

EVALUATING THE LEADERSHIP ROLE OF HEALTH AND WELLBEING BOARDS AS DRIVERS OF HEALTH IMPROVEMENT AND INTEGRATED CARE ACROSS ENGLAND

FINAL REPORT

April 2018

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Policy Research Programme Project PR-X03-1113-11007

EXECUTIVE SUMMARY

Introduction

Health and Wellbeing Boards (HWBs) are statutory partnerships established under the Health and Social Care Act 2012. They bring together partners within the NHS, public health, adult social care and children's services, as well as local authority elected members and representatives from Healthwatch in an effort to ensure strategic planning based on local health needs. HWBs became fully operational statutory bodies in April 2013, after almost two years in shadow form. Local authorities and clinical commissioning groups (CCGs) have statutory duties to develop Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) to be discharged through the board. HWBs also have a duty to encourage integrated working between commissioners of health and social care services in their area.

Though generally welcomed, these changes were implemented during a time of unprecedented financial pressures on local authorities and of changing patterns of need that demand new ways of thinking and working in how health improvement and wellbeing are delivered. A team led by Durham University, in collaboration with Sheffield University, the London School of Hygiene and Tropical Medicine, and independent colleagues, has been funded by the Department of Health Policy Research Programme to conduct a national evaluation of HWBs.

Methods

The study focused upon a number of aspects around the configuration, operation, and impact of HWBs. The research questions in the study included:

- How are HWBs viewed by key actors, particularly in terms of relationships, leadership, governance and accountability?
- How successful has reconfiguration of the policy landscape resulting from the Health and Social Care Act 2012 been in shifting power in order to meet policy objectives for health improvement and reduced inequalities?
- Are HWBs extending democracy?
- What are the barriers and facilitators to enhanced collective decision-making?
- How are HWBs using joint strategic needs assessments and health and wellbeing strategies to inform local priorities?
- Are HWBs leading to more integrated service provision between health and social care?
- Have any improvements in outcomes or process measures in relation to health and wellbeing been identified by HWBs and if so, what are these?

These questions are addressed in brief in the ‘Overview of study findings’ below in this Executive Summary and in detail in Chapters 4 to 4.5. of the report.

To address these questions, data were collected from multiple sources: (1) a literature review focusing on partnership working and system leadership – Work Package 1 (WP1); (2) national interviews with key policy actors involved in setting up HWBs and a national online survey of HWB chairs and Directors of Public Health – Work Package 2 (WP2); (3) in-depth fieldwork conducted in five local authorities involving two rounds of interviews (initial and follow up), follow up national interviews with key policy actors involved in setting up HWBs, focus groups and selected observations – Work Package 3 (WP3). Finally, Work Package 4 (WP4) consisted of delivering local workshops and a national event to disseminate good practice and make recommendations to assist future HWB development. The following overview details the findings from the first three Work Packages.

Overview of study findings

How are HWBs viewed by key actors, particularly in terms of relationships, leadership, governance and accountability?

- In our literature review, it was found that widespread progress was being made across some common themes, such as the building relationships between HWB members, using development sessions or informal meetings to clarify priorities; developing sub-structures and working groups to support the HWB; and using the Better Care Fund (BCF) to provide a focus for their efforts. However, progress had been slower than anticipated and many boards were still some way off from acting as a driver on key issues.
- A key challenge from the literature review arose from the absence of statutory powers and the need for boards to acquire ‘soft power’ as influencers and negotiators of change. Questions arose regarding both the form that leadership should take and the skills and attributes of individuals needed to enact such leadership.
- Many HWBs were yet to position themselves as the key strategic forum for driving the health and wellbeing agenda. The review concluded that recent literature demonstrated that HWBs remain a case of ‘work in progress’ when it came to leadership, collaborative working and integrated service provision. It also suggested that many of the lessons from previous models of partnership working had not informed the working practices of HWBs.
- From our national interviews with key policy actors involved in setting up HWBs, in terms of leadership, there were multiple views on the nature of good leadership, what it means, how it is identified, and how it is developed.

- A consistent finding from the national survey was the level of variation between HWBs in terms of their size, membership, governance arrangements, priorities and workload. They had a range of priorities, although obesity, an ageing population and mental health were identified by many respondents. These priorities were expressed in many different ways, from specific output- related targets to overall strategic intent. It was evident that there was not a 'one size fits all' approach to HWBs.
- A lack of strategic direction and a focus on clear objectives on the part of HWBs was a common theme amongst participants in the interviews (WP3 above).
- Participants in part of WP3 also believed Boards were generally not viewed as system leaders, more a collection of leaders accountable to their own organisation; each with its own (often conflicting) priorities and working in organisational silos with partners not held to account.
- Despite the concerns and weaknesses over ownership and accountability of the JHWS in WP3, it was also recognised that HWBs were the only forum at present where the system came together however imperfectly.

How successful has reconfiguration of the policy landscape resulting from the Health and Social Care Act 2012 been in shifting power in order to meet policy objectives for health improvement and reduced inequalities?

- Our national actor interviewees voiced concern that HWBs were established as partnerships, a favoured policy instrument used by government, without much evidence of previous success.
- A finding from WP3 was that participants believed that relationships and trust matter in HWBs; having the appropriate individuals in the key organisations willing to invest the time, commitment and energy to create a successful partnership are key elements that can mean the difference between success and failure.
- From our national interviews a key concern was with the introduction and operation of HWBs being set against a backdrop of policy tension and conflict. One of these tensions was between the meta-policy of localism and the desire to ensure consistency between local authorities, although there was a clear difference of understanding and narrative around the notion of localism. For some interviewees, the introduction of HWBs and the transfer of public health responsibilities to local authorities was seen an example of the increasing fragmentation of the system. In comparison, others saw localism as desirable, bringing decisions about place and personalisation to a local level. But there were also tensions locally, both because of cultural differences between key HWB partners and because of differences in targets, performance frameworks and policy expectations between partners. A further tension was created by fuzzy, sometimes conflicting, policy objectives. Several examples were provided, one of which was the tension between a focus on

being transformational and transactional respectively, particularly in terms of the BCF.

- Respondents from WP3 noted that institutional complexity and competing system hierarchies (e.g. the demands and priorities of Sustainability and Transformation Plans (STPs), NHS and policy initiatives such as the BCF) tended to result in the dilution of local priorities and focus of HWBs.
- Many in our WP3 work package said that STPs side-lined HWBs, since they were perceived as having a larger geographical footprint and a degree of power and influence which HWBs did not possess.
- There was some concern from respondents in WP3 that there was a lack of focus and action on health determinants and inequalities.

Are HWBs extending democracy?

- There was widespread acknowledgement that little had been achieved by HWBs in terms of public and user involvement.
- Healthwatch were generally seen as engaged and contributing to and challenging HWBs, but there were issues about their role in terms of acting as a conduit for public engagement for HWBs.
- In regard to VCF sector organisations, HWBs had not capitalised on previous (better) engagement processes and a lack of investment in infrastructure to the sector had hindered engagement with inconsistent engagement across HWB footprints.

What are the barriers and facilitators to enhanced collective decision-making?

- Decisions were viewed by respondents in WP3 as taking place elsewhere in the system by partner organisations and at different levels, rather than within the HWB. Boards were not viewed generally as decision-making bodies but rather as bodies to ratify decisions with a lack of challenge and accountability from, and to, partners on the board. Boards tended to 'rubber stamp' decisions, which were often deferred to sub-groups due to HWBs meeting infrequently (and in public). HWBs had no formal executive power and were reliant on 'soft power' to influence the system.

How are HWBs using joint strategic needs assessments and health and wellbeing strategies to inform local priorities?

- A lack of strategic join-up was evident in WP3, for example in respect of the JHWS and other policy initiatives where there was (at both strategic and operational levels) little ownership of the JHWS, with a lack of accountability for elements of the strategy. The strategies were not regarded as an integral part of the health and social care landscape.

Are HWBs leading to more integrated service provision between health and social care?

- Significant developments were evident in two case study sites from WP3, but in one site this integration was overseen by the HWB and in another site it was a process (largely for historical reasons) separate from the board. This demonstrates how far factors such as history and the development of partnerships (which had historically been developed in both sites in terms of work on integration) could make a significant difference.
- Concern expressed in four of the five study sites over how the integration of health and social care and the BCF could dominate the focus of boards (as opposed to the actual work on integration in three sites) to the detriment, to some extent, of a focus on the wider determinants of health.
- Overall, historical context, good relationships/partnerships and trust were key drivers to work on integration.

Have any improvements in outcomes or process measures in relation to health and wellbeing been identified by HWBs and if so, what are these?

- Our national survey found that respondents identified significant barriers to successfully delivering against policy objectives for HWBs, including challenges related to developing and maintaining good relationships between partners, reducing resources coupled with increasing need, and the complexity of the health and wellbeing system. Despite these challenges, respondents were generally positive about the ability of HWBs to deliver against stated policy objectives and to improve outcomes in terms of prevention, service integration, tackling health inequalities and enhanced democracy. Although a range of output and outcome measures and reporting mechanisms were identified by respondents, it was evident that some issues were yet to be addressed, including attribution (particularly in relation to preventative and public health interventions) and resources.

In terms of outcomes, across the majority of study sites in WP3, there was an absence of outcomes which could be clearly attributable to the HWB. The reasons for this included the following factors:

- Insufficient accountability, a lack of strategic focus and not enough monitoring (with some HWBs having no systems in place for performance management) were cited as key factors in terms of there being a deficiency of outcomes.

- The study sites did not overall offer much evidence of outcomes that were driven specifically by HWBs or how they linked to the overall JHWS or were driven by the JSNA.
- There was also evidence that some outcomes were generally process-based, for example, improved relationships and communication between partners and in one site improved procedures on integrated care commissioning.
- An important point was the extent to which boards were 'retro-fitting' the JHWS to existing programmes, with the outcomes being 'badged' as a HWB outcome despite possibly being achieved anyway, and how much of a role the HWB had in acting as a system leader in co-ordinating areas of work to ensure that activities moved at a faster pace due to the co-ordinating efforts of the HWB.
- Respondents from our national follow-up interviews argued that good system leadership, engagement by partners and having defined goals were seen as essential requirements for successful outcomes.

Conclusions

Our research has demonstrated that, by and large, respondents valued HWBs and were only too well aware that they are the only place where the system can come together. Boards have the potential to act, as one participant put it, as 'the beating heart' of health in the local landscape. Unfortunately, HWBs in their current form are for the most part unable to occupy this pivotal role or to function accordingly. They have little power to hold partners and organisations to account, and other place-based mechanisms¹, notably STPs/ACSs, have a larger geographical footprint and arguably more traction on the system because of the investment in them. It is hardly surprising, therefore, that STPs were viewed by study participants as potentially eclipsing HWBs. With the advent of ACSs (now referred to as Integrated Care Systems or Partnerships), the eclipse risks becoming total.

It is no exaggeration to conclude, as speakers at the project national event in September 2017 did, that HWBs are currently at a crossroads with two possible future scenarios ahead of them. The first scenario involves HWBs being revisited and reconstituted to assume responsibility as the accountable organisation for the delivery of place-based population health in an area, with STPs/ACSs and CCGs being held accountable to boards.

An alternative scenario would see HWBs merely becoming, or continuing to be on the basis of the evidence from our study, talking shops which are effectively left to wither on the vine as STPs/ACSs effectively take over their role and function. We suggest this second scenario would be regrettable for a number of reasons notably the following: HWBs enjoy member participation from the highest levels in partner organisations; they are the only body with a democratic accountability and the only body able to connect with, and respond to, local

¹ An emphasis on a geographical place, such as a local government area or community, rather than on an institution.

communities. They are, therefore, well placed to act as ‘the beating heart’ in coordinating population health. Unfortunately, in their present form they do not have the power to hold partners to account and act as a binding decision-making body. Consequently, JHWSs are not adhered to, and plans and strategies are not always co-ordinated or followed up to ensure they are implemented. This can only be regarded as a waste in terms of the potential of HWBs to reduce duplication in the system and ensure scarce resources are used wisely and to best effect. HWBs could have a very bright future, reasserting their focus on their place leadership role and being ‘the anchors of place in a sea of new initiatives’ (Councillor Izzi Seccombe, Chair, LGA Community and Wellbeing Board, speaking at the project national event in September 2017). They just require the means to do so and to be given the support to enable them to realise what remains, by and large, their untapped potential.

CONTENTS

EXECUTIVE SUMMARY.....	2
Methods.....	2
Overview of study findings.....	3
Conclusions.....	7
CONTENTS.....	9
Acknowledgements.....	14
Disclaimer.....	14
1. INTRODUCTION.....	15
The challenge of system leadership.....	20
Evaluation aim and objectives.....	21
Structure of the report.....	22
2. LITERATURE REVIEW.....	23
Core HWB functions.....	23
HWB composition and configuration.....	24
Opportunities and challenges.....	25
Progress and outcomes.....	27
3. METHODS.....	32
Evaluation design.....	32
Work package 1: Scoping review of existing evidence.....	34
Review aim and questions.....	34
Design.....	34
Methods and analysis.....	35
Work package 2: Mapping partnership working arrangements.....	35
Aim and questions.....	35

Study design.....	36
Data collection.....	36
Data analysis.....	38
Work package 3: In-depth case studies.....	39
Aims and questions.....	39
Study design and settings.....	39
Data collection.....	41
Data analysis.....	42
Work package 4: Disseminating good practice.....	44
Ethical considerations.....	45
Public and user engagement and involvement.....	46
Equality and diversity issues.....	47
External advisory group.....	47
4. KEY FINDINGS.....	49
Case study site characteristics.....	49
Overview of study findings.....	51
4.1. FINDINGS: THE CHANGING CONTEXT OF HWBs.....	55
Background: the context of HWBs.....	55
Policy drivers.....	55
Partnership working.....	56
Local challenges and opportunities.....	59
The move of public health to local government.....	60
Changes over time.....	61
Devolution.....	62
Austerity and lack of resources.....	63
Summary.....	64
4.2. FINDINGS: PURPOSE AND STRUCTURE OF HWBs.....	65

Perceived purpose of HWBs.....	65
Views on membership and board organisation.....	68
Meetings.....	69
JSNAs and JHWSs.....	72
Summary.....	74
4.3. FINDINGS: MECHANISMS OF HWBs.....	75
Relationships, partnerships and collaborative working.....	75
System leadership.....	77
Decision-making processes.....	79
Influence of HWBs on commissioning.....	81
Governance and accountability.....	83
The role and perceived contribution of elected members.....	84
Public and user engagement.....	86
Summary.....	88
4.4. FINDINGS: OUTCOMES.....	90
Outcome enablers.....	90
Process outcomes.....	90
Health, wellbeing and inequalities outcomes.....	92
Performance management of outcomes.....	94
The lack of outcomes.....	98
Outcomes and the integration of health and social care.....	101
Summary.....	104
4.5. THE FUTURE.....	106
Challenges.....	106
Opportunities.....	108
The relevance and ongoing role of HWBs.....	111
Changes for the future.....	113

Summary.....	114
5. DISCUSSION.....	116
Summary and interpretation of key findings.....	116
System leadership and governance.....	116
Membership, relationships between HWB membership and key stakeholders.....	119
Political, institutional and organisational enablers and barriers to leadership and health improvement.....	121
Decision making: facilitators and barriers.....	123
HWBs’ impact on integrated service provision.....	124
Citizen involvement.....	124
Strengths and limitations of the evaluation.....	125
Implications for policy.....	126
Implications for practice.....	127
Conclusions.....	128
REFERENCES.....	129
APPENDICES.....	135
Appendix A: Relevant sections of the Health and Social Care Act 2012.....	135
Appendix B: National online survey questionnaire.....	140
Appendix C: National stakeholder initial interview schedule.....	143
Appendix D: National stakeholder follow-up interview schedule.....	144
Appendix E: Case study initial interview schedule.....	145
Appendix F: Case study follow-up interview schedule.....	146
Appendix G: VCF focus group topic guide.....	148
Appendix H: Example of coding framework for follow up national interviews.....	149
 BOXES, FIGURES AND TABLES	
Boxes	
Box 1: Lessons from previous research on partnerships.....	19

Box 2: WP1 review questions.....	34
Box 3: WP2 research questions.....	36
Box 4: WP3 research questions.....	39
A Vignette on sub-committees and accountability – site 2.....	71
A vignette on building relationships and partnerships – site 3.....	76
A vignette of a HWB and lack of influence on decision-making – site 1.....	79
A vignette of the HWB helping to raise the profile of issues – site 4.....	91
A vignette of health and social care integration – site 3.....	103

Figures

Figure 1: The New Health and Care System in April 2013.....	17
Figure 2: HWBs at a glance.....	18
Figure 3: Factors impacting on HWB progress.....	28
Figure 4: Evaluation design.....	33

Tables

Table 1: Factors influencing partnerships in public health.....	26
Table 2: Attributes of an effective HWB.....	29
Table 3: National stakeholder interview sample.....	37
Table 4: Case study sites.....	40
Table 5: Case study fieldwork – phase one.....	42
Table 6: Case study fieldwork – phase two.....	44
Table 7: Key features of the case study areas.....	49
Table 8: Key features of each HWB.....	50

Acknowledgements

We would like to thank everyone who participated in this project, particularly those who gave up their time to take part in the interviews and focus groups. The information, views and insights provided have been invaluable in meeting the evaluation aims and objectives. We would like to thank Michelle Cook and Lisa Monkhouse, research administrators with the Centre for Public Policy and Health (CPPH) at Durham University at the time of conducting the evaluation, for their invaluable administrative support. We also thank Chris O’Leary, formerly a postgraduate research associate at Durham University, and Sally Brown, a freelance researcher, who were involved during the early stages of the project. Dr O’Leary in particular organised and conducted many of the initial interviews. The draft final report was revised in light of reviewers' comments and we are very grateful for their constructive input.

Disclaimer

This report is based on independent research commissioned and funded by the NIHR Policy Research Programme (Evaluating the leadership role of Health and Wellbeing Boards as drivers of health improvement and integrated care across England, PR-X03-1113-11007). The views expressed in the publication are those of the author(s) and not necessarily those of the NHS, the NIHR, the Department of Health, ‘arms’ length bodies or other government departments.

1. INTRODUCTION

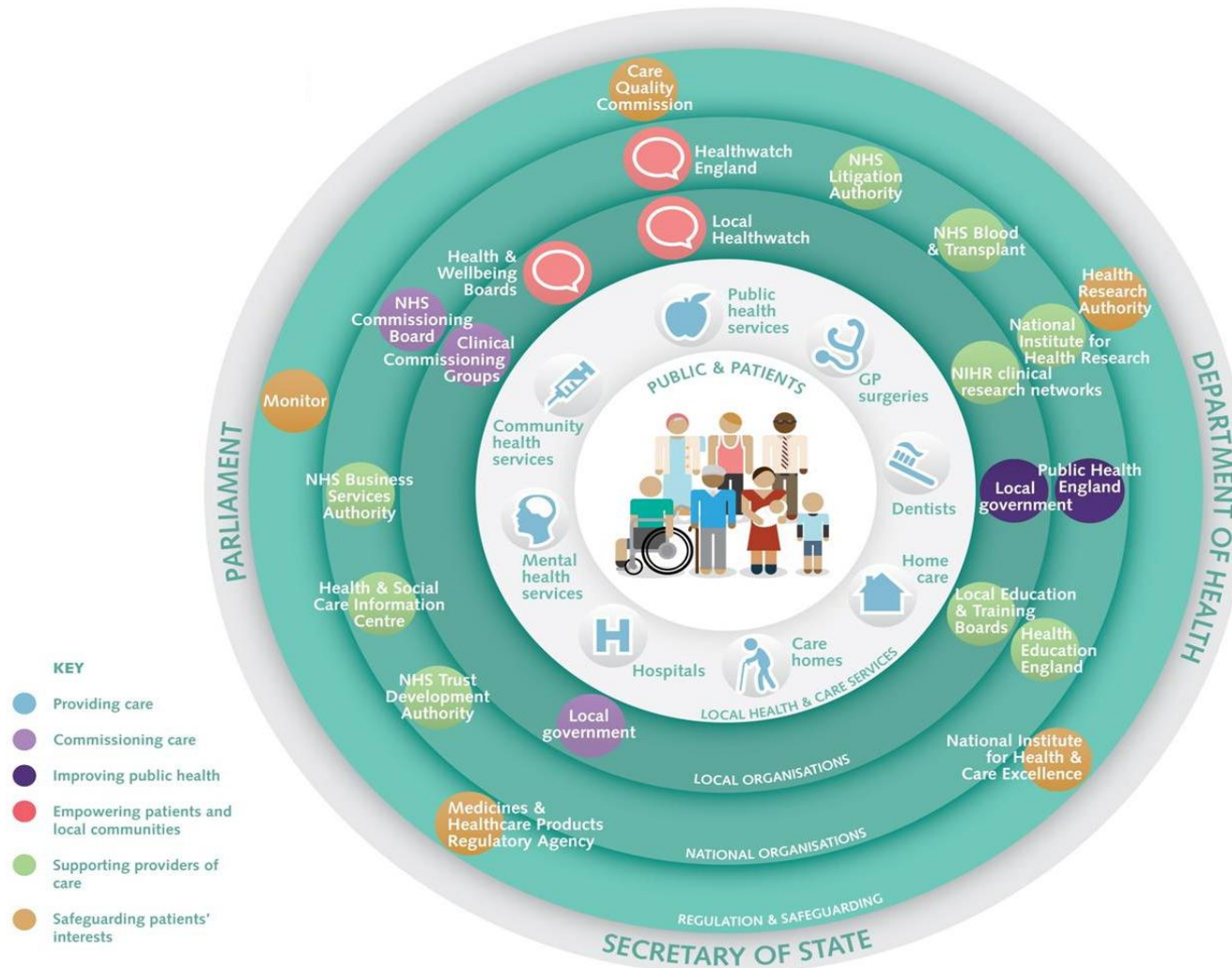
Background and policy context

In May 2010, the UK Coalition Government published its White Paper, *Equity and Excellence: Liberating the NHS*, setting out its intention to strengthen the role of local government in local health services in England (Department of Health, 2010). The Health and Social Care Act (HSCA) 2012 subsequently set in motion major changes in responsibility for public health, with local authorities being given new duties to improve the health of their populations (UK Parliament, 2012). The return of public health from the NHS to local government was generally welcomed in recognition of the fact that, among other things, services such as housing and education have the most significant impact on health, wellbeing and quality of life (Hunter, 2003, Hunter et al., 2010, Hunter and Perkins, 2014). However, this shift took place at a time of unprecedented financial pressures on local authorities and of rapidly changing patterns of need that demand new ways of thinking and working in how we deliver health improvement (Ham et al., 2012, Department of Health et al., 2013). Opponents expressed major concerns that the reforms effectively opened the door for privatization of the NHS in England (Scambler et al., 2014, Pollock et al., 2011). There was also widespread concern about the potential for increasing fragmentation between local government, the NHS, and two new national agencies, NHS England and Public Health England (Thraves, 2012). For an illustration of the new system as it was in April 2013 see Figure 1.

In an effort to overcome some of these challenges, the HSCA placed a statutory duty on local authorities to create a Health and Wellbeing Board (HWB) as a committee of the authority. HWBs bring together partners within the NHS, public health, adult social care and children's services, as well as elected members and representatives from local Healthwatch (the consumer champion for health and social care patients, service users and carers), in an effort to ensure strategic planning based on local health needs. They were also encouraged to engage providers in local decision-making processes, ideally as formal (although not statutory) Board members. The relevant sections of the HSCA are reproduced at Appendix A, highlighting that the primary intended role of HWBs was to encourage integrated working between commissioners of health and social care services in their respective areas (UK Parliament, 2012). In particular, they were expected to provide appropriate advice, assistance or support in making section 75 risk sharing arrangements in connection with the provision of such services. Local authorities and clinical commissioning groups (CCGs) also have statutory duties to develop Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs). These are the mechanisms by which HWB members are able to jointly plan and support delivery of improvements in the health and wellbeing of their local populations, although they have no executive powers to ensure the

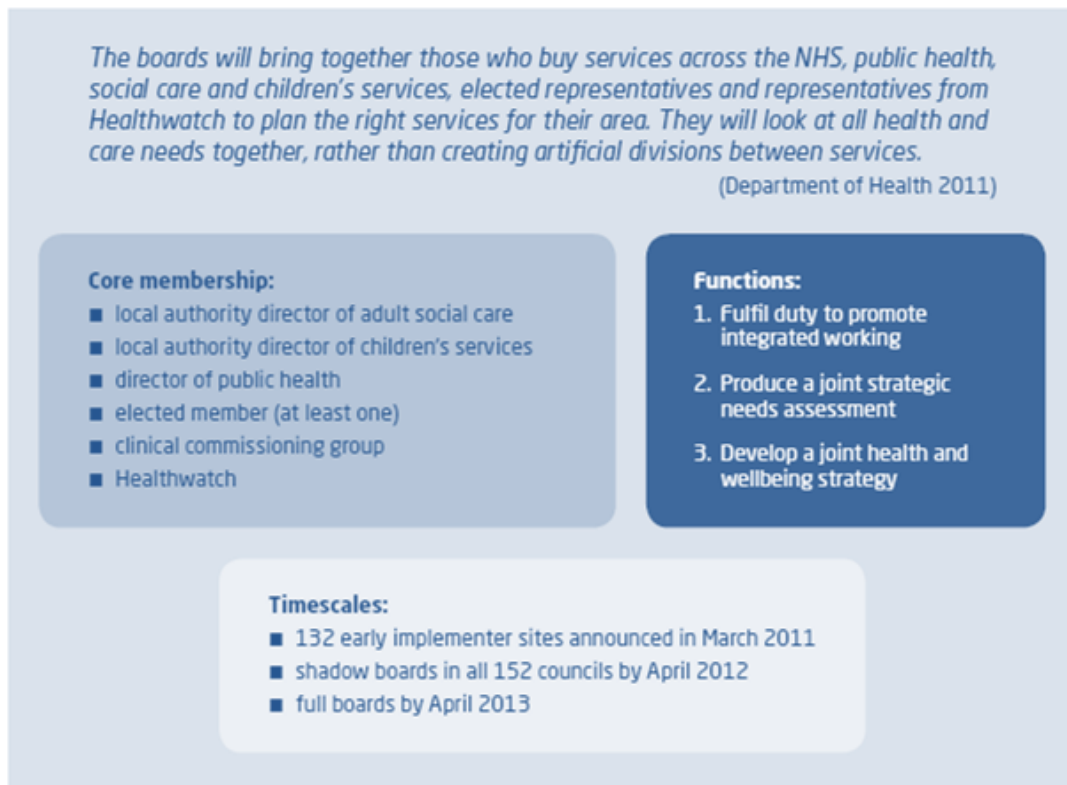
implementation of the JHWS (Rogers, 2012). For an overview of their core membership and functions see Figure 2.

Figure 1: The New Health and Care System in April 2013² (taken from Regional Voices, 2016)



² There have been a number of changes to this system since 2013; for example, Monitor no longer exists, while STPs and ACSs are in place in many areas (discussed below).

Figure 2: HWBs at a glance (Humphries and Galea, 2013, p.4)



HWBs became fully operational statutory bodies in April 2013, after existing in shadow form for almost two years. The hope was that they would take account of the lessons from previous partnerships and initiatives – notably, Local Strategic Partnerships, Local Area Agreements, Healthy Cities and Health Action Zones – and become different kinds of bodies able to secure sustainable change across a local area (see Box 1 for a summary of lessons). A King's Fund survey of 50 shadow boards highlighted potential tensions between the role of HWBs in overseeing commissioning on the one hand and in promoting integration across sectors on the other hand, alongside concerns that national policy imperatives would override locally agreed priorities (Humphries et al., 2012). The biggest anticipated challenge was whether HWBs would be able to deliver strong leadership across organisational boundaries and against a backdrop of existing structures and agendas. A follow-up survey suggested that local authorities had met this challenge (Humphries and Galea, 2013) although more recent work by researchers at Durham University and others suggests a more mixed view (Perkins and Hunter, 2014, Brown et al., 2016, Peckham et al., 2016). Early evidence also highlighted considerable heterogeneity in the configuration and operation of HWBs across England (Humphries and Galea, 2013). The fact that HWBs have statutory duties but no statutory powers suggests that their role is a 'soft' one, as brokers, enablers and catalysts for change (Miller et al., 2010). This led some observers to question whether

HWBs would become ‘talking shops’ as opposed to system leaders with real decision-making capacities (Humphries et al., 2012).

