3 *References*

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Appendix 4 *Commissioning responsibilities of local authorities in relation to public health*

The following provides a provisional list of commissioning responsibilities of local authorities in relation to public health:

- Tobacco control and smoking cessation services
- Alcohol and drug misuse services
- Public health services for children and young people aged 5-19 (including healthy child programme 5-19)
- The national child measurement programme
- Interventions to tackle obesity such as community lifestyle and weight management services
- Locally-led nutrition initiatives
- Increasing levels of physical activity in the local population
- Nhs health check assessments
- Public mental health services
- Dental public health services
- Accidental injury prevention
- Population level interventions to reduce and prevent birth defects
- Behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- Local initiatives on workplace health
- Supporting, reviewing and challenging delivery of key public health funded and nhs delivered services such as immunisation and screening programmes
- Comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the gp contract and sexual health promotion and disease prevention)
- Local initiatives to reduce excess deaths as a result of seasonal mortality
- The local authority role in dealing with health protection incidents, outbreaks and emergencies

- Public health aspects of promotion of community safety, violence prevention and response
- Public health aspects of local initiatives to tackle social exclusion

Appendix 5 *Summary table of the duties and powers introduced by the Health and Social Care Bill*

Local Democratic Legitimacy: powers and duties	CCGs	Local Authorities	NHS Commissioning Board	Local Health-Watch	Health and Wellbeing Board
Establishment and membership of health and wellbeing board					
Duty to send representative to Health and Wellbeing Board	X (including those with overlapping boundaries)	X	X (not permanent, but when requested by HWB)	X	
Power to appoint additional members to the board as deemed appropriate		X (in initial establishment of HWB only)			X
Power for two or more HWBs to exercise their functions jointly					X
Functions of health and wellbeing board					
Duty to cooperate with the HWB in the exercise of its functions	X				
Power for HWB to request information for the purposes of enabling or assisting its functions from: • the local authority • any of its members or their representatives	X (duty to provide)	X (duty to provide)	X (duty to provide)	X (duty to provide)	X
Duty to prepare JSNA in relation to LA area with regard to guidance from Secretary of State. To consider need or likely need capable or being met or affected by LA or CCG functions	X*	X*	X (to participate)		X
Duty to prepare JHWS based on JSNA in relation to LA area with regard to guidance from Secretary of State	X*	X*	X (to participate)		X
Duty to involve third parties in preparation of the JSNA and JHWS: • Local HealthWatch • people living or working in the area • for County Councils – each relevant DC					X
Power to consult any other persons it thinks appropriate on preparation of the JSNA					X
Duty to have regard to the NHS Commissioning Board mandate and statutory guidance in developing the JSNA and JHWS					X

Duty to consider health act flexibilities when developing JHWS					X
Duty to publish the JSNA		X			
Duty to publish the JHWS		X			
Power to include in the JHWS a statement of views on how the commissioning of health and social care services, and wider health-related services** could be more closely integrated – i.e. the ability for the JHWS to look more broadly than health and social care					X
Impact of duties on other associated functions					
Duty to have regard to JSNA and JHWS in the exercise of relevant commissioning functions	X	X	X		
Duty to promote integrated working: • between commissioners of health and social care services • using health act flexibilities					X
Power to encourage integrated working across wider determinants of health: • between itself and commissioners of health related services • between commissioners of health and social care services and of health-related services					X
Power to delegate any local authority function (except scrutiny) to the HWB		X			
Ensuring alignment of commissioning plans					
Duty to involve HWB in preparing or revising the commissioning plan – including consulting it on whether the plan has taken proper account of the JHWS	X				X
Duty to provide opinion on whether the commissioning plan has taken proper account of the JHWS					X
Power to also write to NHSCB with that opinion on the commissioning plan (copy must also be supplied to the relevant CCG)					X
Duty to include a statement of the final opinion of the relevant HWB in the published commissioning plan	X				
Power to provide NHSCB with opinion on whether a published commissioning plan has taken proper account of the JHWS (copy must also be supplied to the relevant CCG)					X

Duty to review how well the commissioning plan has contributed to the delivery of the JHWS and to seek opinion of HWB on this	X				X
Duty to get view of HWB on how well CCG has contributed to delivery of JHWS when conducting its annual performance assessment of the CCG				X	X
Other duties, which can be contributed to through the JSNA and JHWS					
Duty to exercise functions with a view to securing continuous improvement in quality of services	X				
Duty to act with a view to secure continuous improvement in outcomes achieved	X				
Duty to exercise functions with regard to need to reduce inequalities between patients in outcomes and access to services	X				
Duty to promote the involvement of patients, their carers and representatives in decisions about the provision of health services	X				
Duty to promote innovation in the provision of health services	X				
Duty to exercise functions with a view to securing integration in the provision of health services, and the provision of health and social care services to improve the quality of the services or reduce inequalities between patients in outcomes and access to services	X				

X*- duty discharged via HWB
** - "health services", "health-related services" and "social care services" are defined in s.192:

- "health services" – means services that are provided as part of the NHS
- "social care services" – means services that are provided in fulfilment of the social services functions of local authorities (within the meaning of the
- Local Authority Social Services Act 1970).
- "health-related services" – means services that may have an effect on the health of individuals but are not health or social care services

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