At the time of commencing the research described in this report, little was known about the relationships within HWBs, to what extent existing power structures had been reconfigured, how these factors influenced co-ordinated decision-making, and what impact they were having, if any, on health, wellbeing and health inequalities locally. Research was needed to evaluate whether HWBs in England were fulfilling their functions in line with policy objectives for public health reconfiguration, as well as identifying factors that helped or hindered in these efforts. In addition, there was a need to examine the extent to which HWBs had successfully discharged their duties to involve local people in decision-making as part of broader efforts to strengthen democratic legitimacy and enhance public involvement in health and social care (Regional Voices, 2016). This was one of the key features of *Equity and Excellence* (Department of Health, 2010).

There has also been an increased focus on integrated care, following the creation in June 2013 of a £3.8 billion pooled budget (known as the Better Care Fund (BCF)) across health and social care intended to improve integration (UK

Parliament, 2013). The NHS England *Five Year Forward View* (2014) and *Next Steps* (2017) strategy documents placed further emphasis on integration via new models of care (involving 50 Vanguard sites), Sustainability and Transformation Plans (subsequently renamed Sustainability and Transformation Partnerships (STPs) and, most recently, accountable care systems (ACSs). In order to deliver the STPs – which were intended to help drive transformation in health and care outcomes between 2016 and 2021 – NHS providers, CCGs, local authorities and others have come together to form 44 STP ‘footprints’. This adds a further layer of complexity to an already complex health and social care system, which provides the context for the work of HWBs in England and the research described here.

Box 1: Lessons from previous research on partnerships

- Policies and procedures need to be more streamlined – focus on outcomes not process and structure
- Those at higher strategic levels could learn from frontline practices which operate in a more organic and integrated way
- Partnerships in practice can be rather messy constructs
- Tendency to over-engineer partnerships, often to the exclusion of being clear about purpose and achievement
- Structures are less important than relational factors such as trust and goodwill
- Importance of leadership styles – collaborative, integrative and adaptive

(Hunter and Perkins 2014)

The challenge of system leadership

The policy intention is that HWBs will fulfil a system leadership function to drive change for improved health and wellbeing of the population. System leadership is collective and shared, involving leaders from across a system working collaboratively around a shared purpose to address complex, 'wicked' problems (Timmins, 2015, West et al., 2014). HWBs create the necessary structural conditions through which this can happen, creating the space for leaders from across the newly-reconfigured public health system to come together in a way that transcends organisations. However, effective system leadership relies on agency as well as structures; relationships of trust between members based on a coalition of shared versus siloed interests, a capacity to create the conditions for others to work collectively across a system and distribution of leadership for others to have autonomy to drive and enact change are key (Senge et al., 2015), in addition to individuals having the appropriate skill-sets to deliver this (Hulks et al. 2017). For HWBs, not least in the absence of any statutory powers, this 'soft' role of influencing, engaging and relationship building across the system is integral (Miller et al., 2010), if they are to 'turn their health and wellbeing strategies into reality' (Communities and Local Government Committee, 2013).

However, HWBs are likely to face a number of challenges in enacting such a role. System leadership requires having the capacity to overcome well-recognised challenges of the wider institutional environment to move away from competition to collaboration, focus on integration versus fragmentation and collectivism versus siloed hierarchical working (Hulks et al. 2017). Furthermore, as will be discussed later in the report (see page 77), system leadership was viewed by respondents in the study as a multi-faceted concept with different emphases on various aspects, including the elements of system leadership that were most important to ensure its success. A study of system leadership undertaken by the King's Fund (Timmins, 2015: 8, 9) also identified a number of common themes on system leadership echoed in our work including:

- It requires a conflicting combination of constancy of purpose and flexibility.
- It takes time – often a lot of time – to achieve results.
- It starts with a coalition of the willing.
- It is important to have stability of at least a core of the leadership team across those involved.
- System leadership is an act of persuasion that needs to have an evidence base for change – not least because that is the key tool for persuading the unconvinced.
- In most people's eyes, financial stringency has yet to lead to a fundamental acceptance that system working is key to the future of health and social care.
- The pressures of regulation, financial balance and organisational targets are still leading people and organisations to draw in their horns and 'hunker down' to survive, rather than seeing the way forward in terms of changes that will alter and, in some cases, downsize what their organisation does. Regulation, in particular, needs

to be reformed. All too often, the current system gets in the way of system change, and thus system leadership.

.For HWBs, there are likely challenges associated with working collectively across the boundaries of local authority, NHS, third sector and public stakeholders against a backdrop of wider institutional uncertainty, power hierarchies, diverse and fragmented directives and accountabilities and resource constraints in a climate of austerity, all of which carry the potential to undermine collaboration around a systems perspective and shared interest in population health and wellbeing. There are, therefore, questions to be addressed through the evaluation, regarding the extent to which HWBs are able to effectively fulfil their system leadership function, how and under what conditions.

Evaluation aim and objectives

The aim of this study was to evaluate how well HWBs in England function to extend democracy locally, facilitate collective decision-making, and promote integrated service provision to improve health and wellbeing and reduce health inequalities. It involved considering barriers to, and facilitators of, success and exploring in-depth the experiences and perspectives of HWB members in purposively selected case study sites.

The over-arching objectives of the evaluation were to:

- Describe the varied ways in which HWBs are configured and organised, considering key issues such as leadership, governance, membership and citizen involvement
- Analyse the nature of relationships between HWB members, key stakeholders from health and social care, service providers, Healthwatch and other lay interest groups
- Identify key political, institutional and organisational facilitators and barriers to effective leadership and action by HWBs for health improvement and tackling health inequalities
- Work with stakeholders to identify and disseminate examples of good practice for collective decision-making and integrated service provision to achieve health outcomes.

The intention was for the evaluation findings to inform future decision-making and action in relation to the creation of new partnerships, joined-up local services and delivering greater accountability to improve population health. A number of other relevant studies took place at or around the time of conducting this evaluation. These included: an NIHR School for Public Health Research project on prioritising investment in public health (lead: Hunter, Durham); a project funded by the Department of Health Policy Research Unit in Commissioning and the Healthcare System (PRUComm) on commissioning for health and wellbeing (lead: Peckham, Kent, with Hunter as an advisor); and a second Department of Health Policy Research Programme study on commissioning public health services (lead:

Marks, Durham, with Hunter and Visram as co-investigators). It was anticipated that the various projects would act as mutually informative pieces in the evidence jigsaw on the impact of the health reforms in England. We have made reference to these studies where appropriate in what follows.

Structure of the report

Chapter 2 provides an overview of relevant published and unpublished (grey) literature specifically in relation to HWBs, highlighting gaps in existing knowledge. Chapter 3 describes the overall research approach and specific methods employed to address these gaps and meet the aim and objectives set out above. Chapter 4 summarises key findings from the evaluation, which are described in detail in Chapters 4.1 to 4.5. These concern the changing context of HWBs, their purpose and structure, mechanisms, outcomes, and perceived future challenges and opportunities. The findings and their relevance to policy are discussed in detail in Chapter 5 and concludes the report by setting out a series of implications for future policy and practice, particularly in relation to future HWB development occurring in a rapidly changing policy context.

2. LITERATURE REVIEW

This chapter sets out the research context for the evaluation, with an emphasis on publications relating specifically to HWBs and similar partnership working arrangements. A systematic scoping review of the evidence was undertaken in 2015 as part of the evaluation (see Chapter 3) and the results are reported in detail elsewhere.³ This involved reviewing empirical and conceptual literature on: leadership and governance; extending democracy; collective decision-making; integrated service provision; and progress and outcomes in relation to HWBs. The review has been updated to include literature on HWBs published since 2015 and relevant findings are set out below. Emphasis was placed on locating papers describing primary research (e.g. surveys or qualitative studies involving HWB members) or secondary research (e.g. content analysis of key strategy documents).

Core HWB functions

HWBs have a duty to produce a JHWS that is informed by the JSNA and underpins joint working, leading to agreed commissioning priorities (Tomlinson et al., 2013). In some areas this includes a Joint Strategic Assets Assessment, reflecting a growing interest in capturing community assets as well as deficits (Boardman and Friedli, 2013, Foot and Hopkins, 2010). The choice of priorities in the JHWS should be based on evidence both of need and what works, and therefore HWBs require the knowledge and skills to balance conflicting demand and understand conflicting evidence. Beenstock *et al.* (2014) examined a random sample of one-third (n=47) of JHWSs produced by upper tier local authorities in England and found that, most often, 'evidence' was used to mean 'evidence of need'. This was usually identified through the JSNA and appeared to be locally gathered intelligence, rather than from a national source of research evidence or intelligence. Most strategies referred to JSNAs, with some making explicit links between their JSNA and JHWS. However, two strategies did not make any reference to their JSNAs. A more recent study, involving an online survey of Directors of Public Health (DsPH, n=65), found that only half (48%) felt the HWB was 'definitely' instrumental in identifying the main health and wellbeing priorities in their local patch (Gadsby et al., 2017). Some HWBs were seen as not engaging significantly with the public health agenda, having focused instead on health and social care integration.

Similar studies have been undertaken by organisations looking at the presence or absence in JHWSs of specific priorities, such as HIV, diabetes or social isolation (Cupitt, 2013, Diabetes UK and Novo Nordisk, 2013, Evans et al., 2013, Scrutton, 2013). The Terrence Higgins Trust conducted an analysis of JSNAs and draft or final JHWSs produced by 35 local authorities identified as having relatively high levels of HIV diagnosis and high levels of late diagnosis (Evans et al., 2013). Only 34% prioritised HIV in both documents and just over half of JHWSs

³ To download the report, go to: <https://www.dur.ac.uk/public.health/projects/current/prphwbs/output/>.

did not include HIV as a priority, despite 83% of JSNAs recommending HIV priority actions. Research conducted as part of the Campaign to End Loneliness found that around half of the JHWSs located (n=61 of 128) mentioned loneliness, but only eight were deemed to be 'gold-rated', i.e. containing measurable actions and/or targets on reducing loneliness (Cupitt, 2013). This was in spite of efforts to influence HWBs through the 'Loneliness Harms Health' campaign, which sought to get HWBs to measure loneliness in JSNAs and commit to taking action to reduce loneliness in older people in their JHWSs. These studies demonstrate that JHWSs' content tends to be variable in terms of the links made to evidence from JSNAs and other sources. Instead, a number of HWBs have used policy objectives from the Marmot Review (Marmot, 2010) to drive their JHWSs and ensure a collective focus on inequalities and the wider determinants of health (Boardman and Friedli, 2013, Humphries and Galea, 2013). Beenstock *et al.* (2014) found that the Marmot Report was the most referred to national source of evidence, being cited as justification for proposals in 19 of the 47 strategies. This finding is reinforced by a recent review of JHWSs produced by the 12 local authorities in North East England (Learmonth *et al.*, 2017). Marmot's strategic priorities were referenced by eight (of 12) local authorities, with three using them to frame their entire JHWS. There was considerable consensus in terms of the main priority issues identified: 'children to have the best start in life' (12/12) and 'early death/life expectancy/inequalities' (11/12).

HWB composition and configuration

Findings from previous studies highlight considerable heterogeneity in the configuration and operation of HWBs across England. A 2013 survey conducted by the King's Fund found that, of the 70 boards that responded, two-thirds had 12 or more members and a similar proportion had a composition beyond the core membership prescribed in the HSCA (Humphries and Galea, 2013). The survey also indicated that local authorities had shown strong leadership in establishing the boards, with most (83%) being chaired by a senior elected member, and nearly all having produced JSNAs and JHWSs. This contrasts with the findings of a national study on prioritising investment in public health which suggested that, although HWBs were seen as offering the potential for a more holistic and joined-up approach to decision-making, questions were raised as to whether they offered anything new (Brown *et al.*, 2016). This study identified perceived tensions around provider membership of the boards, and the King's Fund survey also highlighted differences in the level of engagement between HWBs and local providers (Humphries and Galea, 2013). This is associated with commissioners having to make difficult decisions about their priorities and potentially cutting or withdrawing funding from some services. These decisions have been implemented through contracting processes, which include performance management of providers, thereby creating serious consequences for partnership relationships between commissioners and providers on the HWB (Staite and Miller, 2011).

Participating in HWB meetings is not the only way in which stakeholders may be involved in decision-making processes. In fact, placing too much emphasis on formal meetings has been found to be a common feature of less effective HWBs. Research undertaken by Shared Intelligence (2016b) on behalf of the Local Government Association (LGA) suggests that drivers of effectiveness include boards meeting in a variety of settings, adopting formal and informal meeting formats, and making use of workshops. This is supported by the 2013 King's Fund survey, which demonstrated that the main ways in which successful engagement tended to occur was through partnership groups, provider forums and specific workshops where priorities were discussed (Humphries and Galea, 2013). A number of localities have implemented wider partnerships for wellbeing that include a range of providers, VCF organisations and representatives of local communities (Boardman and Friedli, 2013). Local authorities have tended to have structured community engagement embedded within their organisational culture, as well as having a longer history of competitive tendering and service commissioning than the NHS. As a result, the health reforms have prompted broader changes in public health commissioning and in relationships between commissioners, practitioners and providers. These issues were explored in a 2014 survey of DsPH (n=96), which found that, in areas where HWBs were perceived as instrumental in identifying health priorities, it was more likely that new services had been set up and that providers of existing services had been changed (Jenkins et al., 2016).

Opportunities and challenges

There was a great deal of initial optimism around the potential for HWBs to achieve health improvement through the integration of public health with health and social care, and through the development of place-based approaches to health improvement (Boardman and Friedli, 2013, Colin-Thome and Fisher, 2013). However, this integration posed a tension and a challenge due to the risk of public health being eclipsed by the focus on social care (Perkins and Hunter, 2014, Gadsby et al., 2017). There was also a perceived danger that HWBs could become expensive 'talking shops' rather than system leaders and that failure might result from a narrow focus on a small number of clinically-driven priorities (Humphries et al., 2012). At the same time, they had the potential to take on a wider role and create the conditions required for producing better health at lower cost, as set out in Wanless's vision of a 'fully engaged scenario' (Wanless, 2004). A study consisting of a systematic review and case studies conducted across England revealed a range of issues concerning similar partnerships and their operation in the public health sphere (Hunter et al., 2011, Smith et al., 2009). See table 1 below. These included the need for clarity of objectives, roles and responsibilities, and good working relationships between partners.

Although a succession of policy initiatives has promoted partnership working, the literature highlights a lack of evidence to support the effectiveness of partnerships for health improvement (Hunter and Perkins, 2012, Hunter et al., 2011). Existing power relationships

tend to be left intact, with partnerships usually dominated by the more powerful partners and failing to 'deliver' for others (Hunter and Perkins, 2014, Balloch and Taylor, 2001, Secker and Hill, 2001). This risk exists for HWBs, along with the risk of failure to achieve a shared vision, reluctance or inability to share information, and a lack of effective leadership across boundaries. Professional structures and diverse, inconsistent policy imperatives at the institutional level pose challenges for the realisation of objectives for integrated working across organisations (Currie et al., 2008, Finn et al., 2010). In recent years there has been a 'backlash' against the ill-defined concept of partnership that has been seen as a solution to all problems, with little evidence of concrete outcomes (Kingsnorth, 2013). On the other hand, partnerships remain a potentially powerful way of increasing accountability and inclusivity, and addressing the kinds of 'wicked issues' that single organisations cannot resolve by themselves (Wildridge et al., 2004, Hunter et al., 2010, South et al., 2014). The challenge for HWBs is to find ways to work with the multiple institutional, policy and cultural factors that both threaten their success but which may also secure it if effective working practices can be established and sustained.

Table 1: Factors influencing partnerships in public health

Determinants of successful partnerships	Barriers to effective partnership working
Clarity regarding the goals and objectives of the partnership	Conflicting agency priorities negate or limit the potential of the partnership
Clarity regarding roles and responsibilities within the partnership	Good information-sharing protocols not in place
A clear strategic overview of performance through robust monitoring and evaluation	Lacking vertical as well as horizontal linkages, i.e. absence of ownership
The existence of goodwill and trust between partners, particularly at the frontline level	Bureaucracy, making it easy to get 'bogged down' with process issues
	Too many initiatives, targets, policies and reorganisations from central government

A qualitative study conducted in one London borough set out to explore the transfer of public health responsibilities to local authorities and the implications for health and wellbeing through partnership working (Kingsnorth, 2013). The local HWB was seen by interviewees as central to ensuring commitment to and delivery of a partnership approach to health and wellbeing, but there was some uncertainty as to whether it was developing with an appropriately broad understanding of health and wellbeing. There remained a general concern that HWBs could become preoccupied by the integrated care agenda and therefore their impact on public health could be lost. There were also felt to be challenges posed by the fact that elements of the public health skill-set are defined through clinical

competencies, whereas the local government skill-set is defined through management competencies. A recent study by Greaves and McCafferty (2017) on public health decision-making found that HWB members sought consistency with the mandate or strategy of the board and its partners, rather than relying solely on wider public health decision-making criteria. These findings highlight the importance of trust and relational factors being more important than structures and processes, as demonstrated in previous research on partnerships in public health (Perkins and Hunter, 2014, Hunter and Perkins, 2012). The HWB needs to be at the centre of wider engagement with a range of stakeholders about the local vision for health and wellbeing. Guidance produced by the LGA emphasises the importance of HWBs being agents of change and having clear strategies for communication and engagement with a range of stakeholders, including the public (LGA, 2013, LGA and NHSCC, 2015, LGA, 2014). HWBs must perform an important hub function – bringing together key players to have conversations that lead to decisions and action – and also act as the fulcrum around which things happen (Shared Intelligence, 2015).

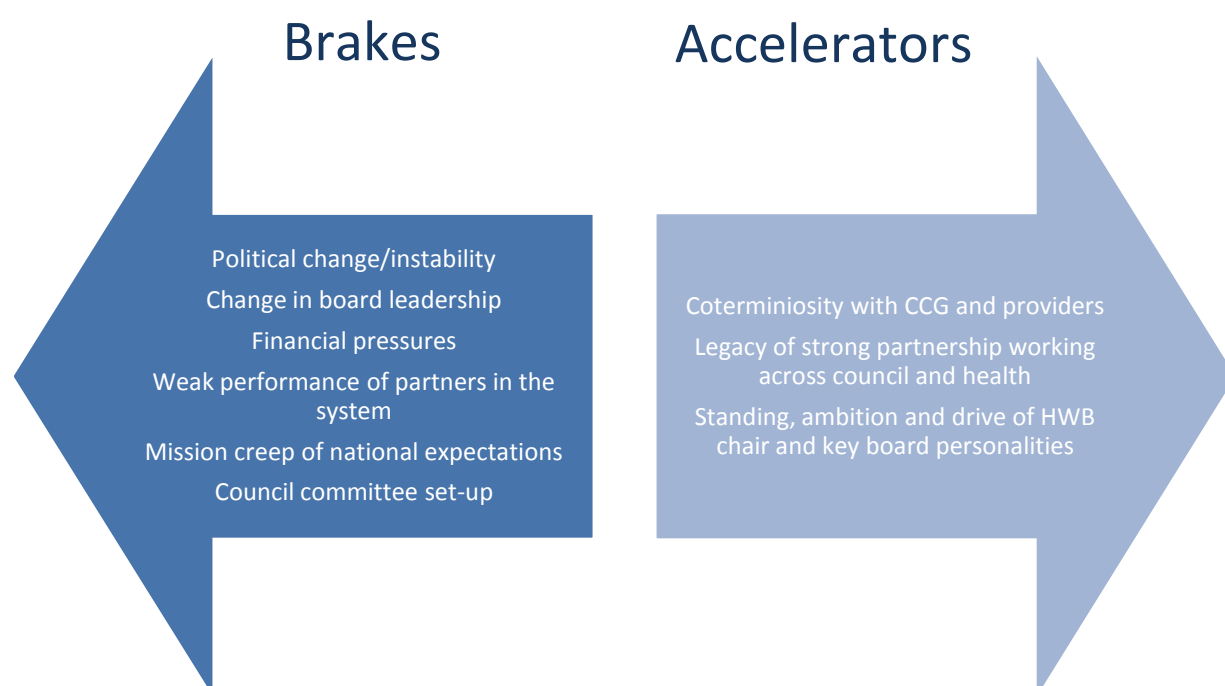
Progress and outcomes

The findings from a series of research projects commissioned by the LGA suggest that most HWBs have addressed the challenges set out above with variable success (Shared Intelligence, 2013, 2014, 2015, 2016b, 2017). The 2015 study drew on evidence from a range of sources, including six in-depth case studies and telephone interviews with 16 HWB chairs and vice-chairs across England. It suggested that widespread progress was being made across some common themes: building relationships between board members; using development sessions or informal meetings to clarify priorities; developing sub-structures and working groups to support the HWB; and using the BCF to provide a focus for their efforts. However, progress was slower than widely anticipated and many HWBs were still some way off driving the big issues. Frustration existed within and outside the boards, locally and nationally. A study conducted at a similar time in London also found that the majority of members described their local HWB as being on a journey, with very few claiming that the board was fulfilling its potential (London Councils, 2015). HWB chairs had the single biggest influence over a board's focus and tone, and the status of HWBs as council committees was seen as one of the main challenges. There was some evidence of added value on specific issues, such as instigating a review of access to primary care and establishing a Black Health and Wellbeing Commission, but little evidence of HWBs providing genuine systems leadership across the piece.

In 2015, many boards were yet to position themselves as the key strategic forum for driving the health and wellbeing agenda (Shared Intelligence, 2015). A number of factors that tend to sit outside the immediate control of the HWB were identified as having an impact on progress. See figure 3 below for an illustration. Despite the apparent lack of progress, HWB members and other stakeholders were said to be cautiously optimistic (Shared Intelligence, 2015). It was generally acknowledged that HWBs had an important role to play in creating

the conditions in which discussions can take place between councils, CCGs and service providers on the future shape of local health and social care systems (London Councils, 2015). The minority of HWBs identified as being ‘ahead of the curve’ were characterised by their ability to look beyond tackling immediate problems in the system and keep a focus on the bigger picture (Shared Intelligence, 2015). In London, the more effective HWBs had created forums for open and honest debate, either by ensuring board meetings were planned and managed differently to other council committee meetings or, more often, by creating alternative opportunities for members to meet in informal settings; for example, sub-groups, chair’s briefing meetings or development days (London Councils, 2015). Small changes, such as not using council headed paper for board papers, made a difference. The national studies by Shared Intelligence (2015, 2016b, 2016a) have resulted in the identification of key features of a successful HWB. See table 2 on the following page.

Figure 3: Factors impacting on HWB progress (Shared Intelligence, 2015, p.19)



By 2016, a number of HWBs were described as considerably more effective than they were the previous year and starting to play a role across local health and care systems (Shared Intelligence, 2016b). However, these boards were believed to be in the minority; although examples of impact were given, the majority were still described as “some way off driving the big issues”. A prior history of partnership working and the complexity of the local context were identified as key factors in the success or otherwise of HWBs. These findings came from research involving interviews with 23 local and national stakeholders, plus observations, workshops and documentary reviews. STPs were in the early stages of

development at this point but were felt to represent the emergence of “a more muscular, top-down approach by NHS England” (Shared Intelligence, 2016b, p.2). They created concerns for members of even the most effective boards, with fears that NHS partners would respond “to the strength of national rather than local accountability” (p.9). Devolution was also beginning to pose a number of challenges as well as opportunities.

Table 2: Attributes of an effective HWB (Shared Intelligence, 2016b, p.11)

Key attributes	Key actions
Evident passion and ambition	Recognises the need for fundamental change to health and care system e.g. has ambitious BCF and plans for future
Enthusiasm, drive and leadership – notably, but not solely, from board chair	The council leader and chief executive pay attention to the board and there is either a CCG co-chair or a senior councillor and CCG representative act as co-chairs
Demonstrates positive behaviours	Has refreshed priorities which align clearly with council, CCG and other relevant plans
Strong foundation of partnership working	Has developed a narrative and road map for change setting out how system can move from where it is now to where it needs to be and which can help staff, providers, partners and the community
Trust, respect and genuine collaboration across board and with key external stakeholders	Invests in new ways of working e.g. uses developmental sessions to develop trust and collaboration, operates as a board not a council committee
Open to learning and challenge – self aware	Has developed a coherent radical strategy which underpins an integrated approach to commissioning
A geography that works or has been made to work	Has pragmatic and effective approach to engagement of providers (for e.g. provider forums, provider engagement in sub structures, providers on board)
Committed to engaging with local people and communities	

Shared understanding of how board fits with other structures e.g. scrutiny	The board has a shared understanding of the role of providers in delivering change
The HWB is more than a meeting	<p>The board acts as a hub (bringing people together) and a fulcrum (a point around which things happen)</p> <p>Ensures effective engagement with the public is everyone's business and local Healthwatch is building on networks to increase engagement and visibility</p>

The most recent Shared Intelligence study, published in April 2017, involved interviews with 19 local and national stakeholders, plus observations, workshops and documentary reviews (Shared Intelligence, 2017). By this point, many HWB members were playing a bigger role in the STP process but interviewees still felt that there had been a lack of any substantial local political input. Often the formal involvement of HWBs centred on signing off the plan, reducing the role of the board to one of 'rubberstamping' reports. In this context, which also involved financial and operational pressures faced by many HWB partners, the study authors identify five factors considered to be important drivers of effective HWBs:

- A focus on place
- Committee leadership
- Collaborative plumbing
- A geography that works (or making the geography work)
- A Director of Public Health who 'gets it'

They suggest that a number of boards are now focusing on the wider determinants of health and exercising place-based leadership (Shared Intelligence, 2017). This is in contrast with the results of a 2015 survey, where only 28% of DsPH felt their HWB had definitely begun to address the wider determinants and less than 5% felt that it was definitely making difficult decisions (Gadsby et al., 2017). The most recent Shared Intelligence report states that a focus on place is the defining characteristic of the most effective HWBs, although it is not clear how effectiveness has been defined in their research or how effective HWBs have been identified (Shared Intelligence, 2017, 2016a)). The report ends with top tips for HWBs, which include devoting time and effort to partnership development, ensuring that the board has a genuinely shared strategy and action plan, reviewing membership of the board as it evolves, and holding a reflective session at least once a year. A key recommendation

involves thinking about the HWB “as being the centre of a network rather than just a meeting” (p. 12).

This chapter highlights that the existing evidence base relating to HWBs is limited and that published literature on this topic tends to be descriptive rather than evaluative. The Shared Intelligence reports provide some indication of progress made to date, as well as identifying key drivers and challenges, but are based on research involving unspecified numbers of HWBs. The sampling criteria for these studies are not known and the reports contain scant description of the methods used to generate relevant data. There is therefore a need for in-depth, robust research that evaluates the success or otherwise of HWBs across England in bringing partners together to improve health and wellbeing and reduce health inequalities. There is also a need to further explore key issues identified in previous studies, such as: the role of HWBs in priority-setting and decision-making, including the use of evidence in these processes; heterogeneity in the configuration of HWBs, particularly the involvement of providers and the balance of informal and formal engagement mechanisms; whether lessons have been learned from previous partnerships; and factors that help or hinder the efforts of HWBs in providing effective leadership across boundaries.

3. METHODS

This chapter describes the methods used to generate and analyse data in order to address the evaluation aim and objectives set out in Chapter 1. It also provides details of key ethical considerations and how these have been addressed during the project, as well techniques used to ensure public and user engagement and involvement in the research.

Evaluation design

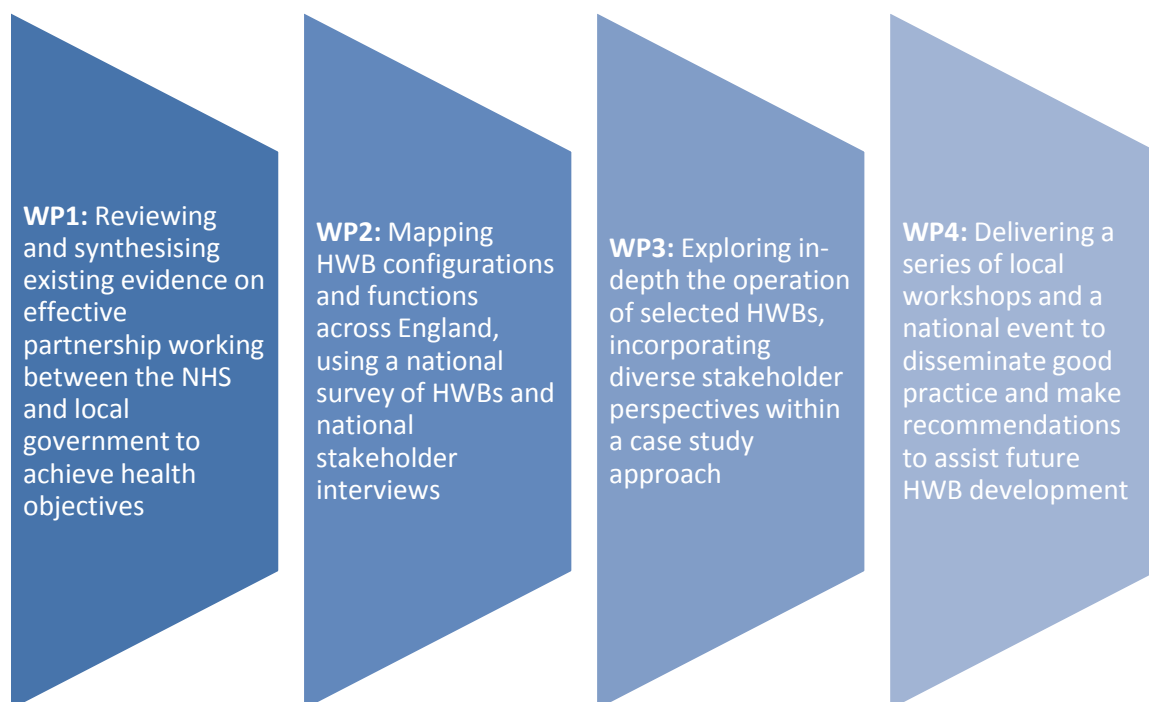
The overall programme of work described in this report was informed by the principles of a realist evaluation approach, which involves understanding the crucial mechanisms of an intervention, service development or policy, and the conditions under which they operate to produce specific outcomes (Pawson and Tilley, 1997). This approach was deemed suitable for use in the present evaluation as the emphasis was largely on understanding the local contexts, conditions and mechanisms through which HWBs can successfully work in partnership with a range of stakeholders to facilitate health and wellbeing improvement. Rather than asking “Does the intervention or policy work?”, a realist evaluation involves asking “What works, for whom, and under what circumstances?”. Pawson and Tilley (1997) describe this as the context-mechanism-outcome (CMO) framework. A realist evaluation would usually involve exploring how various CMO configurations play out in an intervention, service or policy, as part of a process of developing, testing and refining a series of programme theories (Blamey and Mackenzie, 2007). However, within the CMO framework many issues and factors will almost certainly influence the context, mechanisms and outcomes of a particular policy. As Pawson (2013: 26) notes: *“Programmes do not come in pre-ordained chunks called contexts, mechanisms and outcomes”*. We therefore consider that the different aspects or issues influencing a policy or programme, such as the strength of relationships between actors, may impact on all three stages of the CMO framework. As Greenhalgh et al (2009: 413) argue in their study utilising realist evaluation methodology on modernising the health service: *“...drawing realist conclusions about the generative causality of particular context-mechanism-outcome alignments is not a logical-deductive exercise. Rather, it is an interpretive task and will be achieved only through much negotiation and contestation”*. In the evaluation reported on here, this has involved identifying contextual factors at the local and national levels that are perceived to impact on the intended role of HWBs as system leaders, as well as examining the mechanisms through which they seek to achieve public health policy objectives.

A complex systems perspective has also been employed in recognition that contemporary health and social issues are increasingly described as complex or ‘wicked’ problems that are deeply embedded in the fabric of society (Hunter et al., 2010). Complex systems thinking recognises the importance of understanding context and both multi-level (local, regional,

national, international) and multi-sector (health, education, housing, leisure) initiatives that bridge science, policy and action (Seddon, 2008). In this evaluation, systems thinking took into account the fact that complex adaptive systems (in this case, HWBs) are dynamic entities that evolve and adapt in the light of changing circumstances and in ways that may be unforeseen and unpredictable (Plsek and Greenhalgh, 2001, DeSavigny and Adam, 2009). Key insights and lessons learned are highlighted in subsequent chapters in terms of HWBs that offer opportunities to create effective partnerships, join up local health and social care services, and deliver greater accountability to improve population health and wellbeing.

The evaluation aims and objectives have been met through four sequential but overlapping work packages (WPs), which are illustrated by figure 4 below. These involve: a scoping review of existing evidence (WP1); a national survey, supplemented by interviews with national stakeholders conducted at two time points (WP2); in-depth case study research in selected HWBs (WP3); and a series of events delivered to share learning and disseminate good practice (WP4). The specific aims, research questions, methods and analytical techniques employed in each work package are described in turn below.

Figure 4: Evaluation design



Work package 1: Scoping review of existing evidence

Review aim and questions

The aim of WP1 was to examine the existing evidence base relating to HWBs and similar partnership arrangements, with a particular focus on system leadership, public participation, collective decision-making and integrated service provision. The review questions are shown in box 2. This work built on a previous systematic review of the impact of organisational partnerships on public health outcomes in England between 1997 and 2008, undertaken by Hunter and colleagues (Smith et al., 2009). Our scoping review focused primarily on literature published from 2008 onwards.

Design

A time-limited (three-month) scoping review was initially conducted, following guidance on conducting rapid evidence assessments (REAs). REAs provide an assessment of what is already known about a policy or practice issue, using systematic review methods to search and critically appraise existing research (Government Social Research Service, unknown). They aim to be rigorous and explicit in method, but make concessions to breadth or depth by limiting particular aspects of the review process. In this review, limits were placed on the following stages:

- Searching – using a short search string
- Screening – conducted by a single reviewer
- Data extraction – extracting only on key findings
- Quality appraisal – no formal appraisal

We adopted a broad and inclusive approach to reviewing commentaries, editorials, theoretical papers and research articles exploring partnership working for health improvement between NHS and local government partners in any UK setting and for any duration. Partnership working in this context was defined as individuals, agencies or organisations from different sectors working to achieve shared goals in relation to

Box 2: WP1 review questions

- What evidence is available in relation to previous and existing arrangements for partnership working between NHS and local government bodies?
- What are the relative strengths and weaknesses of the various models in terms of working collaboratively to achieve health and wellbeing outcomes?
- Who are the main leaders in collaborative decision-making and what challenges do they experience in attempting to fulfil their leadership roles?
- Which leadership styles are most effective in working across boundaries and developing whole-system approaches and solutions?
- What other factors (for example, local and national political priorities) impact on any differences in effectiveness, acceptability and sustainability of partnerships?

improving health and/or reducing health inequalities. There was a particular focus on locating published and grey literature on the creation, operation and impact to date of HWBs in England.

Methods and analysis

Searches of major bibliographic databases – CINAHL, EMBASE, MEDLINE and Web of Science – were conducted by two researchers (Visram and Brown, a freelance researcher). Searches of the internet were also conducted using Google to locate grey literature. Specific search strategies were employed for each database, involving combinations of the following key terms: partnership, health, health improvement, NHS/National Health Service, local government/authority, and social care. One team member (Finn) conducted separate searches specifically on the subject of leadership models in health.

After conducting each search, the results were exported into a database using EndNote 7 software and duplicates were automatically removed. Study titles were scanned (by Visram) to make an initial assessment of relevance. In cases where there was any doubt, abstracts were retrieved in order to make a further judgement. PDFs of all references included after the title and abstract screening stage were uploaded to a dedicated Dropbox folder. All team members assisted in identifying additional literature through their contacts and networks, and uploaded relevant files to Dropbox, which were then added to the EndNote database. Given the time constraints and the relatively small number of articles located, no formal quality appraisal or data abstraction was undertaken.

All publications that met the inclusion criteria were descriptively summarised and analysed in a narrative synthesis, with elements of realist synthesis used to explore what works, for whom, in what settings (Pawson et al., 2005). Narrative synthesis relies primarily on the use of text rather than statistics to ‘tell the story’ of the findings from the papers included in a systematic review (Popay et al., 2006). It is often used to increase the chances of the review findings being used in policy and practice, and was therefore deemed appropriate for use in the present study. The review methods and findings were detailed in an interim report submitted to the Department of Health and published on the project website in May 2015⁴. The review has been updated periodically over the course of the evaluation and summarised in Chapter 2 of this report. The findings also informed the development of the sampling framework used in selecting case study sites in WP3 (see below).

Work package 2: Mapping partnership working arrangements

Aim and questions

The aim of WP2 was to map current partnership working arrangements between NHS, local government and third sector partners – specifically in terms of the configuration and

⁴ To download the report, go to: <https://www.dur.ac.uk/public.health/projects/current/prphwbs/output/>.

operation of HWBs – across England. The research questions addressed during WP2 are shown in box 3 on the following page.

Study design

A survey was conducted to gather evidence on the organisational arrangements, form and function of HWBs and to identify their priorities, challenges and successes. This method builds on previous survey work undertaken by the King's Fund (Humphries and Galea, 2013, Humphries et al., 2012). A number of national stakeholder interviews were also conducted to understand the complexity of HWBs and the ongoing policy flux at a national level. The interviews were central to the realist evaluation approach, as they aimed to understand the wider policy context, the objectives and expectations of policy in this area, and whether and how policy-makers used partnership as a policy instrument to achieve policy objectives. The survey and initial interviews were conducted between June and September 2015⁵, and follow-up interviews were conducted between January and February 2017 to explore changes over time. By using the two methods in combination, the study design for WP2 incorporated both cross-sectional and longitudinal elements.

Box 3: WP2 research questions

- How are HWBs operating to fulfil their stated brief or local objectives, and how does this compare with the brief set out in Department of Health policy?
- What factors or conditions impact on differences in the configuration and operation of HWBs across the country? In other words, how do local contexts shape the translation of national policy?
- In what ways has the creation of HWBs changed working relationships at a local level?
- What factors facilitate effective partnership working to improve health and wellbeing?
- Have any improvements in outcomes or process measures in relation to health and wellbeing been identified since the creation of HWBs?

Data collection

The survey was developed in collaboration with team members and the external advisory group (EAG, described below), based on insights gathered from WP1. It was then piloted with three HWB members – a director of public health, a local authority partnerships manager and a corporate policy and improvement manager – from different local authorities in the North East. The survey was amended based on the feedback received and the online version was developed using the Bristol Online Surveys platform. The final version included questions on: composition and organisation of the board, including issues relating to membership, leadership and governance; priorities of the board; relationships with service providers and other local partners; barriers and enabling factors; and any

⁵ One interview took place in November 2015 and was therefore not included in the previous interim report.

progress to date. A copy of the questions is provided at Appendix B. Invitations to participate in the survey were sent by email to chairs of all HWBs in England (n=150), with two reminders sent at one month intervals between July and September 2015. Invitations were also sent to all directors of public health (n=135) in an effort to generate a higher response rate. In total, responses were received from representatives of 28 different HWBs (a response rate of 19%).

Initial one-to-one interviews were conducted with key individuals involved nationally in the development and implementation of policy around the introduction of HWBs and the transfer of public health responsibilities to local authorities. Interviewees (n=13) were identified using a purposive sampling approach to ensure representation from key organisations involved in decision-making in relation to health and wellbeing nationally, such as the Department of Health, Public Health England and LGA. See table 3 below for an overview of the interview sample. The interviews were conducted by telephone (n=11) or in person (n=2), using the interview schedule shown at Appendix C. The schedule was used to explore why policy was developed in this area, what HWBs were intended to achieve, and whether and how previous research around partnership working was taken into account. All participants were invited to take part in a follow-up interview around 18 months after the initial interviews took place; seven agreed to take part, while others declined, did not respond or had changed roles and were non-contactable. These follow-up interviews were conducted by telephone. The follow-up interview schedule is shown at Appendix D.

Table 3: National stakeholder interview sample

Characteristics	Initial interviews	Follow-up interviews
Organisation ⁶ :		
Department of Health	4	3
Public Health England	2	1
Local authority	2	1
Clinical commissioning group (CCG)	1	0
Local Government Association (LGA)	1	1
Association of Directors of Public Health (ADPH)	1	1
National Institute of Health and Care Excellence (NICE)	1	0

⁶ The interviewee's host organisation at the time when HWBs were being developed and implemented.

Regional Voices	1	0
Gender:		
Male	9	6
Female	4	1
Total	13	7

Data analysis

Responses to closed survey questions were analysed in Microsoft Excel and descriptive statistics were produced, where appropriate. Responses to open-ended questions were exported to NVivo v.10 qualitative analysis software for coding under the main sub-headings used within the survey.

Interviews were digitally recorded and transcribed verbatim by a professional transcribing company. Transcripts were uploaded to NVivo v.10 for analysis and coded using a framework developed by the team based on the findings of WP1 and the principles of a realistic evaluation approach (i.e. focusing on contexts, mechanisms and outcomes). The full survey results and initial interview findings were detailed in an interim report submitted to the Department of Health and published on the project website in November 2015.⁷ The findings informed the sampling framework and data collection tools used in WP3, and have also been incorporated into subsequent chapters of this report.

⁷ To download the report, go to: <https://www.dur.ac.uk/public.health/projects/current/prphwbs/output/>.

Work package 3: In-depth case studies

Aims and questions

The aims of WP3 were to explore in-depth the configuration, operation and perceived impact of purposively selected HWBs, and to explore stakeholder experiences and perspectives on the process of working in partnership as members of HWBs or as key local partners. The research questions addressed in WP3, which were consistent with the CMO framework associated with realist evaluation, are shown in box 4.

Study design and settings

A comparative case study design was employed, in order to maximise explanatory power by elucidating key factors associated with similarity and variation across case study sites (Yin, 2008). The intention was to select six contrasting local authority areas, ensuring diversity according to pertinent features highlighted through WP1 and WP2 and through discussions with the EAG members. Sampling criteria included geographic location, political affiliation, type of authority, urban/rural setting, population size, and whether or not they were an integrated care pioneer. It was felt important to avoid sites involved in related studies, including the DH PRP-funded project led by Linda Marks at Durham University⁸ (Hunter and Visram were co-investigators).

Box 4: WP3 research questions

- What form do decisions take in the context of HWBs? What are the barriers and facilitators to enhanced collective decision-making, and how is evidence used in this process?
- Are HWBs viewed positively by key actors, particularly in terms of relationships, leadership, governance and accountability?
- How successful has reconfiguration been in shifting power in order to meet policy objectives for health improvement and reduced inequalities? Are HWBs extending democracy?
- How are HWBs using the outcomes frameworks to inform local priorities, joint strategic needs assessments, and health and wellbeing strategies?
- Are HWBs leading to more integrated service provision between health and social care?
- Have any improvements in outcomes or process measures in relation to health and wellbeing been identified since the creation of HWBs?

⁸ Further information on the Commissioning Public Health Services (CPHS) study can be found on the project webpages: <https://www.dur.ac.uk/public.health/projects/current/cphs/>.

Invitations were sent to 27 local authorities and 21 declined to take part, for reasons that included time/workload pressures, having recently completed the LGA peer review process, and being in a period of significant transition (for example, merger with a neighbouring authority). No response was received from one local authority, despite repeated reminders being sent. Significant time and effort was expended on trying, without success, to recruit a London-based site and/or a Conservative-led authority. The process of site selection commenced in October 2015 and was completed by the end of October 2016, at which point five local authorities had agreed to be part of the study. Key features of these sites (at the time of conducting our fieldwork) are shown in table 4, highlighting the degree of heterogeneity achieved across a number of the main selection criteria.

Table 4: Case study sites

Characteristics	Details	No. of sites
Region	North East	1
	North West	1
	East Midlands	1
	West Midlands	1
	South West	1
Type of authority	County council	1
	Metropolitan council ⁹	2
	Unitary authority	2
Political control	Labour	3
	No overall control ¹⁰	2
Geography	Rural	1
	Urban	4
Population size	Under 300,000	2
	Over 300,000	3
Number of CCGs	Single	2

⁹ One metropolitan district and one metropolitan borough council.

¹⁰ One Labour majority (previously Liberal Democrat) and one Conservative (previously Labour-led).

	Multiple	3
Integrated care pioneer	Yes	1
	No	4
Participated in LGA peer review	Yes	2
	No	3

Data collection

The following methods were employed to address the WP3 research questions:

- i) Semi-structured interviews with between 10 and 15 key informants per site to explore: their experiences of partnership working, collaborative decision-making and/or integrated service provision; their views on the impact of the HWB in terms of improving the health of the local population and tackling inequalities; and any factors perceived to help or hinder in achieving these outcomes.
- ii) Non-participant observation of HWB meetings to determine how each board operated, what form discussions took, how important decisions were made, and where power appeared to lie within the system (particularly in relation to whether or not the views of local citizens were considered).
- iii) Documentary analysis of relevant publications including the JSNA, JHWS, the Director of Public Health's annual report, and the Council's annual report and business plan, in an effort to assess whether any improvements in health outcomes or process measures could be attributed to the HWB and whether resources were being spent with greater efficiency since the implementation of the board.
- iv) Focus group discussions in each site involving representatives of selected voluntary, community and faith (VCF) sector organisations (n=20 interviewees), to explore their views on the local HWB and its mechanisms for engaging local citizens. Further detail is provided below in the section on public and user involvement.

Core HWB members in each case study site were approached and invited to take part in the study; these included the HWB chair/elected member(s), vice chair/CCG lead(s), director of public health, adult social care and children's services lead(s) and local Healthwatch representative. Other key local partners – primarily representatives of VCF infrastructure organisations and NHS providers – were identified through our discussions with HWB members (i.e. a form of snowball sampling) and invited to participate in interviews.

In total, 57 initial interviews were conducted across the five case study sites between October 2015 and August 2016. See table 5 for details. Where possible, interviews were

carried out in person, (n=36) although several took place by phone by mutual agreement (n=21). Follow-up interviews (n=22) were conducted with selected key informants to examine whether and how the role and function of each HWB had changed over time. These interviews took place by phone (n=11), or in person (n=11), between November 2016 and February 2017, and are detailed in table 6. These interviews proved very informative in terms of illuminating the changing policy context and, in particular, the impact of STPs on HWBs. The initial and follow-up interview schedules are shown at Appendices E and F.

Data analysis

The interviews and focus groups were audio-recorded (with participants' written consent), transcribed and analysed thematically in conjunction with relevant data extracted from the observation notes and documentary review. The interview schedules were devised and agreed by the whole team, and NVivo v.10 qualitative analysis software was used to systematically organise and index materials around a CMO coding framework (developed by Perkins and agreed by all team members; see Appendix H for example). Visual and diagrammatic methods were used alongside text-based methods to assist in mapping local configurations and roles in HWBs. This process took place during five one day workshops involving all members of the research team to undertake analysis of one case study site per workshop. Analysis was first conducted at a 'within-case' level to integrate and triangulate data in order to holistically describe the composition and function of the HWB within each site (Yin, 2008). Cross-case and longitudinal comparisons were then conducted across the sites to illuminate key contextual factors that shape the likely impact of HWBs as system leaders in facilitating health improvement, as well as whether and how these factors have changed over time (Eisenhardt, 1989, Pawson and Tilley, 1997).

Table 5: Case study fieldwork – phase one

Role	Site				
	1	2	3	4	5
HWB chair	✓	✓	D	✓	✓ ¹¹
Director of public health	✓	✓	✓	✓	✓
CCG member 1	✓	✓	✓	✓	✓
CCG member 2	✓	✓	N/A	✓	✓
Chief executive (local authority)	✓	✓			

¹¹ Reflects change in leadership post-May 2016.

Director of children's services	✓	✓	D	✓	✓
Director of adult services	✓	AA	✓	AA	AA
Strategic director (local authority)	✓	✓	D	✓	
Healthwatch chair/CEO	✓	✓	✓	✓	✓
Elected member 1	✓	✓	✓	D	✓
Elected member 2			✓		D
VCF representative		✓	D	✓	
Others: District council representative	✓	N/A	N/A	N/A	N/A
CCG member 3	D		N/A		N/A
Elected member 3			✓	N/A	D
NHS provider	✓	✓	✓✓	✓	✓
Housing/other provider		D	✓		
Local MP		✓			
HWB development lead			✓		
Assistant chief exec (local authority)			✓		
Public health consultant/deputy DPH				✓	✓✓
Total no. of interviews conducted	12	12	12	10	11
HWB meeting observation	✓	✓	✓	✓	✓
Documentary analysis	✓	✓	✓	✓	✓
VCF focus group	✓	✓	✓	✓	✓

Key:

✓	Conducted	D	Declined
Blank	Not invited	N/A	Not applicable
AA	As above (single role – director of children's and adult's services)		

Table 6: Case study fieldwork – phase two

Role	Site				
	1	2	3	4	5
HWB chair/vice chair	✓	✓	✓	✓	✓
Director of public health	✓	✓	✓	✓	✓
CCG member	✓	✓	✓	✓	✓
Healthwatch chair/CEO	✓	✓	✓	✓	✓
VCF representative		✓		✓	
Total no. of interviews conducted	4	5	4	5	4

Key:

✓ Conducted Blank Not invited

Work package 4: Disseminating good practice

The aims of WP4 were to: 1) deliver a series of workshops and events to disseminate good practice in relation to HWBs as system leaders for health improvement and better integrated care; and 2) make recommendations for the future so that opportunities for the NHS and local government to achieve effective integrated practice in relation to health and social care are fully realised. These dissemination events and recommendations have drawn on insights generated through the preceding work packages.

Workshops were delivered in four of the five case study sites; the final site declined to take part. The purpose of the workshops was to share and verify preliminary findings with the HWB members and key local partners, as well as generating further discussion and useful learning. In addition, a national event was organised for late September 2017 (postponed from May 2017 due to the general election and purdah rules affecting some invited speakers) to disseminate and discuss the evaluation findings, with an emphasis on sharing key learning points and pitfalls to avoid in relation to HWBs¹². The event was open to all interested parties, with invitations being distributed widely to local government, NHS, Healthwatch and VCF sector representatives with an interest in partnership working for health improvement. The event also functioned as a networking opportunity for those

¹² For details, see: <https://www.dur.ac.uk/public.health/projects/current/prphwbs/event/>.

working, studying or volunteering in this area across England. There were 74 delegates in total although no one attended from our five case study sites despite several people in at least three of the sites promising to come or send representatives. Conceivably having to postpone the event from May to September was partly responsible since delegates from at least one study site were signed up to attend in May. Key speakers, from the LGA, PHE and elsewhere, addressed the conference and workshops were held in relation to:

- Public engagement and involvement
- Integration of health and social care
- Wider determinants of health, wellbeing and inequalities

The purpose of the workshops was to seek feedback on – and verify – our evaluation findings and to generate additional insights, particularly examples of good practice, pitfalls to avoid and other key learning points in relation to HWBs. The event succeeded in achieving its aim and feedback from it was positive.

Findings from WP1 and WP2 were presented at the Health Policy and Politics Network (HPPN) Spring Meeting in Manchester (May 2016) and the Dilemmas for Human Services conference in Northampton (September 2016). A policy session was delivered at the LGA and Association of Directors of Public Health (ADPH) Annual Public Health Conference in London (March 2017); the session focused on systems leadership and involved presenting findings from the two DH PRP-funded projects led by Durham University. The findings from the study are to be presented to the HWB at South Tyneside MBC at a special event organised by the Director of Public Health in January 2018.

Ethical considerations

Key ethical issues to be addressed in this evaluation included: obtaining informed consent; avoiding coercion; ensuring confidentiality; anonymity and safekeeping of data. National stakeholders interviewed during WP2 and participants in the WP3 interviews and focus groups received tailored information sheets that clearly explained the purpose of the evaluation and what would be expected from them if they decide to take part. They were asked for their consent to take part in the interviews or focus groups, have the discussions audio-recorded and for (anonymised) information to be used in published material. Written consent was obtained from those interviewed by phone as well as those who took part in face-to-face interviews; consent forms were sent to participants in advance by the project administrator. It was made clear that interviewees and focus group participants were free to exit the evaluation at any time and without giving a reason. HWB meetings are open to the public and therefore consent was not necessary for the observations, although the chair was made aware of the researcher's presence and asked to notify the other members.

All data generated during the evaluation have been treated as confidential and kept secure at all times, in a locked cabinet or on a password protected computer at Durham University

Queen's Campus. These include personal contact details, transcripts and field notes. Each participating local authority was given an identifier code, as were the individual participants, and only this code has been used to label the interview recordings, electronic files and transcripts. Case study sites will be anonymised in all project outputs. Respondents to the national survey were required to identify their host organisation so that this information could be used in sampling the case study sites. This created a risk that anonymity would be lost for individual respondents. However, the technical architecture for the survey (using Bristol Online Surveys) preserves the confidentiality of respondents and none of these organisations will be named in any publications arising from the study.

Public and user engagement and involvement

A central aspect of the research has involved evaluating how well HWBs understand and engage with service users and members of the public, in order to extend democracy locally. The extent to which each HWBs' approach to user engagement and involvement is authentic and effective has been assessed by:

- Exploring the mechanisms that HWBs use to engage with service users and members of the public, and the robustness of their relationship with relevant local bodies and forums (i.e. Healthwatch and VCF sector organisations)
- Examining how each HWB was established, with an emphasis on the degree of consultation and engagement with the public from the outset
- Assessing the investment – in terms of money, skills and time – that HWBs put into engaging with hard-to-reach communities (geographic and communities of interest) to enable them to have the skills and confidence to have a voice in local decisions
- Engaging with relevant local bodies and forums, including local Healthwatch and VCF sector organisations, to understand their perspectives on what does and does not work in relation to HWBs

A number of different approaches have been used to collect relevant data, both generally (through the document review, case study interviews and HWB meeting observations) and through specific, public engagement-themed work. Local Healthwatch organisations have a statutory role on HWBs and therefore acted as a starting point for exploring the scale and impact of public and user involvement within each HWB. A factsheet on each local Healthwatch was produced (by Forrest) and circulated to the research team before commencing fieldwork. A focus group was also conducted with representatives of VCF sector infrastructure organisations in each case study site to explore their views on public engagement by the HWB. In four of the five sites, the local VCF infrastructure body (generally the Council for Voluntary Services (CVS)) assisted in identifying relevant organisations, distributing invitations and selecting an appropriate venue for the focus groups. See Appendix G for details of the focus group topic guide.

In site 1 a focus group was also conducted with members of the public. It quickly became clear that they had little or no knowledge of the HWB, and that they sought information on health and wellbeing from organisations working at a community level. Therefore a decision was made to focus on seeking the views of citizens through VCF organisations who had reach into those communities, as well as reach either with the HWB directly or through the VCF and/or Healthwatch representative on the board. Team members' previous experience of public and user involvement has helped to deliver on the above activities. In particular, Forrest led on the VCF focus groups (with assistance from other members of the study team) and used her network to identify lay representatives from HWBs and CCGs within the case study sites. She is a lay member of Sheffield CCG, co-leading on strategic engagement, patient and public engagement, and equality, building on past experience in advocacy, service improvement and community development. Other research team members also have experience in these sectors, particularly Adams.

Equality and diversity issues

The research was carried out in accord with Durham University's Diversity and Equality Policy and the research instruments were subject to the university's ethical review processes. Diversity and equality issues were reflected in the PPI strategy by trying to engage many local VCF groups representing diverse communities and in investigating how HWBs policies and strategies reflected the diversity and needs of local populations, including how the VCF sector engaged locally with HWBs, CCGs, public health teams and other community groups. The case study sites were selected to reflect a range of factors such as being an urban or rural population, indices of deprivation and political affiliation. The research investigated the extent to which HWBs use their knowledge and experience of their local communities to help shape policies and strategies that reflect the needs of different groups within the local population. HWBs as place based bodies were devised to ensure that they reflect and help shape the health needs of local populations which may be diverse. The research therefore highlights how HWBs had developed programmes, policies and services, targeted to different communities, or those with specific health needs, and how HWBs aim to reduce health inequalities overall and between different communities.

External advisory group

An EAG was convened, involving lay members as well as academic, policy and practice partners, many of whom were chosen for their commitment to, and experience of, patient, public and service user involvement. The purpose of the group was to have input into developing participant information resources and data collection tools, and to assist with interpretation and dissemination of the findings. The members were:

- Graeme Currie, professor of public management at Warwick Business School
- Mark Gamsu, lay member of Sheffield CCG and visiting professor at Leeds Beckett University

- Ann Hoskins, formerly the director of children, young people and families at Public Health England (now retired)
- Jim McManus, director of public health at Hertfordshire County Council
- Jonathan Owens, deputy leader at East Riding of Yorkshire Council
- Steve Studham, chair of Derby City Healthwatch
- Richard Webb, Executive Director of Adult Social Care at North Yorkshire County Council.

Because of considerable difficulties in finding dates to suit at least most EAG members, combined with unforeseeable and unavoidable disruption arising from a restructuring of the School of Medicine, Pharmacy and Health at Durham University, in which the CPPH was located, and its eventual transfer to Newcastle on 1 August, only one face-to-face meeting of the EAG took place, although members were also asked to contribute to discussions and comment on draft study documents via email. Two members also took part in the national event in September 2017 mentioned above, with one, an elected member, chairing the day.

This chapter has described the methods used to generate data in order to answer the research questions associated with each work package and ultimately to address the overarching evaluation aims and objectives. Subsequent chapters detail the evaluation findings arising from the processes of data collection and analysis outlined here; the findings are organised around themes and sub-themes that are consistent with the CMO framework.

4. KEY FINDINGS

This short chapter provides an overview of the five case study site areas that were the focus of WP3 (table 7) and highlights pertinent features of their respective HWBs (table 8). The main findings from across all work packages are then summarised before being presented in detail in subsequent chapters (4.1 to 4.5).

Case study site characteristics

Table 7: Key features of the case study areas

Feature → Site ↓	Deprivation quintile* ¹	Children in low income families (%)	Local life expectancy gap (years)	Population from ethnic minority group (%)	Dependency ratio* ²	Local priorities (from the PHE Health Profiles)
Site 1	4	16.8	M: 8.2 F: 6.4	2.4	64.6	<ul style="list-style-type: none"> Reducing inequalities in healthy life expectancy Emotional health and wellbeing of children and young people Smoking in pregnancy
Site 2	2	29.4	M: 13.1 F: 10.9	14.4	48.1	<ul style="list-style-type: none"> Delivering the best possible start in life for all children Increased emphasis on broader policies to deliver health and wellbeing across the life course Better integration and effectiveness of services to help reduce inequalities
Site 3	2	21.5	M: 7.3 F: 5.8	4.4	57.1	<ul style="list-style-type: none"> Improving health and wellbeing overall Reducing inequalities
Site 4	1	32.9	M: 8.6 F: 6.6	40.6	58.0	<ul style="list-style-type: none"> Childhood obesity Statutory homelessness Reducing the numbers of vulnerable children and adults
Site 5	4	16.3	M: 9.6 F: 9.7	6.1	66.0	<ul style="list-style-type: none"> Increasing physical activity Focusing on early years health in deprived communities Whole systems

						approaches to reducing alcohol misuse, smoking and obesity <ul style="list-style-type: none"> Promoting mental wellbeing and healthy ageing
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Source: PHE (2017). Health Profiles: <http://fingertips.phe.org.uk/profile/health-profiles>.

*¹Derived from Index of Multiple Deprivation (IMD) rankings, where quintile 1 is the most deprived and quintile 5 is the least deprived.

*²Dependency ratio = (dependants / working population) x 10

N.B. Text in **red** denotes values that are higher than the averages for England as a whole, whereas **green** denotes values that are lower than the national averages.

Table 8: Key features of each HWB*¹

Feature → Site ↓	Chair	Meeting frequency	NHS providers represented	VCF represented	Other reps	Sub-group
Site 1	Cabinet member for health and communities	Six times per year	Yes (multiple reps)	Yes (multiple reps)	Yes (police, probation, fire, PHE, district councils, parks)	Yes (high-level core group, plus task-and finish groups at sub-board level)
Site 2	Leader of the council	Six times per year	Yes (multiple reps)	Yes (multiple reps)	Yes (housing, universities)	Yes (sub-committee at chief officer level, plus a health and social care integration group)
Site 3	Cabinet member for health and adult social care* ²	Quarterly	Yes (single rep)	Yes (single rep)	Yes (police, pharmacy, university, wellbeing service)	Yes (operations group focused on integrated commissioning)
Site 4	Cabinet member for health and social care	Quarterly	Yes (single rep)	Yes (single rep)	Yes (community safety)	Yes (operations group made up primarily of less senior officers)
Site 5	Cabinet member for health* ²	Six times per year	No (although this changed between phases 1 and 2)	No	No	No

*¹ Details correct at the time of undertaking fieldwork; any changes between phases 1 and 2 are highlighted.

*²These two sites experienced a change in HWB chair during the course of the study, although not a change in cabinet role.

Overview of study findings

In this section we summarise and list our study findings in respect of each of the four work packages (see Chapter 3, Figure 4).

WP 1 – Literature review

Our literature review, which focused on reviewing the evidence on partnership working, found that:

- Widespread progress was being made across some common themes, such as the building relationships between HWB members, using development sessions or informal meetings to clarify priorities; developing sub-structures and working groups to support the HWB; and using the BCF to provide a focus for their efforts. However, progress had been slower than anticipated and many boards were still some way off from acting as a driver on key issues.
- A key challenge arose from the absence of statutory powers and the need for boards to acquire ‘soft power’ as influencers and negotiators of change. Questions arose regarding both the form that leadership should take and the skills and attributes of individuals needed to enact such leadership.
- Many HWBs were yet to position themselves as the key strategic forum for driving the health and wellbeing agenda. The review concluded that recent literature demonstrated that HWBs remain a case of ‘work in progress’ when it came to leadership, collaborative working and integrated service provision. It also suggested that many of the lessons from previous models of partnership working had not informed the working practices of HWBs.

WP 2 – National survey and interviews

WP2 comprised two parts: (a) a series of elite actor interviews conducted with key individuals involved nationally in the development and implementation of government policy around HWBs (n=12); and (b) a national survey to add to existing evidence on the organisational arrangements, form and function of HWBs, and identify their priorities, challenges and successes. A total of n=28 out of 150 HWB responses were received.

Three key themes emerged from the elite actor interviews:

- HWBs were established as partnerships, a favoured policy instrument used by government without much evidence of previous success.
- In terms of leadership, there were multiple views on the nature of good leadership, what it means, how it is identified, and how it is developed.
- The third theme concerned the introduction and operation of HWBs being set against a backdrop of policy tension and conflict. One of these tensions was between

the meta-policy of localism and the desire to ensure consistency between local authorities, although there was a clear difference of understanding and narrative around the notion of localism. For some interviewees, the introduction of HWBs and the transfer of public health responsibilities to local authorities was seen as an example of the increasing fragmentation of the system. In comparison, others saw localism as desirable, bringing decisions about place and personalisation to a local level. But there were also tensions locally, both because of cultural differences between key HWB partners and because of differences in targets, performance frameworks and policy expectations between partners. A further tension was created by fuzzy, sometimes conflicting, policy objectives. Several examples were provided, one of which was the tension between a focus on being transformational and transactional respectively, particularly in terms of the BCF.

Key findings from the national survey:

- A consistent finding was the level of variation between HWBs in terms of their size, membership, governance arrangements, priorities and workload. They had a range of priorities, although obesity, an ageing population and mental health were identified by many respondents. These priorities were expressed in many different ways, from specific output-related targets to overall strategic intent. It was evident that there was not a 'one size fits all' approach to HWBs.
- Respondents identified significant barriers to successfully delivering against policy objectives for HWBs, including challenges related to developing and maintaining good relationships between partners, reducing resources coupled with increasing need, and the complexity of the health and wellbeing system. Despite these challenges, respondents were generally positive about the ability of HWBs to deliver against stated policy objectives and to improve outcomes in terms of prevention, service integration, tackling health inequalities and enhanced democracy. Although a range of output and outcome measures and reporting mechanisms were identified by respondents, it was evident that some issues were yet to be addressed, including attribution (particularly in relation to preventative and public health interventions) and resources.

WP 3 – Five local authority case studies

For WP3, semi-structured interviews (n=57) were conducted across the five case study sites. Follow-up interviews (n=22) were conducted with selected participants to examine whether and how the role and function of each HWB had changed over time. Five focus groups in the study sites were conducted with VCF infrastructure organisations. A series of elite actor follow-up interviews (n=7) were conducted with key individuals involved nationally in the development and implementation of government policy around HWBs.

Key findings of WP3 were:

- Participants believed that relationships and trust matter in HWBs; having the appropriate individuals in the key organisations willing to invest the time, commitment and energy to create a successful partnership are key elements that can mean the difference between success and failure.
- Institutional complexity and competing system hierarchies (e.g. the demands and priorities of STPs, NHS and policy initiatives such as the BCF) tended to result in the dilution of local priorities and focus of HWBs.
- Many in our study said that STPs side-line HWBs since they were perceived as having a larger geographical footprint and a degree of power and influence which HWBs did not possess.
- A lack of strategic direction and a focus on clear objectives on the part of HWBs was a common theme amongst participants.
- Boards were generally not viewed as system leaders, more a collection of leaders accountable to their own organisation; each with its own (often conflicting) priorities and working in organisational silos with partners not held to account.
- A lack of strategic join-up was evident, for example in respect of the joint health and wellbeing strategy (JHWS) and other policy initiatives where there was (at both strategic and operational levels) little ownership of the JHWS, with a lack of accountability for elements of the strategy. The strategies were not regarded as an integral part of the health and social care landscape.
- Despite these concerns and weaknesses it was also recognised that HWBs were the only forum at present where the system came together however imperfectly.
- There was widespread acknowledgement that little had been done by HWBs in terms of public and user involvement.
- Healthwatch were generally seen as engaged and contributing to and challenging HWBs, but there were issues about their role in terms of acting as a conduit for public engagement for HWBs.
- In regard to VCF sector organisations, HWBs had not capitalised on previous (better) engagement processes and a lack of investment in infrastructure to the sector had hindered engagement with inconsistent engagement across HWB footprints.
- There was a clear lack of outcomes in delivering on HWB goals and priorities, with insufficient accountability, a lack of strategic focus and poor performance management being cited as factors.
- There was some concern that there was a lack of focus and action on health determinants and inequalities.

WP 4 - Dissemination

WP4 consisted of delivering local workshops and a national event to disseminate good practice and make recommendations to assist future HWB development.

- Workshops were delivered in four of the five case study sites with the purpose sharing and verifying preliminary findings with the HWB members and key local partners, as well as generating further discussion and useful learning.
- A national event was organised in September 2017 to disseminate and discuss the evaluation findings. Invitations were distributed widely to local government, NHS, Healthwatch and VCF sector representatives with an interest in partnership working for health improvement. There were 74 delegates in total. Key speakers addressed the conference and small group discussions were held in relation to three topics relating to the research: public engagement and involvement; integration of health and social care; the wider determinants of health, wellbeing and inequalities. The purpose of the small group discussions was to seek feedback on – and verify – our evaluation findings and to generate additional insights, particularly examples of good practice, pitfalls to avoid, and other key learning points in relation to HWBs.

Additional dissemination activities took place during the study as follows:

- Findings from WP1 and WP2 were presented at two conferences in 2016: the Health Policy and Politics Network (HPPN) Spring Meeting in Manchester (May 2016), and the Dilemmas for Human Services conference in Northampton (September 2016).
- A policy session was delivered at the LGA and Association of Directors of Public Health (ADPH) Annual Public Health Conference in London (March 2017); the session focused on systems leadership and involved presenting findings from the two DH PRP-funded projects led by Durham University.

4.1 FINDINGS: THE CHANGING CONTEXT OF HWBs

Background: the context of HWBs

This section considers the political, cultural and economic context in which HWBs were, and continue to be, shaped. Context is the first component of the realist evaluation framework employed in the study and includes features such as social, economic and political structures, organizational context, programme participants, programme staffing, geographical and historical context and so on. As Pawson and Tilley (2004:7) note: *‘Context describes those features of the conditions in which programmes are introduced that are relevant to the operation of the programme mechanisms. Realism utilises contextual thinking to address the issues of ‘for whom’ and ‘in what circumstances’ a programme will work’*. Therefore, there is a focus upon factors such as the policy drivers behind the formation of HWBs, the history of partnership working in our case study sites, the move of public health into local government, the abolition of primary care trusts (PCTs) and subsequent formation of CCGs. More recently, there have been the changes arising from the *NHS Five Year Forward View* with the introduction of New Care Models, STPs, Accountable Care Systems (ACSs) and the response of HWBs to this new emerging policy landscape.

Policy drivers

In our second interim report, it was argued that policy development and implementation around the introduction of HWBs were not clear, with a number of different and occasionally conflicting policy objectives in evidence. We highlighted that respondents to our national survey (DsPH and HWB chairs) identified several significant barriers to successfully delivering against policy objectives for HWBs, including challenges related to developing and maintaining good relationships between partners, shrinking resources coupled with increasing need, and the overall complexity of the health and wellbeing system. Our interviews with national and local policy actors and voluntary sector focus groups also highlighted some of these concerns.

It was claimed by participants in our case study sites that national policy drivers could take precedence over HWB priorities and undermine local initiatives, with the following frequently cited: the Better Care Fund, New Care Models/Vanguards, STPs, Success Regime, and The Care Act. NHS priorities could also take precedence with papers from the Department of Health having to be signed off by boards. A local authority Chief Executive in site 3 discussed some of these themes:

'There is government legislation and we have to, we can't ignore that. So it is very much about how we work within that rather than ignore it. But inevitably last year there was a lot of work going on with the care act as you'd imagine'.

In site 2, for instance, it was also believed that insufficient time was spent on the board's own agendas and this proved distracting. Some national agendas did not fit with the board timetable in site 2 and got delegated to the board's sub group. There was a belief by a local authority Assistant Chief Executive in this site that the board needed to do more to manage the work programme *'...rather than feel that we are being pushed into doing things that are required by central government...'*

These themes were largely echoed in our follow-up interviews with national stakeholders. A concern among participants was that with STPs, Vanguard and multispecialty community providers (MCPs), influence was moving away from HWBs as these newer organisations, and the initiatives they bring with them, have money and power. Another participant described how with the continued development and implementation of STPs there was a need to avoid duplication between JHWSs and STPs. Again, the concern of power and influence moving away from HWBs was evident:

'...it's also in the context of everything else that is going on, keeping up the profile and momentum of the health and wellbeing boards, I think this bit about being effectively relegated because other things become more important, supersede it, is a challenge. I think that's it really' (National Interviewee, 2).

This interviewee also discussed the influence of Vanguard and MCPs:

'And the question then is where do the top table players go to do their business? And essentially, you know, thinking about the vanguard in...[the local authority] they're tight, they're wanting to take control, they're wanting to be their own place, because we're distinctive, we know what we're doing, we've got good relationships and so on, so they're thronging away and the health and wellbeing board is a bit of an afterthought. People go to it, but where the action is, is the MCPs effectively, the vanguard. And when you say where are the meaningful conversations taking place? You know, CCGs, the providers, even the local authority is going into those places because that's where the money conversation is taking place' (National Interviewee, 2).

Our interviewees argued that the HWB was a 'clearing house' for discussions on STPs and Vanguard as the local authority was not tied into those discussions.

Partnership working

Our study site participants highlighted that in terms of partnership working, good relationships, trust between partners and having the right individuals in the key

organisations willing to invest the time, commitment and energy required to create a successful partnership were key elements making for success or failure. The history of partnership working had an impact on the approach adopted by HWBs. Our field sites displayed a variety of approaches to partnership working as described below.

Partnership working in site 1 was generally considered in positive terms. A strong history of working in partnership was cited in the spheres of social care and health. There was felt to be an ethos of trust underpinning the health partnerships previously and, more generally, with partners building relationships, sharing resources, working collaboratively and setting targets and goals together. This level of trust had been eroded somewhat in terms of local authority and CCG relationships and there was some concern that there was variable engagement and lack of trust between the CCGs and the council, and a lack of sharing of information and engagement between these partners. It was also commented upon that continuous reorganisations of the health service had not helped the cause of partnership working.

In site 2, until 2011 there was an LSP with a number of thematic partnerships but the incoming new administration in 2011 dissolved the LSP. However, partnerships generally were not always harmonious as this HWB Development Lead officer explained:

'...there has been a big issue really around the quality of the working relationships between agencies... And our former PCT and our FT did not get on at all. And in a way the CCG has inherited some of that relationship with the FT is quite awkward, the council has been able to be in there being a bit of a referee and nurturing that a little bit'.

However, to counter-balance these deficits, it was argued that other facilitators for partnership working, which included an authority-wide health initiative, had helped shape the focus on wider determinants of health.

In site 3, previous relationships between the PCT, acute trust and the council were described by one participant as 'dire', with the Chief Executive of the PCT and the council communicating only by letter. A previous inspection of the council by the former Audit Commission saw it not performing as well as it could and this led to the impetus for undertaking partnership working in a different way and encapsulated with the formation of the HWB. A recurring theme from participants in this site was that there was a desire for the HWB to do things differently and not be just another council committee but rather a true partnership board. Very early on it was decided to utilise system leadership approaches to achieve HWB aims and objectives. Consequently, HWB members joined a programme offered by the King's Fund adopting system leadership methods. In the year preceding the formal establishment of HWBs, partners decided not to set up a shadow board, instead dedicating time and energy to thinking about the model of the HWB they wanted, what it

would aim to achieve, and how it would define health and wellbeing. This included holding externally facilitated development sessions for HWB partners.

In site 4, there was a generally, although not entirely, poor history of partnership working. Personality conflicts, tensions within the health sector (providers and former PCTs not working together), and lack of partnership working with the local authority and the VCF sector were all cited as factors making for poor partnership working. Cultural differences were also cited as a dynamic making partnership working more difficult. Different leadership approaches and cultures within the PCTs and different personalities were also cited as contributing factors. A CCG Chair commented on the acrimonious nature of the previous PCT and local authority relationship:

'I think historically it's fair to say that the primary care trust did not have a good relationship with the local authority. And that the local authority did not have a good relationship with the primary care trust, I think, you know, there was I think blood on the floor at times'.

Relationships between two of the three CCGs in site 4 were characterised as poor and partnership working was seen as problematic in some instances. Again, these problems were the result in part of cultural and personality differences.

In site 5, a change in senior leadership roles in key organisations before the formation of the HWB had brought about a cultural shift with a focus on the integration of health and social care. There was a separate health and wellbeing partnership board, a precursor to the current board that had a slightly broader membership including the voluntary and community sector. Changes in leadership in key organisations brought about a desire to change and focus on the integration of health and social care in addition to a recognition that working collaboratively made sense when there was a lack of resources.

In terms of partnerships with the VCF sector organisations it was argued by our focus group participants in the case study sites that since the Health and Social Care Act 2012, partnership commitment had declined, particularly with regard to the third sector. A voluntary sector manager noted that:

'I don't think central government has actually gone far enough in trying to actually require that the third sector becomes involved at the strategic level as a partner' (Site 3, focus group).

It was further noted that, previously, various infrastructure bodies gave a strategic voice to the sector, but these had suffered from funding cuts. It was observed that LSPs were involved and worked with the voluntary sector and with communities, and that LSPs were less structured around the local authorities and more around strategic partnerships but LSPs had now largely been disbanded.

Overall, across all five sites, although there was some evidence of successful partnership working this did not axiomatically mean that successful partnership working would continue. It was argued that partnerships needed trust and good relationships as their bedrock, with the right key players in position and clear goals agreed concerning what was to be achieved with buy-in at all levels, from the strategic level downwards. Cultural and relational factors could also help or hinder the contextual development of HWBs and there remained tensions between agencies and key personnel on HWBs. Whether this was a key factor in current board partnerships was not clear. But it was clear that changes in personnel at the top of key agencies (as cited in site 5 in terms of the drive for health and social care integration), and a desire to do things differently by working in partnership (site 3) can, as will be seen in terms of the integration of health and social care, make a real difference. It was noted, too, that system reorganisation did not help ensure the stability of partnerships, with the abolition of PCTs and creation in their place of CCGs, and the move of public health into local government which had the effect of destabilising former partnership networks and personal relationships. In their place was a more fragmented local health and social care system.

Local challenges and opportunities

The fragmentation theme just noted was echoed by all our participants. Working with multiple CCGs created a complex policy landscape; in two study site areas one CCG covered two local authority areas, adding to the complexity. There was also discussion of the health landscape becoming more complex generally, with a large number of NHS trusts in addition to CCGs. Furthermore, the system was in constant flux, with new initiatives and programmes constantly appearing. The HWB Vice Chair in site 2 encapsulates some of these issues:

‘So...we had two CCGs...and we’ve now got one CCG across the whole area. All the time you’re structuring. And that actually takes away the focus from what you need to be doing and how you need to be spending your money and what you need to be prioritising for the future’.

There was a comment by a national interviewee that policy under successive governments had fragmented the NHS:

‘But in a way you sit there, say, somewhere like the middle of Nottingham or Leicester or wherever and you basically say well where’s the beating heart of health and wellbeing here, and you’d get six different answers....there’s variability’.

Participants in the VCF focus groups discussed how difficult it was for the public and VCF organisations to understand local structures, and how there was now less contact and engagement with CCGs. This had followed the move of public health to local authorities.

There was also discussion that some CCGs did not understand the complexity and range of the VCF sector and the contribution it could make to improving health and wellbeing.

The move of public health to local government

While some positive engagement was cited with local authorities in terms of health becoming embedded more widely across local government functions (including planning housing and transport), there was an acknowledgement that a greater emphasis on, and clarity over, tackling the wider determinants of health and health inequalities were needed. In two study sites, there was some evidence of a commitment to tackling the wider determinants agenda and inequalities. Some of our interviewees described a growing emphasis on prevention, with Directors of Public Health (DsPH) playing an increasingly important role in the new structures as discussions around health and social care shifted to Sustainability and Transformation Partnerships.

Our follow-up interviews found that public health was still in the process of becoming embedded in local government, although the degree to which this was occurring varied. In one site under a new DPH, public health was driving the prevention agenda and had set up or help fund initiatives around anti-poverty work (such as helping organisations who provide food for food banks, or locating advice centres in GP surgeries). In another site, the public health perspective at HWB level was seen to be lacking and it was argued that public health should become more embedded within local government. The chair of the HWB in another case study area cited smoking cessation and drug and alcohol work as having a significant impact in a relatively short space of time. There was also still the view expressed in our follow-up interviews that there needed to be more emphasis on the wider determinants of health.

Our national follow-up interviews found that participants believed that the move of public health to local government was welcomed overall, but not at a time of austerity. Operating within such severe financial constraints had led to a focus on prevention and tackling the wider determinants of health with the goal of preventing health problems before they arose and therefore being more cost effective. But while there was a perception that public health would be central in the way HWBs worked, in practice the function was described as a shadow of what it had been in 2011/12. It was argued that there needed to be some way of strengthening the public health input if the commitment to the prevention agenda was both genuine and achievable. However, in this regard it was of serious concern that public health funds going to local authorities had been cut with further cuts envisaged.

Although it was encouraging that in some sites there was thought to be stronger public health leadership emerging, the agendas for HWBs remained dominated by health care and in fewer cases by social care issues. They were not primarily driven by addressing the determinants of health and tackling inequality.

Changes over time

At the time of the first phase interviews there were both concerns and opportunities cited in some sites in terms of the then emerging Sustainability and Transformation Plans (STPs – subsequently renamed Sustainability and Transformation Partnerships). As noted in Chapter 1, STPs are based around ‘place’, not single organisations, with 44 geographical footprints initially proposed across the country. The aim of STPs is to integrate care, with an emphasis on more collaboration between providers, less competition, and a focus on population health. Each partnership was invited to form a board, appoint a leader, and identify resources and staff to implement the plans. In March 2017 new accountable care systems (ACSs), which were characterised as evolved versions of STPs were announced, giving greater support and freedom by national NHS bodies to manage local resources and implement services changes. At the time of writing, eight ACSs had been announced (Ham et al, 2017; Iacobucci, 2018). The term currently favoured to describe them is Integrated Care Systems or Partnerships.

Concerns were expressed that HWBs would become increasingly irrelevant and at risk of being subsumed by STP boards. However, other interviewees mentioned newly configured STPs operating across larger footprints which could offer the prospect of collaboration with HWBs. In our follow-up interviews, participants reflected on how STPs had dominated the agenda. There were concerns in three of the sites that there had been no engagement over the STP plans that had been produced and also concern expressed in two of those sites that the HWB could become side-lined. In one case study site, the HWB had an oversight role of the STP but only when a plan had been produced. Another site was part of a combined authority which negated the need for an STP. One participant in our national follow-up interviews noted how STPs were the ‘acid test’ for HWBs and boards needed to engage with them or risk becoming irrelevant. Another national interviewee commented on how STPs had absorbed many of the roles of HWBs, with STPs being the central focus of a larger place-based exercise as opposed to HWBs operating on a smaller local authority footprint. There was also concern that the larger STP footprints could mean a loss of focus on smaller local authority areas. There was a perception that the NHS had ignored HWBs and had ‘gone it alone’ in deciding on their own place-based STPs, and that many STP leaders did not want or welcome local government engagement. It was felt by another national participant that STPs were the place where leaders had coalesced and local government had to react. An interviewee who was a leader of an STP believed it would be helpful if HWBs had an oversight role of STPs. Also, a governance structure was required which reflected the engagement of the NHS and local government. This person noted there was no appetite for further structural reform following the much-criticised Health and Social Care Act 2012. The HWB Chair in site 4 outlined some of the themes discussed by interviewees:

‘We have really had to fight to get a voice on the STP process. As a councillor, I felt it was very important that I understood the STP process, so I sort of budged my way in. You know, basically the STP seemed to only want the leader and...the [local

authority] *chief exec, but I felt it was very important that as the Health and Wellbeing Board chair and the head of health and social care in the council that I was part of that. So from day one I have ensured that I have been a part of it...I am now sat on the board as the health and wellbeing board chair, but I have no voting rights. So the only people with voting rights are the leader and the chief exec*'.

Devolution

Devolution involves the delegation of a range of functions, powers and funds from central government to new configurations of local authorities in an area. At the time of writing, 10 devolution areas have been agreed.¹³ Most notable is the scale of devolution in the Greater Manchester area which is the only devolution area with devolved health powers, bringing together 10 local authorities, 12 CCGs, 15 NHS trusts and foundation trusts, and NHS England (Walshe et al, 2016). Four main issues emerged on devolution from our research:

- Little consultation and lack of debate on devolution proposals or the functions of a combined authority.
- Devolution footprints differed from STP, CCG and local authority footprints and were overlaid on, and added to, an already complex geography.
- There were opportunities to integrate services at scale in areas such as transport, safeguarding issues, economic development – HWBs could work in a more strategic and cohesive manner.
- Our follow-up interviews found that in three of the five case study sites (one site was part of a combined authority) the devolution proposals had largely stalled.

Although health care was not a devolved function in four of the five study sites, in site 5, devolution was a major theme because the local authority was part of a combined authority agreement. It was argued that devolution was complex and there was some uncertainty over where the HWB fitted in the policy landscape and whether organisations such as local authorities and CCGs were 'up to speed' with developments on the devolution agenda. It was noted that in terms of devolution the HWB had been reactive rather than proactive. In the national follow-up interviews a number of issues were raised concerning devolution. Participants observed that decisions needed to be made on what to scale up and delegate down. As mentioned by one national interviewee, there was consideration of the need for a combined authority level based HWB: '*...some other places are already thinking about if we got a combined authority do we need a combined health and wellbeing board?*' (National Interviewee, 1). Another interviewee cautioned that a danger in scaling up was that the population focus would be lost. It was also considered how HWBs could keep the focus local

¹³ See: Local Government Association, Devolution deals: <https://local.gov.uk/topics/devolution/devolution-deals>

especially in regard to adopting community asset-based approaches. There was further comment on how a number of public health issues needed to be organised on a regional basis.

Austerity and lack of resources

Lack of financial resources was a concern across all five sites albeit to varying degrees. Discussions centred on cuts to local authorities, CCGs, social care and public health, and on the cuts, and potential cuts, to the voluntary and community sector. In one site in our baseline interviews there was discussion of having to make savings in the region of £150 million. The main concerns were the cuts (or potential cuts to come) in preventative services. In sites where good partnerships had developed, there was more emphasis on combining resources to combat fiscal reductions across health and social care. However, opinion was divided when interviewees were asked whether fiscal constraint had resulted in agencies working more collaboratively or retreating into silos. For instance, it was noted how pooling budgets in one site had mitigated some of the worst of the cuts, while in other sites there was concern that agencies might retreat into silo working. Comments were also offered in regard to how fiscal pressures were undermining new ways of working due to the additional resources required either for new programmes or the scaling back and double funding of existing and new provision.

A number of issues were raised amongst the focus groups with the VCF sector in regard to financial constraint and particularly how they believed this was impacting upon local authorities and HWBs. Budget cuts were severely affecting councils and HWBs had become inward looking, not addressing wider determinants of health. Duplication of service provision was an issue in some sites and the voluntary and community sector was asked to develop services, but there was not a complete mapping of who provided what services and therefore there were missing parts of the picture in terms of provision. There was also some concern expressed that HWBs did not engage the sector to better understand the resources in communities and displayed little understanding of communities and work on deprivation on the ground, only utilising local data to prioritise services and provision rather than focus on work on-going by the sector in communities. This focus group participant discussed the impact of cuts in funding:

‘I’ve lost count of the amount of times in various meetings where you’re working with your social care colleagues who you’ve known for a while and you can almost see them thinking I didn’t come into social care to do this. Literally all I do each week is come in to think well what can I cut today?’ (Site 2, focus group).

Summary

In terms of the changing context in which HWBs operated, a number of themes emerged:

- National priorities often took precedence over local HWB priorities and policies with the BCF and, latterly, STPs cited.
- Although there had been elements of successful partnership working across the sites historically, this did not necessarily translate into successful partnership working at HWB level between existing partner organisations. Previous cultural and relational factors could be seen to influence boards' development and there remained tensions between agencies and personnel on HWBs.
- System reorganisation nationally, particularly arising from the introduction of the Health and Social Care Act 2012, destabilised partnership networks. Factors such as organisations disbanding, agencies restructuring and personnel churn had led to a fragmented health system. It was acknowledged that this fragmentation and churn had continued with, for instance, the study sites having to deal with CCGs merging, and engaging with multiple providers and a constant stream of new policy proposals and initiatives emanating largely from central government and the NHS.
- In the four study sites which had STPs, three saw them as a place-based mechanism which could sideline HWBs. There were attempts by HWBs to have an oversight role but as a result of various factors (such as STPs not engaging with boards and only engaging when plans had already been drafted), the influence that boards had in their development was largely minimal.
- There were hopes that with devolution there would emerge opportunities to integrate services at scale in areas such as transport, safeguarding issues, and so on. However, apart from site 5 which was part of an established devolution agreement, devolution proposals had largely stalled and not all of these included health services.
- The move of public health into local government was largely welcomed and the function had started to become embedded in local authorities, but there remained a need to focus more on the wider determinants of health and health inequalities. In addition, there were ongoing challenges, for example, related to austerity and fiscal constraints, which were a concern of varying levels amongst our study sites.
- Opinion was divided over whether austerity would facilitate agencies working together more or whether they would retreat into their silos. However, there was a general consensus that there had been a negative impact on the VCF sector in particular.

4.2 FINDINGS: PURPOSE AND STRUCTURE OF HWBs

HWBs were established to act as a forum in which key leaders from the health and care system could work together to improve the health and wellbeing of their local population and to promote integrated services. The primary purpose of the boards was to bring together bodies from the NHS, public health and local government, including Healthwatch as the patient's voice, to jointly plan how best to meet local health and care needs (see Appendix A). This section focuses on some of the issues related to the first key objective of our research, which was to describe the varied ways in which HWBs are configured and organised, considering key issues such as governance and membership.

Perceived purpose of HWBs

In terms of the purpose and role of boards, participants from our national follow-up interviews described their role as being to produce a JSNA and JHWS and to comment on commissioning plans. Boards were also seen as the vehicle to agree local priorities across statutory and non-statutory organisations. One participant noted that boards provided a greater collective oversight of the health and wellbeing agenda (linked to the JHWS) and areas around prevention, including the broader place-based approach to health and wellbeing. Another interviewee commented that, most important, was the shared leadership of a strategic approach reaching across a whole range of relevant organisations. This participant argued that there was a commitment to driving real action and change, and that HWBs were supposed to achieve parity between board members. Furthermore, they were intended to be open, transparent and inclusive in the way they engaged with patients and members of the public. This participant asserted that those were the core principles of the boards, commenting: *'I always refer to it as that it should be the beating heart of local health and wellbeing work'* (National Interviewee, 2). It was argued by another participant that HWBs were patchy and variable in regard to being clear about their purpose due to there being minimal statutory guidance.

In respect of our case study sites, HWBs were not seen to have a clear focus, with strategies not linked to outcomes. There was also a perceived lack of accountability by partners for the goals and priorities of the HWB, and deficiencies in regard to the monitoring of priorities. In site 1, for instance, the HWB did not always use the JSNA or the JHWS to refer to, or monitor, outcomes and it was not always clear how reported outcomes from subgroups linked to the strategy. As one DPH explained in terms of the JSNA:

'...I'm not too sure that people would actually always go look there first in terms of if they're making a decision on commissioning a service or changing a service or decommissioning in terms of looking at that needs assessment'.

The DPH commented that the strategy was very much viewed as belonging to public health rather than to the local authority and this was a key barrier to strategic join-up and something that in his view needed to change.

In site 2, issues of agencies having their own priorities and lack of accountability were discussed in terms of the NHS foundation trust having its own priorities, which caused tensions with the Council and CCG in terms of delivery of social care. It was suggested that partners operated in silos with no collective decision-making evident by the board. The JHWS had not worked as a framework for action as it had not been used to generate an action plan or any performance targets or monitoring. It was perceived to represent a lack of progress by most of those interviewed. There was unilateral frustration with the pace and role of the board in terms of making a difference in site 2 as evidenced respectively by the HWB Vice Chair and a Trust Chief Executive:

'We've not got into the nitty gritty of how you deliver it...We are moving at a pace that would only narrow gaps over many decades'.

'But it's not a starting, finishing type. It is possibly a talking shop in part which is healthy, but I'm not too sure it's a starter, finisher'.

A strongly held view was that action was now required for the board to start translating priorities into action.

It was not clear in site 4 what the HWB was intended to achieve, with concerns evident over a lack of national guidance and funding. The HWB was seen as having no identity. The following responses from the Healthwatch representative and HWB chair respectively encapsulate some of these themes:

'I really do think that there hasn't been a clear strategy for a while for the board, and what we had wasn't enough to give the board purpose. There's work being done in a new strategy; however that was always intended to happen at the health and wellbeing operations group, but appears to have now been pulled together by public health, and then passed through again. So actually even the strategy now is being done elsewhere with a few individuals and coming back to the health and wellbeing board to get signed off. And it's very public health heavy'.

'Because as a statutory group we still have a responsibility, the only group out there, we may still have a responsibility, but unfortunately we seem to struggle to know where our responsibilities are...and sometimes the discussions are interesting, but

how we then translate it to the other partners doing something has not always been easy to do'.

The HWB in site 4 was viewed as a forum for bringing people together, but not for developing a shared vision or purpose. It was believed that the board was not set up to operate as a system leader and there was a perception that it needed more powers to be effective and to hold partners to account. It was argued by the Healthwatch representative that pooled budgets would mean more power.

'The health and wellbeing board on paper worked well – that it has a strategy based on a joint needs assessment. The partners come round together, they're all leaders in their own fields to make decisions and join and move forward. But that isn't happening. And therefore if we believe that that should have worked in the first place but hasn't, then the holding people to account for it. [...] It should work, but they might have more power with some pooled budgets in the current climate'.

There was a general opinion across the study sites (more strongly held in some than others) that there was too much focus on the integration of health and social care and, latterly, STPs. Furthermore, it was felt that more emphasis was needed in terms of a focus on the wider determinants of health and tackling health inequalities, with little progress observed in these areas. Boards were not seen as driving agendas across a range of issues and there was also some discussion that agendas had not been sufficiently focused on areas such as children's health.

Despite these weaknesses and deficits, our participants in the national follow-up interviews still believed that, on the whole, the rationale for the introduction of HWBs remained valid, even if their implementation was somewhat flawed. One participant had concerns that HWBs had not remained on track and had become distracted from their original vision. However, it was recognised that *'...there's no alternative plan...'* (National Interviewee, 7). One participant argued that the HWBs' original remit as system leaders was a clear driver at the time and that boards were the go-to place where people knew where the health and wellbeing agenda in all its dimensions was being driven. They also noted that:

'...the transfer of public health in the councils, the focus on a sort of ring-fenced prevention model and a framework that encouraged the different activities in the system to come together for a more integrated service were all kind of part of the drivers which were underpinning health and wellbeing boards' (National Interviewee, 4).

On being asked if the drivers for the introduction of HWBs remained valid, one participant stated: *'Oh absolutely, I mean it's a complete no brainer'* (National Interviewee, 1). However they went on to note candidly that the NHS sometimes does not understand HWBs and vice versa:

‘The NHS is not very bright, and a lot of that is because it is command and control, short termist, all of those kind of things, so a million very bright people end up behaving like automatons candidly for cultural reasons. So the set of people who were engaged in health and wellbeing boards, in other words the leaders of clinical commissioning groups, completely understand the relevance of health and wellbeing boards. But they have to operate in a power system in the rest of the NHS which sometimes gets it but quite often doesn’t....’ (National Interviewee, 1).

The VCF focus groups in the study sites commented that a strategic approach should include the sector, which it was believed had a lot to offer in terms of bringing solutions and having a reach into communities.

In light of the deficiencies of HWBs in our case study sites, in particular in respect of lack of focus, clear goals and priorities, coupled with poor accountability in addition to the absence of outcomes, some HWBs had reconfigured their board structures to try and address their weaknesses. Board membership was one issue that needed to be addressed (see below).

Views on membership and board organisation

A main theme in regard to HWB membership was the danger that a large board could result in less time for meaningful, in-depth discussions at board level. However, there was also a view that broad membership offered a range of perspectives and was thereby more inclusive. The view was expressed in our follow-up case study interviews that a large membership made decision-making difficult, although one site had addressed this by altering the structure of the HWB’s core and sub-groups to facilitate decision-making. Tensions were evident in some sites over provider involvement in our first phase interviews. Our follow-up interviews found that one site which previously had no provider representation now did; they were not full board members but had an open invitation to attend the board. In the time between the first and second phase interviews, two boards had elected new chairs and in one site this had resulted in continuity in terms of policy and objectives despite the change in political control. In the other board, the new chair had begun to make a series of changes including (as noted) having NHS providers as members of the board.

It was evident that HWBs did get ‘buy in’ and representation at the highest level from partner organisations and there was a commitment by these partners to attend board meetings. HWBs appeared to have a ‘symbolic function’ in terms of making key stakeholders visible to one another and also to members of the public. Our VCF focus groups observed that there was no clear process for determining who serves from the sector and in one site there was no voluntary sector representation whatsoever. In addition, in three sites Healthwatch was, to varying degrees, mistakenly viewed as the third sector representative on the HWB and the third sector was sometimes excluded from subgroups where the real decision-making was perceived to be taking place. Participants in our national follow-up

interviews observed the need for provider representation. One participant queried how HWBs could influence how money allocated to health was spent without providers present. It was also viewed to be a mistake not to have board representation from other sectors, including spatial planning, economic regeneration and the private sector.

Two sites had reviewed the purpose of their boards to varying degrees between our initial and follow-up interviews, with a view to having a greater focus on what were regarded as key issues and, as discussed, to confront the concern that boards had no clear purpose and strategies and were not linked to the JHWS. Boards had developed different meeting styles. In site 1, the board had adopted an approach where members spent more time discussing items of importance in a more informal setting. This involved a shift from a formal committee feel, where meetings focussed on ratification, to a more informal, inclusive and interactive forum which promoted discussion. This change in format was viewed as a 'change for the better' and was explained with reference to a number of factors, including the response to the peer review/LGA assessment that had been carried out, a change in council leadership, and the proactive involvement and vision of the DPH.

Site 2 had adopted a themed approach to meetings with the theme of the meeting linked to themes covered in the JHWS. As this DPH explained:

'What had tended to happen, and I think has happened elsewhere, and certainly some of the national approach to health and wellbeing boards was kind of pushing them towards a fairly mechanistic rubberstamping approval of documents, signing things off type function... So what we've tried to do is then bring it back. So the board is meeting five times a year and what we've done is aligned the five meetings with the major strands of the [JHWS] so that there can be a better informed strategic discussion about where we're trying to go as a city with the different aspects of that. So we had our first of those looking at working lives and health a little while ago, and it went very well. It was very well received'.

In site 4, there had been an academic evaluation of the board which had resulted in meetings being held at various venues rather than just local authority buildings. It was discussed in our initial interviews that after long deliberations providers were now a feature of the board, with a provider representative on the HWB from a Community Healthcare Trust. The board had a focus on commissioning and did not initially see a need for provider involvement.

Meetings

The role of sub-groups of the HWB

Sites 1, 2, 3 and 4 had sub-groups of the board (i.e. executive, operational and task-and-finish groups) and these were points of major discussion. Sub-groups were set up in sites 1, 2 and 4 on the recommendation of a review, conducted either by the LGA or through an

academic evaluation. Sub-groups were regarded as the forum where the real in-depth issues and discussions took place and where the agendas and priorities were set. As one participant described them, they were the 'engine room' of the HWB. However, there were also concerns over the accountability of these sub-groups and for the sites that had them they all operated slightly differently with different emphases.

In site 4, it was noted that nobody was aware of what happened to decisions made by the board, or where they went to. Nominally it was thought they were referred to the sub-committee. In site 3, a sub-group focused on integrated commissioning. In site 1, in the initial interviews the main sub-group of the HWB was regarded as where the HWB board agenda was set and where difficult discussions (although not necessarily decisions) took place in a non-public setting. In addition to setting the agenda, the group also set the HWB priorities. But there was some disquiet over the lack of transparency of the group and how to get items onto the HWB agenda. The Chair of the HWB noted that they did not involve districts in any strategic working groups, although there was no district representation on the main sub-group of the board. Other 'task and finish' groups were also convened at sub-board level.

In our follow-up interviews in site 1, the overall purpose of the HWB was stated as having a public health focus, aligning with the JSNA and four priority areas outlined in the JHWS, with sub-groups responsible for the work around each. A number of initiatives were identified where progress had been made including in children's mental health, leisure, housing and planning supervision all occurring within a prevention-focussed agenda.

In site 2, a major theme was discussion of a sub-committee of the HWB at chief officer level (see vignette). Membership included the CEO of a hospital trust, mental health trust, CCG and Council directors. The board met on a monthly basis around issues such as the integration agenda. The committee was felt to be working well but the group needed time to build trust between members and get out of a silo mindset, although there were some 'small shifts' evident. The committee was having difficulty getting involvement (as was the HWB) from 'major organisations'. As the DPH explained:

'...health and social care integration...It's not the only one, but it's a big deal. And to some extent, that stuff is sort of delegated to the [sub-committee] because it's too difficult to do in a big meeting. Though, in truth, the...group is encountering exactly the sorts of problems over [the] commitment of major organisations...'

It was felt the group was struggling with difficult decisions but had achieved a degree of honesty about the problems being faced if not how to address them. It was also felt that there had been sufficient time for discussion and deliberation and that the priority now was to implement decisions.

A Vignette on sub-committees and accountability – site 2

There were questions over the accountability of the sub-committee which very rarely reported back to the main board. Beneath the sub-committee there was another committee which dealt with the integration of health and social care. It was argued that good progress had been made by the sub-group on the integration agenda.

These participants discuss the sub-committee(s) in terms of integration and the issue of lack of reporting back to the board:

'I think in terms of leadership of the board leading the system, I think until this integration work started there's been very little of that. And actually that's been driven by the [sub-committee of the board]. The [Health and Wellbeing] board came quite late...we got a presentation from a [integration sub-committee] that had been meeting for about 10 months about system integration. And the board knew nothing about it. So it was that kind of I think they will become the place where it's led and overseen, but actually it came from the [main sub-committee] because of financial issues' (Healthwatch Chair, site 2).

'Well, we've created, so the integration [sub-committee] has built a whole place-based process for the city that will integrate, allow teams to come together and begin to think about how an integrated place-based way of working could be developed and begin to implement that. So that's about to start. That's very, very important' (Chair, CCG, site 2).

In site 3, a sub-committee specifically focused on integrated commissioning was described as the 'engine house' of the HWB. Making recommendations on contracts was one of its roles. For example, domiciliary care was put out to tender and was subsequently taken to the sub-committee for overview. Progress could be reviewed at different stages in the commissioning process. Decisions were delegated from the HWB, with the sub-committee reporting to the board.

In site 4, the role of a sub-committee of the HWB was a major point of discussion. Representatives on the sub-committee stated that previously it did not work well; people were not committed to it and were unaware of their roles. It was argued that the sub-committee had since improved following an academic review and was functioning more effectively. The sub-committee met monthly and supported the HWB by setting the agenda and keeping the JHWS up to date. The sub-committee also ensured items were acted upon and all were aware of their roles and responsibilities. The sub-committee ran workshops and development sessions, which were valued. Indeed, where workshops and development sessions were held by boards they were viewed favourably and, apart from providing a learning experience on a variety of issues, they were regarded as an opportunity to view issues differently (in collaboration with other organisations), and an opportunity to network.

There was some concern voiced around the sub-committee's role in setting the HWB agenda in site 4. The sub-committee, it was alleged, could keep items off the HWB agenda because it did not want them to be aired in public. It was contended by a participant in our initial interviews that previously too many items from the Department of Health were on

the agenda. The agenda items were subsequently linked to the strategy, development sessions, workshops and forward programming. A minority of participants in our initial interviews did not know how the agenda was set. It was also argued that there was no transparent mechanism for getting items onto the agenda and there was some discussion of lobbying to get items included. *'Well, if it doesn't get past the [sub-committee]... it doesn't make it onto the agenda'* [Healthwatch Chair].

However, in terms of agendas and agenda-setting it was noted in our follow-up interviews in site 4 that there were packed agendas at the main board with no time for meaningful discussion or debate. It was not possible to explain or discuss complex issues in detail and meetings felt very bureaucratic. The sub-committee was led by public health and therefore the DPH had more of a say on formulating the HWB agenda. Infrequency of meetings, mentioned in our follow-up interviews, was also a point of discussion in this site.

Site 5 did not have any board sub-committees. The chair elaborated on this in the follow-up interview and confirmed that no sub-groups had been formed:

'But we have talked about, we have said if we need to we'll do a task and finish, but we've not seen the need for that yet. And I've said to people, if we need to we'll have a one-off session on something, you know, where we sort things out. And as I said I'm light touch, I'm open to anything, there isn't a right and a wrong way to do anything and there isn't a right and a wrong group of people to be there '.

JSNAs and JHWSs

Across all five sites, three themes were dominant in relation to the JSNA and JHWS:

- There was (at either strategic or operational level) little ownership of the strategies and a lack of accountability for elements of them; they were not seen as an integral part of the health and social care landscape.
- Strategies partly reflected work that was ongoing by other agencies and did not bring any added value; organisations could retro-fit their plans and strategies to reflect elements of the JHWS.
- Strategies were somewhat 'motherhood and apple pie' statements, with too many priorities and themes and no clear measures of success.

The JHWS in site 3 was incorporated as part of a larger strategic plan, rather than being a standalone strategy. Instead, a health module was embedded in the emerging plan which set out a number of strategic objectives relating to health and wellbeing.

There was some 'good work' cited in site 4 in terms of child protection and infant mortality cited by one participant, but another interviewee discussed how these were hampered by financial constraints. In site 5, there was discussion of how the strategy had brought closer working links between the local authority and the CCG.

A HWB supporting officer and a Healthwatch Chair highlighted some of the issues arising from the JHWSs in site 2:

'...so we've got four strands and we report those. It's almost like, because of complexity, I think, it's trying to feel like you're in control of something that you're probably not really. So it's almost like saying well we've got these four things, and nothing wrong with them, absolutely nothing wrong with them, they're absolutely fine, but what does that board, you know, what's its added value, what's its governance? People report in and say oh we're doing this, that and the other, so what difference does it make, because most of that was going to happen anyway. It's not that the board has added something to it or has more accountability. Because of the way it's set up, it's not going to do that'.

'...we've got the wellbeing...strategy. In the year that I've been attending the board, we have not once referred to it. Nothing that's come has been linked to it'.

A Service Director discussed a strategy refresh in site 4 and for partners to alert the board to any activities that were being undertaken, which could be included in the strategy, especially in relation to gaps in provision:

'...give us some good existing stuff that you're doing that we perhaps as a wider partnership need to be aware of that we're not aware of that we need to categorise more on or we need to scale up citywide or whatever, as well as saying there's a huge gap here. One huge gap to give you an example, it might not directly fit in with our priorities and it's not unique...I think most public agencies probably fail some pretty vulnerable teenagers, going from childhood to adulthood. You know'.

The chair of the HWB in site 5 discussed how the JSNA and the refreshed strategy would now drive decisions and outcomes:

'...we've told everybody we're going to use the JSNA as the tool for moving forward, making decisions and looking for outcomes...so the health and wellbeing strategy is based on the JSNA. We already can see how it fits together...So it isn't like well we've got this but that's at odds with that. And what we're trying to do, again go back to the consistency, what we're trying to do is make sure that we've got a consistent approach. So we need to think about what, you know, if we think these are issues then we need to put them in our needs assessment, then we need to get them in our strategy, then we need to commission them, then we need to get the outcomes. Sounds easy doesn't it?'

Summary

In respect of the purpose, structure and configuration of HWBs, we found that:

- National interviewees saw the statutory role of HWBs as producing the JSNA and JHWS, in addition to a strategic oversight role. They also noted the lack of national guidance, which had resulted in boards being variable and 'patchy' in their performance. However, it was felt that the rationale for the introduction of HWBs remained valid.
- In our case study sites, boards lacked identity with no clear vision and purpose. There was also a lack of accountability from partners in terms of being responsible for strategies, goals and priorities and linked to this a lack of monitoring over progress in achieving outcomes.
- It was argued in the study sites that there was too much focus on integration and STPs and more attention on the wider determinants of health and tackling health inequalities would be welcomed.
- In terms of membership there were concerns that boards with too large a membership could mean there was little time for in-depth discussion on issues. Conversely, there was also the view that a large membership could bring a range of perspectives to bear on an issue.
- Changes in the chair of the board could bring continuity for the board in terms of policies and priorities (site 3) or could lead to change in terms of the composition of membership and priorities of the board (site 5). We also witnessed that boards generally had representation from the highest level of partner organisations and partners committed to the board.
- Sub-groups of HWBs were the arena where in-depth discussions could be conducted and where partners could challenge each other away from the spotlight of the main board. The sub-groups tended to set the agenda and priorities for the HWB. There were concerns over the accountability and transparency of sub-groups, how partners could influence their agenda-setting, and how such groups could be held to account. Sub-committees could be seen to keep certain items off the HWB agenda.
- In regard to JHWSs, concerns across the case study sites centred on a belief that there was too little ownership of the strategies; that there was a lack of accountability for elements of the JHWSs which were not seen as an integral part of the health and social care landscape; and strategies partly reflected work that was ongoing by other agencies and did not bring any added value.

4.3 FINDINGS: MECHANISMS OF HWBs

Mechanisms, in a realist evaluation sense, are *‘underlying entities, processes, or structures which operate in particular contexts to generate outcomes of interest’* (Astbury & Leeuw, 2010:368). In this chapter we focus upon mechanisms such as: the relationships, partnerships and collaborative working between organisations and actors; the decision making processes of boards; their influence on commissioning; and HWBs’ influence as system leaders in shaping the local health policy landscape.

Relationships, partnerships and collaborative working

Some trusting and good relationships had been developed in all our sites, among a variety of partners with, as noted earlier, the building of relationships key to garnering trust and goodwill the bedrock of good relationships (see vignette below). It was recognised that, in part due to financial restrictions amongst organisations, partners had to pool resources and collaborate more than previously. However, as already discussed, the potential retreat to silo working was also a concern.

Collaboration was evident in site 5 with the formation of an integrated adult social care organisation (although this existed prior to, and was separate from, the HWB) and good partnership working was discussed between public health and other partners. In site 1, there was evidence of good collaboration in terms of work on the BCF and, in site 5, in urgent care. The main problem cited with partnerships, particularly in four of our five sites, was the lack of engagement by some partners in the HWBs’ policy priorities due to having their own priorities and agendas which could take precedence. Compounding this was HWBs not having a strong influence over partners in terms of holding them to account or being able to mould their priorities according to the strategic priorities of the HWB. This would then act as a block on boards progressing their own key agendas and priorities due to the lack of engagement from partners. Also of concern was the influence of key individuals in certain partner organisations over the boards’ development. In site 2, for instance, it was noted that the Foundation Trust had its own priorities driven by its Chief Executive; and in site 4, it was argued that there were ‘Big people with big personalities’ who could exert a disproportionate influence over policies and agendas. Views gathered from the VCF sector focus groups highlighted a concern that the VCF was largely excluded from having any key influence and sometimes the sector was characterised as being an afterthought.

It was argued in our national follow-up interviews how good relationships were required for HWBs with trust amongst partners seen as a key component. It was argued by one participant that organisations needed to spend time out to get to know each other and invest in organisations in order for the system as a whole to work together effectively. This participant discussed how relationships and group dynamics were important:

‘So if you get people who are forced into sitting down together and they don’t like each other and a couple of them are a bit weak and one of them is a bossy sod and so on, it won’t work. And yet if you actually get people together who are well-meaning, who have got strengths and competences together...they can make it happen... and you see both...And there are some places that are basket cases from the start and they’re never going to make it work, because they haven’t got the relationships and they haven’t got the leadership qualities and whatever, and there are other places who will fly whatever’s going on’ (National Interviewee, 2).

Another interviewee noted: *‘I think for me that just boils down to trusted relationships around the table and a willingness to get on and do stuff’ (National Interviewee, 4).*

A vignette on building relationships and partnerships – site 3

Site 3 had not formed a shadow board but had spent a year in development and adopted a system leadership approach to collaboration partly by participating in a national programme on systems leadership. Working in positive collaboration for collective goals was the most common theme when discussing good engagement from partners. The result of such partnership working had resulted in a pooled budget of over £400 million and the co-location of health and social care workers. The DPH discussed how this had also served to embed partnership working:

‘...so we’ve worked really hard through, we’ve got an integrated health and wellbeing commissioning system. My CCG colleagues sit at the other end of this corridor with a kitchen in the middle. So you do actually do have those water cooler conversations’.

Building trust in relationships through mechanisms such as co-operative commissioning, events with GPs, councillors and senior officers to work through and cement relationships, and integrated commissioning leaders taking part in integrated development days, were cited as ways to embed partnership working. Participants noted that trust enabled strategic decision-making at one end of the spectrum, while being able to do things such as cover for each other and represent each other at meetings at the other end of the spectrum. This HWB Chair highlighted the importance of trust:

‘...right throughout this whole experience for me, it’s all been about relationships and building trust and being open and honest with each other. And I think if there’s one secret, I would say that’s the secret of what we’ve achieved. I think health and wellbeing boards need to focus on that and understand what that can achieve for them’.

The board was viewed as providing an opportunity for system leaders to come together and give the board a sense of joint purpose.

However, there were still difficulties evident in partnership engagement in site 3. It was argued that there was difficulty engaging the acute trust which was dealing with its own priorities. Links with education, housing and the police needed to be improved while children’s services and Community Safety Partnerships were struggling with a systems approach to partnership working. Non-attendance or patchy attendance at meetings was seen as an issue. There was disconnect over GP closures with NHS England (who were invited to the board to discuss these GP closures but

declined), as well as NHS concerns about the success regime and a shift of focus to the STP. There was also recognition that cuts and financial pressures could put collaboration at risk if everyone retreated to protect their own organisation, department or service. In addition, partnerships and collaboration with the VCF had not been harnessed.

System leadership

Various challenges on system leadership have been outlined in the preceding chapters, including the lack of clarity regarding the role and function of HWBs, lack of ownership of JHWSs. and marginalisation of non-statutory partners (particularly those within the VCF sector). As discussed in Chapter 1 when reviewing the challenge of system leadership, respondents viewed this in different ways. Our interviewees commented on some of the different elements of system leadership and the role of the HWB as a system leader:

‘...a health and wellbeing board really should be making sure that there is synergy and there is consistency and coherence between all of the strategies of the partners around the table’ (CCG Chief Officer, site 1).

‘in the past people did tend to work in their own silos, there was nothing joined up, where the board itself does actually, brings them all together’ (HWB Chair, site 3).

‘I think the way it [the HWB] was set up was not conducive to it being leaders in the system. I know they said they wanted people at very high levels, but they should have gone a step further’ (HWB Chair, site 4).

Despite these concerns, weaknesses, and the different emphasis given to system leadership across our study sites, it was recognised that HWBs were the only forum presently in existence where the system came together, however imperfectly. These participants highlighted some of the problems in terms of system leadership and the HWB overall:

‘I think this thing of lack of direction runs throughout. Different people have different ideas and we don't have a single idea of what the board is’ (Healthwatch Chair, site 2).

‘The board is... not itself a system leader. It manifests system leadership and it satisfies itself that system leadership is taking place, and it places system leadership out of discussions into the public, into the formal domain. But I wouldn't describe [it] as being itself focused, the place where system leadership happens’ (DPH, site 5).

The HWB chair in site 4 had pressed for a more focused approach, moving away from the tick-box exercise that the board had become. There was a recognition that ‘soft leadership skills’ were required because the HWB had no formal powers:

‘Although I chair the meeting, I have no veto to stop anybody from doing anything. So that for me doesn't give you the power. They have to make it clear that if you are

leading the system and you're setting the strategic direction, you have to have that power to be able to do so... What's going to happen in the next 12, 18 months, a number of those leaders will want to sit on the STP, because they'll see the power being there'.

In contrast, in site 3 we were informed that a 'systems leadership' approach was adopted early and a strong emphasis was put on building durable partnerships built on trust and good relationships with board members attending a programme on system leadership methods. As this Strategic Director explained:

'...very early on we [HWB members] joined the Systems Leadership Project that was being run through Local Vision, which was LGA/King's Fund/the National Improvement Agency Leadership Centre. And we joined that and used a systems leadership approach to help us work through a lot of the things that we wanted to do'.

It was also believed that the HWB offered strategic leadership and to some extent acted successfully in holding commissioners to account. However, many decisions were taken at sub-board level and the HWB in this site was seen to offer assurance and oversight on decisions (although this was also interpreted as rubberstamping by some interviewees in respect of reports passed without a level of scrutiny at the board). An Assistant Director discussed the formulation of a systems leadership approach:

'...I think that the foundations were established very early on for making this systems leadership a reality... It's not been without its challenges, inevitably, but I think the principles of systems leadership are pretty well carried out, pretty well visible and evidenced...'.

A Chief Executive elaborated on the systems leadership approach adopted in site 3:

'...part of systems leadership is understanding the constraints in which other parts of the system are operating. And working through how you get the best outcome, recognising that people behave in a way in which they're normally driven to behave. So that's quite an important principle of moving forward. The reality for our system, and the reality is once you start pooling your money the conversations that you have are different conversations'.

System leadership was a point of discussion amongst all our national follow-up interviewees. It was argued that there was a need to have 'buy in' from the NHS since, as noted above, the HWB was the only place where the system came together. However, it was felt boards were ignored to some extent by the NHS. System leadership depended on effective leadership of the board, but no leadership or executive powers were invested in boards and they were not equipped to be system leaders as they had no levers or resources. Any traction on the system was a result of 'soft' power around the exercise of persuasion

and influence. It was argued by one interviewee that boards were system facilitators, not leaders, operating at best through persuasion and negotiation. It was also noted that discussions were taking place elsewhere outside the boards with arguably STPs being seen as that place. It was suggested that HWBs were not at the right scale to be system leaders and needed to be organised on and cover a larger geographical footprint.

Decision-making processes

Decisions were largely seen in all of our sites to a greater or lesser degree as taking place elsewhere in the system, not within the HWB. Such decisions might emerge between different partner organisations and on occasion at different levels; decisions might also be referred to sub-groups of the HWB. It was noted that with HWBs meeting infrequently, sub-groups would carry out the work required between meetings (this was the case in four of the five sites). Boards were generally not viewed as decision-making bodies but more as bodies which existed to ratify decisions with a lack of challenge from, and accountability to, partners on the board (see vignette below). It was believed that HWBs generally tended to 'rubber stamp' a lot of decisions, with papers coming to them with recommendations and to be 'signed off' (including papers from national government and Department of Health). It was thought that the HWB was the formal end-point of the decision-making process. Boards had no formal executive power to direct organisations and were reliant on the commitment of partner organisations to translate priorities into action. It was also noted that boards could use 'soft power' to influence the system but the impact of this was regarded as variable.

A vignette of a HWB and lack of influence on decision-making - site 1

A workshop was conducted in site 1 on children's mental wellbeing. The DPH gave a presentation on children's mental wellbeing and a whole system approach. Another presentation focused on suicide and self-harm. This vignette highlights the disconnect between the HWB and decision-making processes.

The workshop was conducted with multiple partners, including mental health services. The main theme to emerge from the workshop was that prevention was the most important element in relation to children's mental wellbeing. The DPH put it in the following terms:

'...we've got to make sure we've got a balanced system, but we need to make sure we make it so that children are resilient and can manage and have the least chance of needing the [Children's Social Services], but then redesign the service. We did all that. What was not said was that the next day the main bit of funding that the children's services has in prevention, they [the council] were planning to remove it completely'.

The DPH discussed how on that day those making the decision knew they were going to have a discussion with the provider of the preventative service, but that was not raised in the workshop.

'And some of the conversations fed back to me were the leader said oh we can't possibly not fund this service - and they're not doing. It's part of their cuts, that's going to go. So it's like how influential is the health and wellbeing board when we kind of summarised it and said the really important things are these, whatever, and then the organisation just goes. The people sitting around that room were the people who were making that decision at the same time. So how does that square the circle between what's discussed and what does it do? And then it's [is] that known necessarily by the health and wellbeing board in general? I mean I know, the director of children's services know, probably the chief exec of the trust where that service is placed knows, but nobody else would necessarily know that this is a decision that's happened. So it's almost like we're playing a game one way and then we're doing something that suits ourselves somewhere else. If the health and wellbeing board truly held the ring, you'd expect them to know about that and to be able to challenge that legitimately and say OK well why is that decision being made when we've just said that that's an important area for us? How do we understand what you're doing which is diametrically opposed to what the members of the board were saying was important? And that happens all the time'.

A Deputy Chief Executive in site 2 discussed how decisions were taken outside the HWB:

'Well there's things like the STP should be at the centre of their agenda; things like how do we deal with the significant funding gap across social care... And to be honest those discussions are all had at the periphery. And we're still all dealing with those issues largely as separate organisations, and then sort of discussing the impact of that rather than actually thinking strategically together how do we deal with the issues at hand? So where those sort of strategic issues are happening they tend to be happening outside of the remit of the health and wellbeing board and not reporting directly into them...'

In site 4, a major point of discussion was that the HWB was largely a 'rubber-stamping' exercise. This was seen in the context of having to sign various off papers in relation to the BCF. Similar situations were observed in sites 3 and 5, as illustrated by the following responses:

'If I'm really honest, I haven't seen us having a conversation. We have a paper. Has anybody got any questions about the paper? Well, you've seen this. The paper goes away' (Healthwatch, site 4).

'...it's done some good things, but what decisions has the health and wellbeing board taken that wouldn't have been taken if it didn't exist? In preparation for this conversation, I was racking my brain because I've been a member of it from its inception, I couldn't think of one' (DPH, site 5).

'...if you sort of step back and ask, where was the decision made? It wasn't at the health and wellbeing board because all of the information and intelligence and

critical thought that enables the decision was offered elsewhere and the decision was taken elsewhere. And what the health and wellbeing board did was to say yes, we agree, carry on. But is that decision making? Some people would say, no, that's rubber stamping' (DPH, site 3).

Although not a main item of deliberation by respondents in our national follow-up interviews, decisions were sometimes seen as taking place elsewhere and signed off by boards. A respondent noted that with a board they peer reviewed it was clear that the important health conversations were taking place elsewhere.

Our VCF focus groups believed that if decisions were made they occurred outside the HWB or at sub-group level of the board. As these interviewees noted:

'I think I've lost faith completely in those...bodies. I think you sit on a body like the health and wellbeing board and you could read all the papers and you could contribute to every single debate and I don't think it would actually change anything that was going on the ground because I think the decisions are made long before it actually gets to the health and wellbeing board and in a sense the health and wellbeing board is a bit of drama, isn't it? It's bringing everybody together in the same room. It's people making comments on papers. But the decisions have already been made, the direction of travel has already been set and this is just in a sense a bit of a presentation' (Site 1, focus group 2).

'So things tend to be noted or approved, I'm not sure if they come to be disapproved, do you know what I mean?' (Site 4, focus group).

There were also concerns expressed over HWBs responding to national agendas. Disquiet was voiced over the volume of paperwork for the boards to process and in particular allowing VCF groups sufficient time to scrutinise paperwork and/or report back to the sector.

Influence of HWBs on commissioning

The influence of HWBs on commissioning varied, from having a direct influence (site 3) to having very little influence (site 5). In site 3, there was an over-arching commissioning strategy and a number of thematic strategies nested below it. These commissioning strategies were signed off every year by the HWB.

Commissioning was a central focus of discussion and a number of themes emerged in site 3:

- There was evidence of a co-operative and multi-agency approach to commissioning (also a desire not to destabilise organisations in the commissioning process).
- Integration was driven by commissioning.

- The HWB sub-board dealt with the operational aspects of commissioning and the main HWB with the strategic elements; opinion was divided over whether the HWB effectively challenged the sub-board and there was a belief that the HWB was trying to hold commissioners to account.

In site 4, the changing role for the local authority, driven by financial constraints, provided opportunities (for public health in particular) to do things differently in relation to commissioning (though not specifically linked to the HWB):

‘The fact that we had a [public health] budget and the fact that was with the council means we could get on and do things that we would never ever have done in the NHS, because everyone was too scared’ (DPH, site 4).

In site 2, commissioning per se was not a major theme. However, the issues that emerged were that the commissioning intentions and objectives of the JHWS may differ. Organisations had different agendas and competing interests and change therefore took time. In site, 1 the county had some services that were delivered ‘in house’ and there was discussion around the need to reconfigure services. There was also a view that the HWB did not commission work that made a difference to how services operated. One participant believed the board needed to be more challenging and set more targets and prove that it brought added value. The following interviewees encapsulated some of these views:

‘...I’m a believer in local authorities providing services, as well as commissioning services. I mean there’s no way we could run all services, but by being part of it and able to provide it gives us the strength and it also gives people in the rest of the county a choice of whether you want to go with the private sector or local authority sector in terms of care, so. And it helps in terms of our credibility with the other organisations. So I live in the world where commissioning is part of it, but I also like to be a provider’ (Chair, HWB, site 1).

‘It’s actually commissioning pieces of work that will make a significant difference to the way services are being provided. It’s providing a forum where we can discuss what should our kind of collective priorities be’ (Strategic Director, site 1).

As noted in site 5, there was already an integrated commissioning function as part of the council, to which both the PCT and council had delegated authority to spend within a Section 75 agreement. The HWB was not part of that process. There was an adult health and social care organisation and significant pooled budgets. The integrated care board and a joint commissioning board oversaw the pooled £200m budget for care of the over 65s. These issues will be discussed further in relation to the integration of health and social care in Chapter 4.4. However, the adult health and social care organisation, pooled budgets and a children and young people health and social care integration organisation – a multi-agency

organisation for improving outcomes for children and young people – were not generally viewed as overseen by the HWB.

Governance and accountability

There was concern across the sites, particularly evident in our initial interviews, that there was little leverage or power exercised by HWBs to hold partners to account, largely due to an absence of resources or executive power to do so. There was a lack of challenge and scrutiny by boards. In site 3, it was noted that the HWB held commissioners to account to an extent but that other aspects of board business were confined to providing assurance. Boards in the other sites also reported ‘rubberstamping’ certain papers and policies and there was a lack of monitoring generally. The need for more monitoring and measurement was required to ensure that the progress of various programmes was kept on the agenda of boards thereby ensuring that they exercised a strategic oversight of policy. Allied to the absence of any systematic monitoring of progress against the JHWS were worries that sub-groups of HWBs (present in four of the five sites) lacked transparency in terms of their roles, remit, policy agendas and reporting arrangements to boards. A Strategic Director in site 1 and a Vice Chair of a HWB in site 2 reflected on some of these concerns:

‘I think it [the HWB] needs to hold public health as a service to account more and to question more about why we’re, you know, for example, contracting trusts to deliver on smoking cessation when all the data is suggesting that they’re failing left, right and centre to deliver any good outcomes, yeah. It’s that kind of hard edge to the health and wellbeing board: that it should be there as a board that challenges, that has teeth, that holds agencies to account, including constituent agencies, and holds public health as a service in particular, given that public health as a service is probably the one service most closely aligned with health and wellbeing board priorities’.

‘The problem as I see health and wellbeing boards is they’re not accountable. And if you’ve got no kind of controls, and you can’t hold people to account, apart from through having a good relationship and a conversation, actually it means they’re not terribly effective’.

In our follow-up case study interviews, mechanisms had been put in place in three sites to ensure greater accountability. In site 1, members identified that an LGA peer review had been a positive experience for the HWB because, along with the self-assessment, it had led to a number of changes for the better in the way in which the board operated and was structured. Overall, along with a change in Council leadership, this review had resulted in a more inclusive and interactive board (versus a formal committee feel) with a core and sub-group structure providing more effective mechanisms for implementation and reporting back:

'And they've created a couple of subgroups or sub, well I'll call them subgroups...to actually look at what the agenda should be etc. And it is working better...'
(Healthwatch Chair, site 1).

However, it was noted that the HWB could still do more to hold itself to account internally, particularly around the integration of the public health strategy across the Council functions and across district authorities. The board planned to use an LGA self-assessment tool for the purposes of ongoing internal review, including efforts to coordinate the work of another local HWB. It was also suggested that a 'dashboard' could be developed in such a way as to integrate with an STP dashboard thereby enabling system-wide monitoring.

In site 3, there was also a dashboard in terms of the development of health and social care integration presented at each board meeting.

The new chair of the HWB in site 5 had ensured that the adult health and social care integration organisation was held to account and reporting regularly to the board. The chair described the new accountability arrangements as follows:

'So we're not just a talking shop anymore, yeah. So when we're coming along now we want to be saying right so what's happening with? Where are we up to with? Why has that happened? And then within that you've got the, these are the must dos we need to be thinking about, you know...So I think what we're trying to do, to say to people is, look, you know, yeah there's a lot going on, but simple message, we know what our priorities are, because we've worked out and we've asked everybody and everybody's agreed them, OK, that then is our strategy, how then do we implement those priorities?'

The role and perceived contribution of elected members

In three of our study sites, there had been changes in the chairs of the board during the time field work was being conducted. In two sites this had resulted in changes in the development of the HWB. It was highlighted by participants in site 4 that the board, since it became statutory, had had three chairs, each with a different leadership style. It was contended that the changes had had a detrimental impact because they hindered progress due to a lack of continuity. However, in site 5 the change of chair meant a new direction for the board in terms of organisations being made accountable to the board, and a provider and other organisations being invited onto the board on an ad hoc basis as required. The chair received lots of expressions of interest from agencies wanting to join the board but decided to hold a workshop to address their issues rather than expanding the board which, it was feared, risked becoming too unwieldy.

In contrast, in site 3 it was strongly believed from the evidence of our baseline interviews that there was strong cross-party support for the health and wellbeing agenda and for health and social care integration. As an Assistant Director noted:

'...both Conservative and Labour have been on this journey with us, and there's absolutely hundred percent signup certainly towards health and wellbeing in its widest sense improving health and wellbeing, and also around integration. We did a lot of work certainly in the last 18 months about taking both parties with us across the line to make sure that if there was a change in personnel that we would be absolutely assured that nothing would be destabilised with a change of administration'.

This would seem to be borne out in our follow-up interviews, as a change in political leadership on the council and a new chair of the HWB did not seem to have had an adverse effect on the HWB. The health and wellbeing and integration agendas had remained unchanged.

In sites 1 and 2, although there had been no changes in the chairs of the boards there was a somewhat stark contrast in styles thus demonstrating that politics and personalities do have an influence for good or ill. In site 1, the chair, who was a councillor, came in for some criticism:

'What he sees as a result is that the meeting finishes on time. That's great for him. He thinks that's managing the agenda well that we've got through the business quick. So that kind of says all you need to know' (DPH, site 1).

As the chair in site 1 noted:

'We have a two hour session for the board meeting and I'm quite determined to finish it in two hours because people need to keep it focused'.

A CCG respondent referred to the chair's style in these terms:

'A nice man - I do like him - but very fixed in his ways' (Chief Officer, CCG, site 1).

In contrast, it was believed that the HWB chair in site 2, who was also the council leader, was a good chair enabling people to participate and contribute. The chair ensured the right people were around the table, and the board was seen as an important meeting for partners. The chair having a public health background was regarded as 'hugely valuable'. It was felt the chair led the board very well while acknowledging the existence of some shortcomings. Hence the desire for staging a peer review. It was also believed that the chair had displayed good leadership, built good relationships, cultivated shared values, and had managed tensions between partner agencies well.

The vice chair of the HWB discussed the chairing of the board:

'[The chair]...is a very good chair and people participate in that, so I think the level of commitment is really good'.

A minority would have preferred an independent chair, not a councillor.

Public and user engagement

There was a widespread view that little had been done by HWBs across our five sites in terms of public and user involvement. It was argued that overall there was an absence of public engagement with the public largely unaware of the work of the HWBs or even, perhaps, of their very existence. Members of the public did not routinely attend meetings, except when a particular issue was of concern as part of a campaign or pressure group involvement. Meetings of HWBs appeared to be ones that took place in public, as required, rather than being public meetings. Our observations of HWB meetings found that board members did not seem to acknowledge those who were not sat around the table and there was no time set aside on meeting agendas to receive questions from the public.

A partial exception to this view was Healthwatch which, according to our case study interviews, was generally perceived to be engaged, and contributing to and challenging HWBs. But Healthwatch was clear that it was not their role to conduct public engagement work on behalf of the HWB. Discussion also centred on funding cuts to Healthwatch and how these affected their capacity to engage with the public and the HWB in two study sites. A Healthwatch representative in site 2 described their role on the board:

‘So we see our role there as very much to sort of bring a pair of fresh eyes, make sure that there's a really clear path of the way in which things have been reached and that people have been involved in the development of that path, but also to be sort of a bit of a critical friend, give it a bit of challenge, that type of thing... we try to work very much as partners. So there's a big bit of work happening at the minute around system integration. We offered half a day of my time to be part of that work, so I'm part of the taskforce on that. And it's very much, yes, we bring that challenge and the grit I think I described as we're the grit in the oyster. But actually, it's about us all moving together to get to the best place, rather than just standing and criticising from the sidelines’.

Voluntary sector representatives spoke of the difficulties of engaging with the wider VCF sector, with little time to engage and consult on complex issues. However, some worked through networks to enable views to be fed into HWB, and to take back issues to the wider sector and local communities but spoke of their frustration in not being enabled to work in advance on some issues.

Webcasting was a feature in two study sites and a main concern was that it might result in partners not holding each other to account effectively to avoid any appearance of disagreeing in public. Webcasting could be perceived as stifling debate and challenge. However, there was also recognition that it provided an opportunity to send out messages from the HWB and demonstrated that the board was open and accountable.

A new element in our follow-up interviews was the concern in two of the study sites over the lack of public consultation over the STP process. In one site, Healthwatch was trying to engage the public and raise awareness of the STPs. In another, some board members were pushing for public engagement but were reportedly told not to discuss the STP by NHS England (an instruction subsequently withdrawn). Our follow-up interviews found that in one case study area the lack of public engagement had led to the establishment of a HWB sub-group focusing upon public engagement and communication strategies led by Healthwatch.

Among our national interviewees, opinion was divided on public engagement. There were those participants who believed HWBs should be, and were, effective in engagement. One interviewee noted that boards had a reach and could build understanding and stood at the interface between public services and the public. Another view was that boards needed to engage the public in terms of the JHWSs regardless of whether the boards' role was as a champion of the strategy, the public face of the strategy, or actively engaging with the strategy. Partner organisations could engage the public as long as it was part of a co-ordinated approach and therefore, it was argued, it was not important who led the process. An interviewee observed that they had seen over 100 HWBs in different stages of development and, in simplified terms, engagement tended to be at one of two extremes: first, the board is a kind of holding company where the constituent organisations need to engage with the public; and second, the board is the public face and looks outwards. Other modes of engagement, it was argued, lie in-between these two positions. An interviewee argued that public engagement was an example of tokenism and that Healthwatch was variable in its impact on HWBs. However, it was conceded that engagement had worked well in a 'handful' of places:

'It's never really going to work [public engagement], I don't think – that's very cynical. But it never does, does it? Healthwatch itself is hugely variable. In some places it's really hectic and works well, but in others it's just hopeless and basically rubbish. Of course, they've got no power, no authority and no money, so they don't stand much of a chance, do they? It will take somebody really good leading them. So I think it is tokenism really. I guess it works in a few places but I would have thought it's only a handful of places where you really get that. And I'm not certain how you would get it anyway. You know, I've struggled with this for 25 years or whatever I've been in public health, how do you get the Joe Bloggs...view into anything, because there isn't one Joe Bloggs' (National Interviewee, 6).

A number of themes emerged from the VCF focus groups on engagement:

- Boards had not capitalised on previous (better) engagement processes
- A lack of investment in infrastructure to the sector had hindered engagement
- Complex and not easily distilled messages from boards were used for information not engagement

- Boards only engaged at the implementation stage
- Inconsistent engagement across HWB footprints with HWBs not heeding or acting on key messages and insights from the sector.

In site 3, a novel method of engaging the public was used to receive their views on health issues. This took the form of a public consultation in the city about a plan for the whole area (which incorporated the JHWS) and health issues were part of the consultation. This was largely seen by HWB members as a worthwhile exercise and there were calls for it to be repeated, or to become part of a rolling programme of public engagement. The local authority Strategic Director discussed the consultation exercise:

'And so people would come up and literally sit down and have the conversation with you and you'd get them to fill in the forms. But you're saying yeah but what's important here? And of course, most of the things were about, well, I want to be able to get the bus, and I want shopping. I want to know where the doctors - and I want this, and, you know, I want to be able to go to do some leisure things. So it was a much wider conversation than about health and care'.

It was also viewed as a good consultation exercise by the VCF focus group in site 3. As one focus group participant stated on the local authority consultation: *'I'll give them some ticks!'* However, it was believed overall that the board needed to engage more with the public.

For a version of the JSNA in site 5, there were four people, one of whom was from Healthwatch, who were responsible for the public engagement feed into the JSNA. The Healthwatch interviewee discussed the public engagement element of the JSNA:

'So for example a couple of years ago we did a massive survey, which contributed towards the JSNA...And we took our report to the, I presented the report at both the scrutiny committee and the board. Very well received and everything. And whenever I go I make the point, I said, you know, great, I'm absolutely delighted, our volunteers put hours and hours and hours of work into...we started doing it before the health and wellbeing board was set up. So we did that...I looked at everybody round the table and they sort of sat back with a smile of contentment on their faces. They looked like the cat that's got the cream. Oh this is great. One of the councillors said, independent councillor said, oh this is excellent value for money. I said well make the most of it because you've cut our money, so it depends on whether or not we've got the volunteers'.

Summary

- In terms of relationships, partnerships and collaborative working, trusting and good relationships had been developed to varying degrees in all the case study sites. Lack of engagement by some partners was a major problem due to them having their own

priorities and agendas, and due to HWBs not being able to hold partners to account or align their priorities with those of the HWB. The VCF sector was largely excluded as a key influence on HWBs and sometimes the sector was characterised as being an afterthought.

- System leadership was seen as largely absent and the lack of strategic direction of HWBs was a common theme. Underpinning this was the general view that HWBs were not system leaders but more a collection of leaders accountable to their own respective organisations; moreover, they were viewed by the voluntary sector as embracing the public statutory sector only. Partners had their own (often conflicting) priorities and still largely worked in organisational silos. There was a lack of strategic join-up, such as of the JHWS and other policy initiatives by the HWBs and little ownership by partners with the strategies not regarded as an integral part of the health and social care landscape. The demands and priorities in other areas of the system (e.g. STPs, NHS) served to make system leadership difficult with an expectation that STPs would assume ownership of the system rather than HWBs. However, at the same time, it was recognised that HWBs were the only place at present where the system came together, which may in part explain the attendance at the highest level by partner organisations and the commitment to the HWB expressed by participants.
- Decisions were viewed as taking place elsewhere in the system by partner organisations and at different levels, rather than within the HWB. Boards were not viewed generally as decision-making bodies but rather as bodies to ratify decisions with a lack of challenge and accountability from, and to, partners on the board. Boards tended to 'rubber stamp' decisions, which were often deferred to sub-groups due to HWBs meeting infrequently (and in public). HWBs had no formal executive power and were reliant on 'soft power' to influence the system.
- The influence of HWBs on commissioning varied, from a direct influence on the one hand to very little influence on the other.
- There was concern across the sites that there was no effective leverage by HWBs whereby partners, their roles and responsibilities and their policies and programmes could be held to account, coupled with a lack of challenge/scrutiny by boards. A lack of monitoring generally was cited.
- There was a general consensus that little had been achieved by HWBs in order to ensure effective public and user engagement; the public did not routinely attend meetings and the input of the VCF was under-valued. Healthwatch were generally seen as contributing to and challenging HWBs in our case study interviews, but their role was not to conduct public engagement work on behalf of the HWB.

4.4 FINDINGS: OUTCOMES

In their discussion of outcomes, Pawson and Tilley (2004:8) observe that: *‘Outcome-patterns comprise the intended and unintended consequences of programmes, resulting from the activation of different mechanisms in different contexts’*. This chapter presents our study findings in relation to outcomes reportedly arising from the activities of HWBs, both within our five case study sites and in other areas as reported by the national interviewees.

Outcome enablers

Participants from our national follow-up interviews argued that good system leadership was required to ensure outcomes were achieved. Good engagement by partners and having defined goals were also seen as essential requirements for successful outcomes. An interviewee noted that HWBs needed to look across the whole system in terms of determining whether they were innovative, saved money or improved health. It was suggested that in these areas progress was ‘patchy’. It was also acknowledged that if HWBs were not improving health and wellbeing in ways that were evident and could be tracked back to their efforts in regard to producing JHWSs then what was their purpose? Another interviewee observed that a different approach was needed if the boards were having no impact. However, the same interviewee also argued that if after five years tentative progress had been made this should be regarded as a relative success since partnerships took time to bear fruit, particularly if partners had not worked together before.

Process outcomes

In our follow-up interviews in site 1, there had been some tangible changes. As noted earlier in the discussion on sub-committees of HWBs, there were now HWB sub-committees aligning with the JSNA and the four priority areas outlined in the JHWS with those groups responsible for the work around each. A number of initiatives were identified where progress had been made including leisure, housing and planning and children’s mental health. There was a sense that whilst some of the advancements made (particularly around public health, planning in communities, children’s mental health) may have happened anyway, this would have been a much more drawn out and difficult process without the HWB. The pace of change had been speeded up through better coordination and from the strategic backing provided by the HWB. The planning in community and planning and health group sped the pace of change by getting NHS and district/borough sign up from the start:

‘So what I would say is with that one and from what I’ve heard from conversations is, we would not have got to where we are as fast or in as a coordinated way as what we have done. We might still have got there, but what we’ve got from the health and wellbeing board is we’ve got NHS support and then borough and district sign-up across all authorities. And we’ve also got them on the back of that to agree to a

planning and health group. And we actually took to the chief execs of all the districts and boroughs last week on the back of some of this with links to the health and wellbeing board, a health statement to go in all local plans and to get public health involvement for all of their local planned development and supplementary planning guidance under it. So I don't think we would have got that the way we have done and to get it across all [boroughs and districts] in that sort of timeframe without having the health and wellbeing board and that sort of place' (DPH, site 1).

Examples of process outcomes were given in site 3 in regard to better relationships, pooled budgets and joint working. The VCF focus groups also considered outcomes but again these discussions were couched in terms of process, of either producing a JHWS or signing-off other strategies. A participant in the focus group from site 2 observed that the board, apart from the health and wellbeing strategy: *'...would struggle to say that it's achieved anything other than that'*. In the focus group in site 4, an interviewee stated of the HWB: *'Well on paper it seems to have achieved things, and it's signed off quite a lot of strategies...But I couldn't say confidently that therefore things are getting implemented'*. In site 4, it was argued that any achievements were generally process-based, e.g. signing off on strategies, better communication (see vignette below):

'As a CCG, there are some things that we have to have approved by the health and wellbeing board and we'd all go 'where the heck are we going to get that approved from if it's not approved there?' You know, the agreements around some of the Section 28 funding happens via the health and wellbeing board, but we agreed that before the health and wellbeing boards were there – Section 28 funding has been there longer than that. So it's like well, yeah, it gets done there. There's some functional stuff, but it could get done somewhere else' (Chair, CCG, site 4).

A vignette of the HWB helping to raise the profile of issues – site 4

It was discussed by two participants in site 4 how the HWB had helped to raise the profile of issues and place them on the policy agenda and although not an outcome per se, this was felt to be a valuable function of the board:

'It has raised a share understanding and profile of some key groups. The work we've done about children for example has now lead into some further exploration of adverse childhood experiences and how those could be countered. It has overseen some difficult work to put that into place so the nought to commissioning of the CAMHS service is I think a real achievement' (Director of Social Care, site 4).

'I think it hasn't hindered, [the HWB] I think it has helped. I mean the fact that you know, I think the fact that vulnerable adults and children were prioritised by the health and wellbeing board could only help couldn't it. As you know we received the annual reports. It's hard to name maybe any specific reasons how it's helped but maybe you'd have to ask the

chair of...the adult safeguarding board...but I hope [they] would've said that [they] felt supported by the health and wellbeing board, [they] knew that we were behind [them] and it was a key priority for the city. But again we don't have a budget, we can't direct more resource towards adult safeguarding so...' (Chair, CCG, site 4).

Health, wellbeing and inequalities outcomes

In site 3, the setting up of the community provider, with the provider operating a triage system thereby diverting patients from A&E, coupled with an acute care at home team were cited as outcomes. A public health programme with an emphasis on prevention in terms of an early help gateway for children and young people – diverting children from children's social care and preventing them entering the system – was also cited. One example given was the 'integrated care pool' which was mobilised when the local hospital was put on 'black alert'. The situation was resolved in less than 24 hours because of the pool which enabled social workers to be sent in to assist with quicker discharge. That was a process and system that was set up and worked when needed, but it also reflected the motivation and a positive willingness to help solve a problem and to work together in partnership which characterised much of site 3.

In terms of successes in furthering the public health agenda, some were reported in our follow-up interviews in site 1 in raising the profile of public health and outcomes identified previously around specific initiatives delivered through subgroups (though the extent to which this was all a product of the board rather than the ambition and proactivity of the new DPH is less clear). However, it should be borne in mind that there appeared to be a willingness to engage the DPH and the public health agenda where the previous DPH was not influential on the HWB or part of the sub-groups and left the authority primarily because of the lack of influence the public health agenda had. The DPH discussed the importance of public health in terms of health and wellbeing:

'The other change area that I think has seen a major improvement is around the whole issue of public health and awareness of what public health offers to the health and wellbeing. So there's all sorts of initiatives going off with regard to public health, and perhaps the biggest one that is closest to my heart is the whole question of housing and health, and the way in which we should be directly influencing housing strategies across the county and growing awareness of the negative impact that housing has or can have on the overall health of the population'.

It was believed in site 2 that there was not enough emphasis on public health, social determinants and the preventative agenda and too much focus on the integration of social care as evidenced in the responses from our initial and follow-up interviews.

It was recognised in site 4 that the board was a good arena for stimulating conversations with different partners around the wider determinants of health, but less successful in engaging with health service partners as this DPH explains:

'I think actually, so getting housing and the police involved, we have had a different conversation. And I think we are, or the health and wellbeing board is now beginning to wield its power in different ways. We're also getting the...Education Partnership, we're getting them involved, and again that's changing a dynamic and having conversations in a different area. So actually if I was to say about the health and wellbeing board, it's about does it stimulate conversations elsewhere? You know, if you look at the wider determinants, is it stimulating conversations in the police world, in the education world, or whatever? I think it's starting to. In fact, bizarrely the one area it's not is the health care system'.

However, as noted there was no noticeable impact on outcomes, particularly in relation to health improvement and wider determinants. There was little mention of inequalities or mental health but, as discussed, an emphasis on sharing information rather than on action.

'I think there's process stuff that's good, but in terms of outcomes, you know, if I look at our public health outcome framework, if I look at the...CCG framework, I'm not certain we've made big strides' (DPH, site 4).

'I suppose the other thing is anything to do with health inequality which tends to be mentioned. So we've had several presentations about the difference in life expectancy between people in the far south of the city and the far north. But there's never any plan for tackling that in any way' (HWB, VCF representative, site 4).

In the baseline interviews in site 4, childhood obesity was seen as one area where progress was arguably being made but this was driven largely by one of the CCG clinical leads. However, it was likely that the council would be reducing services around childhood obesity, which was not an encouraging sign. Obesity was also viewed by one participant as a national issue – they could only 'tinker round the edges' locally. However, there was some discussion on making some headway with looked-after children and obesity.

'Well, there was looked-after children. I think we've made the biggest impact on children. I think, and I fall into this trap, you know, obesity has developed over 30 years, you're not going to see a change in three years. And I think we were slightly mad to put that in in retrospect, and it's one thing I've learned. I think homeless, we should put in and we haven't delivered. The other issues around vulnerable people, we've not delivered, and financial stability clearly not delivered' (DPH, site 4).

'I quite like what we've done around obesity. You know, I'm not saying we're there yet, but I do think we've made a really good start. [...]I feel that we're going to get some really good results, because we've got a willingness from all the partners to

look at it. There's some really good work going on...to really make that make the difference, and again that's around the prevention piece. Also, working with a number of our schools in the city to look at how we can increase activity with young people, so we've managed to get a large number of our schools now doing that mile a day walk for young people. I do think we've had some success, because the board has empowered others to do things' (Chair HWB, site 4).

In regard to the JHWS in site 5, a Deputy DPH observed that they genuinely felt that the strategy was a key part of the adult health and social care integration organisation delivery programme. There were some quite strict governance arrangements which were outcome focused and reliant on a whole range of partners having action plans to take forward some of those key elements of the JHWS. This was also true with the children and young people health and social care integration organisation which was the multi-agency approach to improving outcomes for children and young people.

'We've just got to be careful that the health and wellbeing strategy doesn't, it's consistent with and reflects the ambitions within those two organising environments really. So that's the key thing – because if it's strictly in isolation, then it won't be embedded in the individual organisations priority programmes' (Deputy DPH, site 5).

However, this could arguably, and not unreasonably, be interpreted as the strategy being retro-fitted to existing work and not part of an integral outcome based delivery partnership driven by the HWB.

The HWB Chair in the follow-up interview in site 5 discussed the difficulties of having an impact on the wider determinants of health when asked how confident they were that there would be successful outcomes from the JHWS:

'Very in some cases and not sure in others, so one of the biggest problems we've got and I'm sure it's true elsewhere, I mean we're one of the most polarised boroughs in the country between affluent and deprivation. And that's reflected in...not just life expectancy but ill health onset...So as I understand it what happened last time when we did some work to try and sort this out was we upped the level for those in more deprived areas, but they upped even further in others, so the gap actually got worse, and I think that's an unintended consequence, but you can't say no I don't want that to happen. So we're still trying to work out how we can address some of the health inequalities in our more deprived areas. And if we can crack that we're well away. And that's not easy... So how we deal with that and how we get the outcomes from that is a hard one'.

Performance management of outcomes

It was also suggested across our case study sites, and by our national interviewees, that monitoring of progress was needed; many HWBs had no systems in place for performance

management. In site 2, in the initial interviews, it was viewed that there was not a step by step approach for monitoring and achieving outcomes. More measurable outcomes were needed on the way to achieving long term outcomes to measure and chart progress at interim stages.

'That's another thing which you'll have read in the peer review that we're not really - we've got a very clear strategy and if you like it's focussed on Marmot and trying to prioritise those who are least able to help themselves. So people sign up to the kind of broad values and principles, and so we have got a strategy and a plan, but actually the outcomes aren't really terribly clear. And some of our outcomes are much much longer term. So we haven't got - what would you call them - steps on the way...So I think what the peer review was trying to say was...you also need to have more measureable outcomes that you can achieve on the way to getting there' (Vice Chair HWB, site 2).

It was argued in site 2 in the initial interviews that it was unsure where the board was making progress, and performance management mechanisms were required. A CCG Clinical Lead discussed the prospect of delivering outcomes in a somewhat sardonic manner:

'...in six months or a year you can come back and I'll say we are on the cusp of doing some really, really great things, because we have always been on the cusp of doing really, really great things. And it's true. It's absolutely true. In our mental health agenda we are doing some fantastic stuff, none of which has yet arrived, but it's all going to arrive on one glorious day. And then everybody will say oh, that's what it was all about? Thank goodness! You've saved us. That is definitely what's going to happen'.

A Councillor was also somewhat sceptical over the monitoring of outcomes:

'So I think that is clearer, although I'm not totally convinced that everybody around the table understands that's what we're doing, but I think that's part of it'.

The DPH was asked about monitoring of outcomes in our follow-up interviews and questioned whether they were only measuring indicators that could be measured, not what should be measured:

'I mean the answer is yes we're trying. But I think one of the things that's clear is that when you, this applies to the board...and also...I guess overlaps a bit with both...the...JSNA and the public health outcomes framework. And across that range I think a big problem is starting with the public health outcomes framework there's an established and clear set of indicators. They are really what can be measured rather than, to a very large extent rather than what we need'.

The DPH when asked if there was any defined system of performance management so the board could see what was being achieved responded that:

'We're in the process of developing it in so far as we're looking to have clear action points from each of the discussions, and that on our yearly cycle that we come back to those to look at how we've progressed, so yes. We're not doing it in one package though; we're doing it by stages'.

A councillor observed:

'...but we agreed as a board that we wanted more information. We wanted, so that when you said to me what difference are you making, I can't actually say oh well we've done this and we've achieved that and we've done the other, you know, and I don't think we're there yet'.

It was further noted that there were long gaps between meetings and a Healthwatch participant was not clear who was accountable for what elements of outcomes or if there was an action plan for implementation. However, in our follow-up interviews in site 3, they did note that there were plans in regard to the monitoring of the strategy:

'...but I think that's what we're planning to be doing as part of the board. Is when we're looking at a certain area [of the strategy] and starting to say okay so what actions need to be taken, what are we doing already...when would we expect to be able to evaluate them and that type of thing'

For those being interviewed, in site 3, success was couched in the formal structures and procedures they had developed – integrated commissioning and the public health initiative for example. It was about the processes being developed, with recognition that a lot of public health initiatives required taking a long view, not expecting short term results. Therefore, many of the hoped for positive outcomes were about future potential. Consequently, there were no specific examples of 'this is what the HWB achieved'. At the same time, the issue of outcomes and their achievement was not necessarily looked at in that way. Rather, the HWB was seen more as a facilitator for other organisations to achieve results.

In site 4, there was a distinct lack of performance monitoring or accountability for outcomes. A Service Director described their JHWS (which had been distilled to a single side of A4, referred to as 'the plan on a page') as follows:

'The left hand side is the high level outcomes, what we're trying to achieve. Nice and clear on that. The right hand side was well what are the specific measures, targets and who's accountable for them - we weren't so good at that'.

In our follow-up interviews in site 4, again the lack of monitoring was an issue in measuring progress on targets and priorities. In addition, there was no communication of

achievements within the board. As noted by this participant, the use of outcomes frameworks by public health lacked timely data:

'Well at a population level we use the outcomes framework. I mean locally we try and look at processes. But I think one of the problems is if you then focus on process it becomes process orientated. And we kind of almost, we almost feed the beast because everything's about process. I mean one of our problems is we don't have timely outcome data, because most of our data is at least a year old' (DPH, site 4).

In site 5, when asked about monitoring of outcomes, the Healthwatch interviewee argued: *'I don't think the foundations are sufficiently solid. I think we need to do more work on that'*. The chair of the HWB also reported that there needed to be more stringent monitoring with regular progress updates.

A public health participant argued that the board had a lack of challenge when monitoring outcomes:

'...the key area then is the board endorsing the health and wellbeing strategy alongside the business plans for [the two health and social care integration organisations]...[We] usually have quarterly performance updates in terms of the progress that's been made. I think if you see boards as just a monitoring and keeping an eye on things, then you lose the energy and the power and the creativity of the board. The board is supposed to be constantly challenging us and saying why haven't we made progress on this or areas of kind of like health and equalities aren't improving here and here, collectively what can we do?' .

A councillor commented that: *'I feel my role and the role of the elected members is more of an advisory role'*.

A public health participant argued of the board that:

'...in the main it felt a bit like information being shared and rubberstamping. And there didn't feel enough critical discussion about some of the key issues that were being presented in terms of lack of progress towards targets, widening of inequalities in certain areas'.

It was maintained that the board had to ensure that every organisation was working towards the right outcomes and measuring them and that there was a level of strategic influence, in terms of membership of the board, to make the best impact.

The new Chair of the board in site 5 argued that:

'We need to make sure that we deliver on what we're delivering. And if somebody's having a difficulty, we need to understand the why and if it is because they can't do it, we need to work out who can'.

As this Healthwatch participant noted in our follow-up interviews in site 5:

'I think we've definitely got to do more work on outcomes. And I think in terms of the reports that come to us, they've got to be focused on outcomes and the way forward. When things are working as they should do, they've got to be honest about it. It's got to be this should have happened. It didn't happen. This is why it didn't happen. This is what we're going to do short term to put it right and this is what we're going to do longer term either to make sure it doesn't happen again or to make sure the correct things happen. That's what I want. I don't want 70- odd pages of motherhood and apple pie' [referring to the JHWS].

One of the participants in our national follow-up interviews noted that boards had to take account of where they started from in terms of measuring outcomes. They equated it to measuring educational attainment:

'...it's all relative isn't it? A bit like kids education results, don't measure it in absolute terms, you've got to measure it in terms of where did we start from' (National Interviewee, 1).

Another national interviewee observed that boards needed evidence of progress being made in regard to outcomes and needed to track some areas (not all) where progress would not have been made if the HWB did not exist.

The lack of outcomes

A major finding across our study sites was the absence of a clear or sustained focus on health and wellbeing outcomes as judged by our interviewees. Insufficient accountability, a lack of strategic direction, and insufficient attention devoted to monitoring were cited as key factors in explaining the weaknesses over outcomes.

In our baseline interviews in site 1, there was very little discussion of outcomes. A hospital foundation trust interviewee discussed how the HWB could be in some respects retro-fitting outcomes to programmes that were already in place and the outcomes could have been achieved without the HWB:

'Yeah, I think there's an element of that [retro-fitting]. I think that what the boards have done is perhaps put a macro strategic layer over the top of what was going on. But yeah I think that is a danger. And I think that potentially is more of a danger as we align the outcomes of the health and wellbeing strategy to the STP. You know, we're then piling a whole load of resources in...[the County] and I'm sure everywhere else into making sure that over the next five years we deliver the STP – big whole new infrastructure. You know, that's going to deliver the STP. And therefore by default will deliver the health [and wellbeing outcomes]...Having talked about trying to make it simple to get the achievement by tying things into what's already out there, the

flipside of that is, I think that the outcomes will be achieved, will they be achieved because of the drive of the health and wellbeing board? Now I'm not sure that that's the case'

Not having significant impact on outcomes was an issue in site 2. Although there were good partnerships and a strategy in place, that these were not translating into outcomes was a common theme amongst interviewees.

'I don't think we're at the stage of seeing outcomes; I think we can see progress. I think there's definitely movement in the right direction' (Councillor, site 2).

'The problem is and the frustration for the large membership of the board is: and yet we haven't translated that into fantastically visible action, you know. Is it too much of a talking shop? Or does it bang heads together? Or does it create momentum in terms of that direction of travel? And I think collectively, I think, the membership would agree it probably hasn't done enough of that' (Chair, CCG, site 2).

'There's a bit of pressure for us to be clear about what outcomes we're looking for. Outputs and outcomes...[The] LGA peer review, and that's threw out a lot of the issues ...about a lack of clear objectives, a lack of clear strategy, a lack of how do you demonstrate success, and none of those things are really there... But...how are we actually tied into delivering it on the ground? And that's the fundamental problem, but it's across the board' (Councillor, site 2).

This Councillor in our follow-up interviews in site 2 was sceptical about there being any concrete examples of outcomes:

'I think many of us around the table probably would say we've got better relationships which is all good. And the conversations are more open. But what difference are we making? And I think we'd probably struggle to give examples'.

There were areas in site 3 where more progress on tangible outcomes was required and these centred on the overall strategic plan for the local authority area which incorporated the JHWS. It was felt that in terms of the strategy:

'...it's all motherhood and apple pie. You know, we want people to eat well, come on what we going to do about it? Let's have a safe pavements/no drinking after midnight strategy. Let's have sugar tax in our supermarkets. We've got a low alcohol initiative, but has that really been landed well? So I think the purpose of the health and wellbeing board should take that strategy document and make it real' (Chair, CCG). '...they're motherhood statements. There's no meat on that yet. The next stage is a critical one, is how do we actually do it?' (Healthwatch Chair).

There was discussion that there was a need to develop a focus on delivery of priorities in the strategy.

In the follow-up interviews in site 3, there were health and wellbeing centres and this CCG chair discussed the lack of monitoring and ownership by the HWB of the initiative:

'What we've seen is health and wellbeing centres, fantastic initiative, putting people forward. What you want to do is go and deliver it. But it's not an initiative which the health and wellbeing board have had ownership of. It's not an initiative which the health and wellbeing board have monitored and ensured implementation. It's been a case of yeah I think that's a great idea, go and do it. So I would be very stuck to give you a single initiative that the health and wellbeing board has developed and then delivered'.

In site 4, interviewees were clear that the board had thus far not had any significant impact on outcomes and two main reasons were cited for this state of affairs: the lack of accountability across the system for delivery of outcomes (at organisational, board member and officer level), and, allied to this, a lack of monitoring in place to measure progress on targets and goals coupled with a deficit of strategic focus to ensure outcomes. A disconnect between strategic level goals and the reality 'on the ground' was also a concern.

'I can't say that the health and wellbeing board has made any noticeable impact...If it had made an impact it should be really shouting about that and doing press releases but it certainly hasn't done that as far as I'm aware' (HWB VCF representative).

'...do I know any decision or any outcome that the health and wellbeing board have been focused on in the last 12 months and the answer was no. I could not think of anything... I couldn't think of a single thing that they made a difference on, which is pretty sad really' (Chief Executive, NHS Trust).

In site 5 in our baseline interviews, two themes predominated in the discussions on outcomes:

- Discussions were in terms of aspirations or the board does not achieve any outcomes; no specific outcomes were cited.
- There were real concerns about the ability to deliver the targets in the Better Care Fund plan; the board had the responsibility for producing the plan, approving and then monitoring it but had no power to affect outcomes.

A Healthwatch participant noted of the board that:

'Because they talk about oh we're going to [do] this and this and this. And I look at a load of them and say I'm sorry but that's what the Yanks would call motherhood and apple pie. That's a wish list...these are the outcomes we're looking for. And there's not enough on outcomes'

The former Chair of the HWB in the initial interviews for the study discussed the frustration of the board in not having the power to deliver in terms of the BCF:

'So right, we have a plan, and I say to the people at CCG, we've not achieved the reduction in non-elective admissions. When I look at the figures, provisional figures for 2015/16 it looks like we've got an increase...in non-elective admissions, when they should have been going down. How is this going to be achieved? And so that will be a worry. Now because we've got... [the adult health and social integration organisation], and we've got various groupings there to address those sort of issues, but for the board itself it's been I think a lack of formal powers... So we have the responsibility of producing the plan and approving it and then monitoring. What do we do when they don't deliver? And that's a frustration in our system... So having the responsibility for Better Care Fund plan and monitoring, great...responsible but no power really to do anything about it'.

Outcomes and the integration of health and social care

Our study participants discussed the focus of HWBs on the integration of health and social care, paying less attention to the wider determinants of health and health inequalities. Four themes predominated in discussions over the integration of health and social care:

- Integration was happening largely outside the purview of the board with little involvement of the HWB (sites 1 and 5)
- Very little movement was evident on integration (discussed in three sites)
- Integration with the HWB having a strategic oversight role (site 3)
- There had been a focus on BCF plans and integration in general to the detriment of a focus on the wider determinants of health in some sites.

In site 1, the chair of the board discussed the lack of development over integration:

'Well I think when we first took over, [political control of the authority] the board met, we'd agreed we'd have several working parties and just for the members. One of the things we talked about was integration with health because that was the buzz thing at the time. So we set up several evenings of meetings which was of the CCGs and providers and we were doing quite well until we actually got round to actually talking about money then everybody rushed into the corners and it didn't get much further then. So I think we felt somewhat frustrated'.

The BCF was not generally viewed as a pooled budget with protection from organisations in terms of their contribution to the fund ensuring they got out what they put in financially. There was also discussion of the lack of emphasis on the prevention agenda and the wider determinants of health at the board with discussions on integration and the BCF taking priority.

In site 5, the HWB was largely seen as an 'add on' to existing bodies and structures in place for integration. Two main themes emerged on integration and the HWB:

- Integration was historic with section 75 pooled budget with the former PCT and Council
- Integration largely occurred through the adult health and social care integration organisation and decisions on integration were separate from the HWB which had no influence – the adult health and social care integration organisation had its own governance structures separate from the HWB.

In the follow-up interviews, there was concern that the HWB was not driving the integration agenda which was still seen as separate from the board. However there was discussion of how the adult health and social care organisation was asked to report to the board and that the HWB was developing more of a strategic oversight role in this area.

In site 2, views about integration took the form of how the HWB had focused on the integration agenda and not the JHWS around health inequalities, social determinants of health, or life course approaches. There was a sub-group on integration which participants in our follow-up interviews noted had designed mechanisms to allow teams to come together but, as one interviewee noted, the challenge would come when decisions had to be made on pooling resources and there was scepticism by the hospital trust over whether the HWB had the capacity to tackle integration. The trust had not shown interest in integration discussions. In our follow-up interviews, it would appear some limited progress had been made on the integration agenda as this participant discussed:

'And we are, you know, it blurs a little bit because we do this on a [two local authorities] footprint. So it involves the health and wellbeing board in [one local authority] and separately the...[Health and Wellbeing] board. We've appointed a director of integration across the system, that's new, and I think is emblematic of a commitment. We've created the meetings of people in the system. We haven't completely bottomed out the governance arrangements, and it's hugely complicated by things like STP as well. And we have I think cemented a significant number of the relationships required to make that thing travel, but we have not made nearly enough progress in that fundamental integration agenda'.

In site 4, the discussion of integration was largely in terms of a very large mental health and learning disability pooled budget. However, in the follow-up interviews, interviewees claimed that there had been very little movement on integration. There also was some concern that national priorities could overtake local priorities (e.g. BCF). Preventing admissions to hospital in terms of the BCF was viewed as driving much of the HWB agenda although, at the same time, it was argued that there was a lack of understanding by members on the implementation of the BCF.

Case study site 3 had undertaken a very large integration programme and this was the focus for many of the discussions (see vignette).

A vignette of health and social care integration – site 3

It was argued the HWB set the direction of travel on the integration agenda with an emphasis on prevention/early intervention.

In terms of the history of integration, it was led by the local authority and the CCG, not the HWB. In summer 2014, an integration paper was taken to the HWB. Integration was conducted on three levels:

- *Integration of health and wellbeing – ensure the system is joined upon and focused on prevention/early intervention*
- *Integrated commissioning – joined up plans and pool budgets*
- *Integrated delivery.*

Apart from spending considerable time building relationships and trust at every level, red lines between partners were also set. Participants commented that lots of events and informal events were held to cement relationships. A Section 75 agreement was put in place with a £400 million plus pooled budget. This was an integrated fund from the local authority, CCG and public health.

As part of the integration agenda, the transfer of social care staff to a community health provider was agreed.

There was a co-operative commissioning framework (statement on the ethos with providers and communities etc.) and integrated commissioning strategies between the local authority and the CCG that covered the life cycle and action plans to deliver strategies with corresponding system design groups including clinicians, local authority and CCG representatives and providers to implement plans.

Follow-up interviewees described further integration plans in terms of GP practices (although it was recognised that these were hard to engage) and plans to create health hubs (one stop shops for different services, i.e. various health and welfare services).

Although site 3 had had success with integration, there had been difficulties and a number of themes emerged: lack of data sharing protocols (cited in terms of mental health records and the police), and problems with information flows in terms of service users and patients. It was noted that there were difficulties with the integration agenda in terms of struggling with further budget cuts. Co-location of social care staff took time. In our follow-up interviews, site 3 participants felt they were challenged to prove their integration model worked and was showing results, which was not always easy to demonstrate after such a short period of time. Despite this, there was optimism that positive effects were working through the systems they had set up. For instance, the hospital was one of the few in the country not put on black alert over A&E waits, and GP referrals were more under control and not increasing at the rate they were elsewhere.

Participants also discussed the integration of health and social care in our national follow-up interviews and the focus (as in our study sites) was on how the BCF had taken up boards' time and energy and the dangers of health and social care dominating HWB agendas. As this participant argued:

'Well, I think the whole sustainability of the NHS and social care has kind of taken over. And they've become, for a short time, it seemed a long time at the time but it was actually quite a short time, they were totally taken over with the Better Care Fund and stuff like that. And they are still dominated in general, I think, by social care issues' (National Interviewee, 6).

Summary

In terms of outcomes, across the majority of study sites there was a lack of outcomes which could be clearly attributable to the HWB. The reasons for this included:

- Insufficient accountability, a lack of strategic focus and not enough monitoring with some HWBs having no systems in place for performance management were cited as key factors in terms of there being a deficiency of outcomes.
- The study sites did not offer much evidence of outcomes that were driven specifically by HWBs or how they linked to the overall JHWS or were driven by the JSNA (with exceptions in sites 1 and 3).
- There was also evidence that some outcomes were generally process-based, for example, improved relationships and communication between partners and in one site improved procedures on integrated care commissioning.
- An important point was the extent to which boards were 'retro-fitting' the JHWS to existing programmes, with the outcomes being 'badged' as a HWB outcome despite possibly being achieved anyway, and how much of a role the HWB had in acting as a system leader in co-ordinating areas of work to ensure that activities moved at a faster pace due to the co-ordinating efforts of the HWB. We saw earlier how in site 1 the board had set up sub groups aligned to the aims of the JHWS and it was believed that with the board acting in a coordinating role it had helped to bring programmes to fruition earlier.
- Participants from our national follow-up interviews argued that good system leadership, engagement by partners and having defined goals were seen as essential requirements for successful outcomes.
- Other factors were now in play such as the influence of STPs in place-based agenda-setting and influence and had to be factored into such discussions.

On the integration of health and social care outcomes, there had been:

- Significant developments evident in two sites, but in site 3 this integration was overseen by the HWB and in site 5 it was a process (largely for historical reasons)

separate from the board. This demonstrates how far factors such as history and the development of partnerships (which had historically been developed in both sites in terms of work on integration) could make a significant difference. In sites 3 and 5 trust and good relationships were seen as key factors to enable discussions and work on integration.

- Concern expressed in four of the five study sites over how the integration of health and social care and the BCF could dominate the focus of boards (as opposed to the actual work on integration in three sites) to the detriment, to some extent, of a focus on the wider determinants of health.
- Overall, historical context, good relationships/partnerships and trust were key drivers to work on integration.

4.5. THE FUTURE

This chapter outlines respondents' views on the key challenges and opportunities facing HWBs in the future, the perceived relevance of HWBs in the evolving health and social care context, and any suggested changes that might help to enhance their effectiveness.

Challenges

In the follow-up interviews with the national actors, in terms of challenges facing HWBs was a moderate theme among participants to the effect that with STPs and multispecialty community provider vanguards (MCP), influence was moving away from HWBs as these other initiatives were perceived to have both money and power. One interviewee discussed how with the continued development and implementation of STPs there was a need to avoid duplication between JHWSs and STPs.

Another national interviewee argued that the leaders of key local partners would gravitate towards vanguards as the HWB was 'an afterthought' and little more than a 'clearing house' for STP, MCP discussions as the local authority was not tied into those discussions.

Participants in our follow-up interviews in the case study sites were asked about the challenges and opportunities in the year ahead. In terms of challenges three themes were dominant across the sites:

- The continuing financial challenge arising from a lack of resources across the wider health and social care landscape coupled with the growing demand on services.
- The STP process risked side-lining HWBs which needed to be more actively engaged in the process; STPs were seen to have backing, power and influence.
- System restructuring and reorganisation (i.e. STPs, CCG mergers and/or possible federations, and devolution) was causing instability and uncertainty with the health system in constant flux.

In site 1, future challenges for the HWB centred on the environment and institutional pressures with a need to focus on 'the art of what is doable' in an increasingly difficult context. The STP issue was regarded as a key challenge and one that could send organisations back to their respective silos, alongside a landscape characterised by austerity, critical financial pressures in adult social care, transition funding and closures, and wider population demands on services and managing conversations with the public over these issues. The site also faced an identity issue to resolve, currently ambiguous, regarding whether they were a provider or commissioner – which would be played out through the integration and STP agendas.

The key challenge was how the HWB could improve on furthering the public health agenda in the ways identified against this increasingly challenging environment. It posed a real test for the board in terms of 'how it holds together'.

In site 2, there was a conversation around a lack of resources in terms of council, health and social care cuts. Also important was the continuing restructuring and reorganisation in terms of the STP, the potential devolution process, and the prospect of potentially federated CCGs. There was also a conversation on the need for outcomes and accountability mechanisms for partners in being responsible for outcomes. The Healthwatch chair in site 2 highlighted some of these issues:

'I think it is moving to that focus on action and on outcomes. It's still a bit, it still is a talking shop. And I think it's great that we're there and we have that discussion, we have that input, but it's that. So great, what are we going to do, when is it going to be done by, when are we going to report back on progress, or does this actually come back here in a year's time but in the meantime it's going to be reported to X group because it's their remit? And we don't have any of that, and I think that's going to be a massive challenge'.

In site 3, a key challenge lay in the financial resources available to undertake the work that was needed and also to position the board as a key player within the STP, which would be difficult, as there was a general view that saw the STP as superseding the HWB – it had the power and influence that the HWB never had. There was not much recognition that the board had failed to engage properly with the voluntary sector, instead seeing it as more of a problem of the voluntary sector not engaging with the HWB. This was driven by the realisation that the voluntary sector was a huge resource and that money spent there went further:

'...a pound spent in the voluntary sector is worth £4 in the NHS...besides which we can't invest more and more of the same, because we don't have a workforce to invest in' (Chair, CCG, site 3).

It was argued by the DPH in site 4 that this was a critical point in time for HWBs: *'Well I think the key bit is either use it or lose it'*. It was argued further by this interviewee that the board should be central to discussions, rather than reinventing the wheel with STPs.

'I think we're in grave danger of, I'm not saying health and wellbeing boards are the answer because, you know, I firmly believe that there is not one answer, but if we've got them we might as well use them or stop them'.

The STP was seen primarily as a threat – side-lining the HWB – and not regarded as a vehicle to help change the system. Most HWB members were also STP board members with the HWB being provided with updates but having no opportunity to engage with or challenge

the STP. The chair of the HWB sat on the STP board but in their capacity as cabinet member rather than as HWB chair.

The STP was viewed as one of the reasons for the delay in the refresh of the JHWS in site 4 as those responsible were waiting to see what happened in terms of developments with the STP and the combined authority. It was observed that the STP had taken priority and left the (weak) HWB to 'pick up the scraps'. There was a lack of patient and public involvement in the process and also limits to the role of Healthwatch and the VCF sector that were regarded as disempowered. There was a lack of understanding of STPs in the VCF sector, nor any mechanisms to allow the sector to have any influence and it therefore felt completely removed from it.

Ongoing reorganisation was also causing uncertainty, as explained by the HWB chair in site 4:

'But we've also got the other disadvantage that at the moment we're in the middle of a reorganisation with our CCGs. So whereas they were the commissioners in the past, at the moment with all the stuff going on around them being realigned and it's a merger and that all puts things up in the air again...So that then gives us another year where you've got board members that are really on the way out. And no board works effectively if members of that board don't know where they're going to be in six to nine months'.

In site 5, acute financial challenges, and how to afford transforming a system which was in crisis, were key concerns. It was felt that the success (or otherwise) of the adult health and social care integration organisation could 'make us or break us' according to the HWB chair. There was also discussion over greater emphasis on outcomes and having to be honest in terms of the difficulties and shortfalls in service provision.

The DPH discussed the challenge of transforming a system with financial difficulties:

'The challenges are fiscal. And the question of how you manage to afford system transformation including prevention and the development of more primary care oriented processes, more local processes, earlier treatment, how you manage to achieve transformation whilst the services which you are transforming are in crisis. I mean some people will say well actually the fact that they're in crisis makes it all the more important that transformation happens. Yes it does, but it also makes it, the classic comment when you're fighting off alligators it's hard to remember your original purpose...'.

Opportunities

In our follow-up national interviews there were a variety of points made in regard to the opportunities facing boards in the future. Unsurprisingly, STPs were a focus of discussion

and there were a number of issues discussed in connection with them, namely: HWBs needed to operate at a population health level (larger than local authority footprint, although this was seen as a challenge in site 4 and an issue in regard to the lack of co-terminosity of CCG, local authority and devolution footprints discussed in case study sites). It was argued that there would be a problem if HWBs did not put themselves forward as part of a delivery solution in conjunction with STPs. Therefore, where HWBs were performing well, it was argued they were needed to deliver locally on agendas. This interviewee discussed some of these issues:

'You know I think they [HWBs] will work because the STPs will need them to deliver locally and they are the place where people come together. So I think where all that works, you know, obviously CCGs can morph into STPs at some point or merge or some sort of version of that. It's sort of happening already in a way. So I think they'll be – that side of things will struggle because the focus on the place on the NHS gets diluted. But I think it's very hard to predict actually other than nobody ever talks about the being got rid of in the way they talk about other parts of the system. So people want to get rid of the CQCs [Care Quality Commissions], they want to get rid of CCGs, but they certainly, nobody's talked about getting rid of health and wellbeing boards, at least not that I'm aware of' (National Interviewee, 4).

In terms of opportunities across the five sites, it was believed that system integration, place-based commissioning and pooled budgets were required in the context of the system being financially challenged and there were opportunities for this to occur.

Despite the challenges outlined in site 1, many opportunities were identified for the HWB. There was a sense that it had the opportunity to learn and improve in what it did to achieve more, albeit within a very challenging environment, with ongoing review through the LGA and self-assessment seen as key to this. There was real optimism that the HWB could continue to drive the public health agenda with a coalition of the willing for improved health of the population and that these were exciting times if the HWB could master how to deliver on that ambition. One member commented that there was 'massive' opportunity for real system integration with shared resource for health and wellbeing, with public health defined in its broadest sense and with the HWB having the opportunity to push ahead on the key areas of concern, not least to drive more localised care, with closer to home decision-making and care delivery:

'Well, the opportunities are massive. It's like how can you maximise that STP...integration in terms of a real broad base for that. In terms of how all those partners really do start to collaborate and get past all this commissioner/provider competition, etc. and think around one system, one place, which there's still a lot of money available across this sector, how do we start to use it in the best possible way to give the best health outcomes and if we're starting them conversations, I think we've got a chance of really getting some push on some key issues' (DPH, site 1).

'Well there are opportunities. There are opportunities with regard to improved localised care.... And I think there are opportunities, but they'll have to be extremely gradual changes to actually bring care closer to home, to bring local decision making closer, to bring individual decision making closer. So they are exciting times, I just don't know how we're going to do it' (Chair, Healthwatch, site 1).

That said, commenting on the board it was recognised that this potential was yet to be fully realised: 'at the moment they are teetering on the edge and keep falling back'. Within the current context, there was a sense that, sadly, HWBs represented 'the right idea at the wrong time'.

In site 2, it was recognised that because of the lack of resources there was a need to pool funding and human resources and work together more (i.e. hospitals on financial funding and working with the VCF on supporting communities) and also pooling for prevention funding. Organisations needed to stop working in silos and being protectionist.

Continuing to develop partnership working and integration and being able to sustain the health and social care system financially were seen as successes in site 3. Improvements in the local hospital and improvements in care at home reported by one interviewee were also seen as opportunities. The engagement of hard to reach groups through a public health initiative and with it measures such as detecting the onset of diabetes was also seen as a success.

It was discussed how the STP in site 4 could be helpful in terms of prompting a big shift in service delivery and future outcomes. It was also argued that the HWB could become a subcommittee of the STP or vice versa ('running on the same fuel'). The HWB could also have a role in place-based commissioning and discussions on increasing the emphasis on prevention. A CCG chair and HWB chair discuss some of these points:

'I would make them somehow a subcommittee of an STP or make an STP a subcommittee of them. But I would define much better what the roles of where those things are, where things sit. But I would probably make them a – because STPs need to be bigger, I'd make them subcommittees of STPs and they'd be the place where local place-based commissioning gets discussed in smaller units...But I would make the place-based commissioning agenda sit there. I would make strategic transformation and resilience at the STP level...'

'I think as long as within the next six months we are absolutely clear that we are in that prevention space and we can develop things in that area, I think it will help us going forward. The problem has been we've been far too scattergun, so people don't know whether we stand for something or fall for anything'.

In addition, the amalgamations of NHS providers meant they were overcoming organisational differences, making savings and delivering more joined-up work. There was

also discussion of the potential for transformational change and thinking about long-term health rather than acute care goals. It was argued that the HWB needed to be proactive rather than reactive to opportunities, for example by structuring agendas differently:

‘The optimist in me is the board’s going through a lot of change, and a lot of improvement, and I would hope that that will change to give more impact from our role within that board. And there’ll be less rubberstamping and less things that just have to be passed through the health and wellbeing board, and more things linked to hopefully a robust strategy moving forward’ (Healthwatch chair, site 4).

‘Well the state of the NHS could be an opportunity for the board to show some leadership frankly, and visible leadership, not just be talking to itself’ (HWB third sector representative, site 4).

In site 5, the emphasis was on integrating systems and reducing hospital admissions and the savings from hospital ward closures put back into the system as the chair of the board explained:

‘Well if we can get integrated systems, if our neighbourhood teams work, as we anticipate them, if we can then start doing much more preventative work in spite of public health and other things, grants reduced in, that will then turn the tide for attendances, etc. If that turns the tide and admissions start going down then we can start freeing up the beds which is our aim and closing the wards, which is counterintuitive I know, and re-putting that money back into the system and things should improve even quicker’.

There was also discussion of subsidiarity of health and social care through to local neighbourhoods and the potential to transform the delivery of services with integrated neighbourhood teams of health, social care and voluntary sector professionals established across the local authority area as part of the adult health and social care integration organisation programme. This was seen as a way to deliver joined-up care for patients, through regular triage meetings between health and social care professionals and GP-led multi-disciplinary teams, with the most complex patients being the focus. The long term objective was co-locating teams together permanently in the same buildings.

The relevance and ongoing role of HWBs

A majority of participants in our baseline interviews believed that HWBs would be missed if they were abolished. Two main reasons were given:

- HWBs brought partners together and enabled dialogue on issues and a range of perspectives to bear on issues; in a complex health and social care landscape it was the only place the system came together and forged relationships.
- If boards did not exist, they would have to be invented.

For those who believed the boards would not be missed, two main reasons were cited:

- HWBs did not drive decisions which were made elsewhere.
- The boards had no impact, did not add value, and did not own the health and social care agenda; there was a nascent belief that STPs may have better engagement.

When asked if organisations would continue to work in partnership if there was no HWB the consensus across the sites in our baseline interviews was that organisations would continue to do so but would not be as effective since HWBs served as conduits for leaders to gather for discussions and there would not be the richness of debates. There was also an argument that HWBs provided ownership and strategic focus:

'Things would get done, but I think they'd have to invent, or you should have to invent, options to deal with those cross-cutting dialogues that it facilitates. I think, even the fact that putting everybody in a room once in a while so that they see each and discuss some of the issues is actually quite a useful thing to do...I think you'd have to invent something else to do it if it didn't exist' (DPH, site 2).

'I think it would be missed and people would say, well, we need a forum to pull together partners on this agenda, so I'm confident that it plays a role and it's adding value. The key question is, are we doing enough, having got that in place, to drive the system forward? I think that's where the challenge is, really' (Assistant chief executive, site 2).

These interviewees argued the HWB would not be missed:

'...the fact that we now have an STP focused on place, which is a much better engagement, you could take out the health and wellbeing board and it wouldn't make a jot of difference' (Chief executive, foundation trust, site 4).

'...I think we should just scrap it all and start again because we just added layers of complexity in which the health and wellbeing board sits' (Director of Children's and Adult Services, site 5).

At the time of conducting the follow-up interviews, we witnessed a different response in terms of the ongoing relevance of HWBs. Two caveats have to borne in mind here: first, the sample size was smaller in the follow-up interviews, and, second, not all the interviewees were the same (i.e. a change in DPH or HWB chair). However, there was evidence of mixed opinion over whether boards would or would not be missed. For those who believed HWBs would be missed the main reason given, also given as a principal reason in our baseline interviews, was because the board was the only place where the system came together. For those who did not believe the boards would be missed, the main reason given was that nobody would notice and business could still be conducted outside the boards. There was also a minority who were ambivalent or unsure whether the boards would be missed:

'Being frank, I'm not sure. I really wouldn't know' (Voluntary sector HWB representative, site 2) .

'...it's a tricky question to answer because actually it could be a really powerful force within the city, and I'm hopeful that changes will lead to that. But I'm not seeing it at the moment' (Healthwatch Chair, site 4).

Changes for the future

Our national interviewees raised a number of themes in relation to the changes needed to HWBs in order to make them more effective and guarantee them a future. A number of themes related to STPs and how HWBs needed to work at a population health level (larger than a local authority footprint) with STPs. And, for their part, STPs would need HWBs to deliver local policy priorities. It was observed that HWB membership needed reviewing including giving HWB members' specific roles on agreeing the delivery of local authority and health plans. It was also argued that HWBs needed to evaluate their role and their purpose with an emphasis on a place-based focus, ensuring accountability mechanisms for partnerships and progressing joint working across statutory and non-statutory sectors.

Further points raised were that HWBs would not be abolished as there were too many other agendas and priorities, but there was also a view from one participant that local government had become too 'thinned out' with local authorities having become almost too lightweight to carry the structure of an effective health and wellbeing board properly.

Another view was that there was a need to seize the moment:

'At some point over the next five years some kind of seismic change is going to happen around the relationship between health and social care, around the funding of how we fund social care...You know, this is probably more of a moment in the sun of health and wellbeing boards than when they were created. And if they don't seize the moment, well it's their own bloody fault. ...But both the strength and their weakness is that they were a product of localism. And if they don't seize that opportunity both locally but also collectively nationally, it is their own fault, because they've actually got all the opportunities' (National Interviewee, 1).

However, another interviewee noted that HWBs needed more influence on alignment or pooling of budgets but that since these discussions were going on outside HWBs the boards themselves were little more than mere talking shops.

In terms of suggested changes that might enhance the effectiveness of HWBs, four themes emerged in discussion with interviewees across the five case study sites:

- Give HWBs greater role definition.
- Ensure board members were accountable for delivery of priorities of the board.

- Boards needed to have a commissioning function.
- Boards needed more powers to fulfil their role.

These interviewees encapsulate some of these themes:

'And I feel like to give the board that level of, whether it's an oversight, something that's there that says, this is the board, that it's expected to validate certain decisions and that's what it's there for, I think giving it something like that, that presence that says it's here, it's here to stay, would make that difference in terms of it driving things through...and then operating in that way and then truly being that system leader. Because there is that thing also at the minute where you can see sometimes chief execs will send directors and if you start to get to that point you can sense, oh, whereas if it's there and it's actually making some decisions around that, it changes the game a bit' (DPH, site 1).

'The problem as I see health and wellbeing boards is they're not accountable. And if you've got no kind of controls, and you can't hold people to account, apart from through having a good relationship and a conversation, actually it means they're not terribly effective. So if I was health minister, secretary of state or whoever, would I want them to continue? I think I'd want to give them more powers...' (Vice chair HWB, site 2).

'I suppose the powerful is the money. So you'd have to say they are the commissioners. You will commission your activities at the health and wellbeing board, they will be buying the services...It'll all go through them. So I think...in fact you've given either the STP footprint...or you're going to...become an accountable care system...and you can say OK the health and wellbeing board will be the accountable care system leader, and they will have the budget to spend' (Chair CCG, site 3).

Summary

- In regard to challenges facing HWBs, a key concern was STPs. Our national actors discussed how power and influence was moving away from HWBs to MCP vanguards as part of wider place-based STPs.
- The challenges according to interviewees from our study sites centred on three issues: the lack of resources across the wider health and social care landscape and the demand on services; the STP process could side-line boards although boards needed to be more engaged in the process; system restructuring and reorganisation (i.e. STPs, CCG mergers or possible federations and devolution) were causing instability and uncertainty in regard to a system in constant turbulence.

- In terms of opportunities, our national actors believed that HWBs needed to engage with STPs and work on a larger geographical footprint and, conversely, STPs needed HWBs to deliver on local agendas.
- In terms of opportunities across the study sites it was believed that system integration, place-based commissioning and pooled budgets were required in the context of the system being financially challenged.
- A majority in our baseline interviews believed that HWBs would be missed if they were abolished and the two main reasons given were that HWBs brought both agencies together and a range of perspectives with the HWB being the only place where the system came together. It was also believed that if boards did not exist, they would have to be invented.
- The interviewees who believed the boards would not be missed gave three main reasons: it was believed HWBs did not drive decisions; decisions were made elsewhere in the system; and that boards had no impact, did not add value and did not own the health and social care agenda
- When asked if organisations would continue to work in partnership if there was no HWB the consensus across the sites in our baseline interviews was that they would but would not be as effective as HWBs were conduits for leaders to gather for discussions and there would not be the richness of debates.
- Interviewees were asked what they would change nationally if they were in charge of the development of HWBs. Across the sites, four themes emerged in discussion with interviewees: give HWBs a greater role definition; ensure the accountability of HWB partners for delivery of priorities; address the need for boards to have a commissioning function; and respond to the belief that boards needed more powers to fulfil their role.

5. DISCUSSION

The overall purpose of HWBs was, under local government control, to bring together bodies from the NHS, Healthwatch and other key sectors to plan how best to meet local health and care needs. HWBs were also expected to join up commissioning of local NHS services, social care and health improvement strategies, through the mechanisms of consultation and partnership in local communities. They were to act as system leads on health and well-being improvement and prevention measures. HWBs would also be responsible for the JSNA and this would be used to agree combined action at the local level through the production of a JHWS (Mumford, 2013, LaPlaca and Knight, 2014). Against this backdrop, the over-arching objectives of our evaluation of HWBs were as follows:

- Describe the varied ways in which HWBs are configured and organised, considering key issues such as leadership, governance, membership and citizen involvement
- Analyse the nature of relationships between HWB members, key stakeholders from health and social care, service providers, Healthwatch and other lay interest groups
- Identify key political, institutional and organisational facilitators and barriers to effective leadership and action by HWBs for health improvement and tackling health inequalities
- Work with stakeholders to identify and disseminate examples of good practice for collective decision-making and integrated service provision to achieve health outcomes.

Summary and interpretation of key findings

System leadership and governance

System leadership involves leaders from across a system working collectively around shared aims in a way that transcends organisational boundaries and priorities (Hulks et al. 2017; Senge 2015; Timmins et al 2015; West et al 2014). For HWBs, our research highlighted that they provided a structural opportunity for fulfilment of such a role insofar as being the only place where the system coalesced and discussions of health and social care could take place. HWBs then provided the forum through which organisational leaders from across the system could come together face-to-face as the means through which shared understanding and trust necessary for system leadership could be fostered (Hulks et al. 2017). However, our findings showed that in reality, whilst there was evidence of good relationship building and growing trust among board members, the extent to which HWBs were able to enact a system leadership function to mobilise change was stymied by the wider system fragmentation and hierarchies it had been envisaged they would overcome.

Characterised by a lack of strategic direction and collective purpose, HWBs were not generally viewed as system leaders but rather as resembling more a collection of leaders

accountable to their own respective organisations. This in turn was characterised by partners having their own agendas and priorities with little leverage evident by boards in order to hold partners to account or ensure the priorities of partners were aligned to the priorities of the HWB. Thus, without this collectivity around shared purpose, HWBs' integral 'soft' role of influencing, engaging and relationship building across the system to drive change (Miller et al 2010) was also absent. Boards were seen to lack a shared vision and a purpose or to have a clear role and function. This in turn meant there was little ownership of JHWS by partners, and boards were not viewed as an intrinsic part of the health and social care landscape. It was also reported how developments, demands and mandates in other parts of the system (e.g. STPs or NHS priorities) made system leadership difficult. Insofar as NHS health priorities came to dominate agendas over a focus on reducing inequalities and the wider determinants of public health, this can be seen as a reproduction of existing system hierarchies rather than a challenge to them.

What is clear from the research is that a HWB that displays effective leadership by the board needs to have an overall strategic focus underpinned by shared values and principles coupled with clear aims and objectives which are agreed, owned and understood by all partner organisations. Partnership working built on openness and trust is key: openness to the priorities and problems faced by each partner organisation, and a focus on building strategies embedded in policy, ensuring all partners' priorities and goals can be utilised in a shared strategic framework that is enabling and supportive. In addition, a clear focus on what outcomes are to be achieved, by whom and why they are important to each partner organisation and which, at a strategic level, is linked to the JHWS and priorities of the JSNA. As Glasby (2012:7) noted: *'Above all, the literature (and indeed much recent policy) around effective partnership working tends to assume that partnership is automatically a 'good thing' and that it somehow improves outcomes for service users and carers... In practice, this remains a relatively untested assumption, with research and practice often struggling to link partnerships to improved outcomes...In particular, the literature tends to focus on issues of process (how well are we working together?) not on outcomes (does this make any difference to services or to users?)'* A clear mapping of what work has already been done in these areas (with the help of the VCF sector as discussed in mapping local provision) with any new targets together with a clear and easily understandable monitoring and evaluation system (in one site we witnessed a traffic light RAG – red, amber, green – dashboard being used in terms of the integration of health and social care targets) is desirable. Being inclusive in respect of proposed outcomes and inviting non-board organisations onto the board (or sub-group) where organisations and the board's outcomes and priorities align is also desirable practice. As Fillingham and Weir (2014: 14-15) make clear:

'While decision-making across organisational boundaries and traditional governance structures is a lengthy and often frustrating process, the lack of shared goals, of collective understanding of the issues and of the opportunity to hear from many voices means that system-level plans fail, too often, to deliver system-level change'.

This failure is also noted by the NICE guidelines (2016: 9) on community engagement in improving health and wellbeing and reducing health inequalities. They recommend:

- Processes that make it as easy as possible for people to get involved.
- Service contracts for providers that specify the need to collaborate with local communities.
- Help for local services and organisations to build community engagement principles into their work...
- Planning to ensure the resources needed for community engagement are available...
- Methods of monitoring, evaluating and reporting on engagement with the relevant local communities.
- Processes to ensure learning from community engagement is reflected in health and wellbeing initiatives, for example, in the way they are designed or targeted.

An avenue for boards to focus on key issues was through sub-groups where in-depth and honest discussions could be had in a private setting and where the agenda and priorities of the board were generally set. However, there was concern over the transparency and accountability of such groups which were described by one participant as the 'engine room' of HWBs. But 'task and finish' groups may be a way forward for boards to ensure priorities are accomplished. Such groups could meet regularly and focus upon different aspects of the health and wellbeing strategy in terms of monitoring and evaluation of progress and, in the first instance, act as the accountable body to partners. There were also discussions about partner agencies wanting to be board members and a way of solving this issue in a manner which avoided boards becoming too large was offered in site 5, where the chair of the board held regular workshops with non-board members to discuss key issues of concern. These were seen to be successful and a possible way forward for boards wishing to accommodate partner agencies. Such an arrangement of 'task and finish' groups coming together for a limited period for a specific purpose chimes with Leadbeater (1999) who, while arguing that trust is essential for effective partnership working, challenges the notion that it can only be present where long-term sustainable relationships have been nurtured. He suggests that such an argument may be over-stated and used to provide a convenient excuse for partnership failure. He argues that some of the most creative and productive relationships are often based on intense, short-term trust and points to the film, advertising and entertainment industries as being successful examples of such an approach. For example, he gives the example of people and agencies coming together for a relatively short period of time in the production of a movie. Task and finish groups and other task based workshops could work in a similar manner especially where, as we have noted, HWBs with too large a membership can be seen as unwieldy and unproductive.

Under the Health and Social Care 2012 Act, upper tier local authorities and unitary authorities have a statutory duty to develop a JHWS which would be informed by a JSNA. It was envisaged that between them, JSNAs and JHWSs would form the basis of NHS and local

authorities' own commissioning plans across health and social care, public health and some children's services. Unfortunately, our study has demonstrated that there was little ownership of JHWSs and little accountability for implementing elements of the strategies. JHWSs were not seen as an integral part of the health and social care policy landscape. It was also the case that such strategies could partly reflect the work of other agencies but, at the end of the day, did not add value. It was also discussed that JHWSs had no clear mechanisms for achieving outcomes. There was also a lack of accountability on the part of organisations in delivering elements of JHWSs. The role and impact of HWBs were of central interest in the House of Commons Communities and Local Government's (CLG) inquiry into the role of local authorities in public health (House of Commons Communities and Local Government Committee, 2013). In his written evidence to the Committee, Bentley (2013) argued that HWBs acting as a strategic forum had little value if there was no apparatus for being precise about what had changed due to the HWB selecting a particular priority, or if organisations could not be held to account by the HWB for their contribution, or if it was not clear how collaboration had led to any change (although, as we have noted, our research participants did value the fact that HWBs were the only place where the system came together).

Bentley was also critical of HWBs which planned to meet quarterly since that would be unlikely to generate the momentum required for priorities to be accomplished. The infrequency of meetings was also a concern among our study respondents, especially with STP stakeholders meeting more frequently and HWBs seen to be constantly playing 'catch up'. There may be a case, therefore, for boards to pick a few key themes from the JHWSs and do them well, as there was some concern expressed to the effect that strategies were too 'motherhood and apple pie' and trying to be all encompassing. Such a scattergun approach risked little chance of achieving objectives. It is only through working from the bottom-up and across partner organisations in a clear strategic framework that allows the opportunity to prevent silo working with agencies focused exclusively on their own priorities. This is where task and finish groups may have a useful role to play, meeting more frequently than HWBs and thus ensuring regular accountability at all levels both horizontally and vertically across the system.

Membership, relationships between HWB membership and key stakeholders

In the majority of study sites there was an inclusive HWB membership with a high level of representation from the key partner organisations. In terms of partnerships and collaborative working, trusting and sound relationships had been developed to varying degrees in all the sites. However, such membership did not automatically translate into a HWB that made decisions and acted in a strategic manner with reasons for this finding including: partners having their own priorities and agendas; there being no clear strategic direction or agreement for what partners were responsible for in terms of elements of the JHWS; and, even where there was evidence of such a responsibility, no clear mechanisms

for holding partners to account. These factors may account in part for the lack of engagement with STPs and other bodies (for example, NHS trusts were cited for their lack of engagement).

There was also the vexed question of provider involvement on boards. At the follow-up interview stage in WP3, all HWBs in our study sites could point to provider involvement to a greater or lesser degree, although there had been many discussions by some boards particularly on the issue of which providers to involve on the boards. In site 3, for example, providers were a part of the board; the board also involved providers in shaping service specifications and they were valued for the perspectives they brought. However, there was a separation of provider and commissioning governance arrangements. This may represent a way forward for other boards seeking how best to involve providers. The report, *Health and wellbeing boards: engaging effectively with providers* (LGA, 2016: 6), highlights that:

‘The most successful delivery of HWB priorities has been achieved when all partners are clear on what their remit of influence into strategy and ambition is, and what their role is in executing this ambition locally. Taking a specific healthcare priority – such as substance misuse – as an initial point of focus has proved a successful strategy in areas where development in clarity of role and purpose has been needed. This has also helped to ensure that appropriate governance and accountability mechanisms (commissioning and contracting) have been established to ensure the commitment and accountability of partners for their role in delivering on objectives’.

It was found that although there had been elements of successful partnership working across the sites historically, this did not necessarily translate into successful partnership working at HWB level between existing partner organisations. Previous cultural and relational factors had been seen to influence HWBs’ development in addition to the evidence of fragmentation of, and policy churn within, the system as already noted. There remained tensions between agencies and personnel on HWBs and it was argued by participants that the dynamics between partners were important. It was also the case that having an effective HWB chair, defined in terms of being a good facilitator at meetings and being inclusive, does not necessarily translate into an effective board. There were also differing views on the size of HWBs: too large a board membership could result in a lack of in-depth discussions while, conversely, a large board could offer a range of perspectives. There is no single or right answer to the question of size – it is a matter of judgement to be settled in each particular local context in accordance with prevailing circumstances.

Across the majority of study sites was a clear lack of evidenced outcomes. Insufficient accountability, lack of strategic focus and weak or non-existent monitoring were cited as factors in terms of there being a deficiency of outcomes. In our sites, HWBs were criticised for lacking identity, having no clear vision or purpose, and our national interviewees noted that the lack of national guidance had resulted in boards’ performance being ‘patchy’. Good

system leadership, defined goals, and engagement were considered to be key factors in shaping outcomes by our national actors.

HWBs in our case study sites demonstrated a lack of strategic decision-making and ownership of their JHWSs which may also be factors in the lack of attention to outcomes. A key priority is to communicate to those at the front line the strategic aims in relation to their area of work, why they are important, and what goals are to be achieved (both short- and long-term), and how those so engaged can contribute to that goal in order to ensure ownership and buy-in of the JHWS and its aims. Arguably, it is only through working from the bottom-up and across partner organisations in a clear strategic framework that there exists an opportunity to prevent silo working with agencies each focused on their own priorities. Given the years of inspection and audit of local government, and the robust systems local authorities had in place to monitor performance and risk management, it has to be disappointing to find that HWBs demonstrate a lack of commitment to such activities.

Political, institutional and organisational enablers and barriers to leadership and health improvement

HWBs were not introduced at the most auspicious time. System reorganisation nationally, particularly with the appearance of the Health and Social Care Act 2012, had the effect of destabilising existing partnership networks. With the introduction of HWBs in this environment as *the* forum for the health and care system to work in partnership locally, our study found that HWBs had to navigate a multitude of challenges such as organisations disbanding and agencies restructuring. Perkins et al (2010; 2014) noted in a systematic literature review on public health partnerships that the most effective ‘partnership killer’ is reorganisation, due to established networks being broken up and personnel relocated or leaving. This fragmentation and churn had continued unabated during the course of the research, with study sites having to deal with CCGs merging, engaging with multiple providers and a constant stream of new policy proposals and initiatives emanating largely from central government and the NHS.

In a time of austerity, HWBs found themselves having to work with organisations, particularly those in the VCF sector and local government, facing severe fiscal constraint. A report for Public Health England (2015: 7) observed in relation to the VCF sector: *‘We did not find the...sector consistently at its best. We found many organisations lacking confidence, some lacking hope and most torn between following missions which were born from their communities and meeting the demands of contracts and grants which were defined elsewhere and which in many cases are becoming shorter term, more narrowly focused and more medicalised. Partly this was the impact of austerity. There is significant and often invisible churn in the sector. In many places the sector is shrinking’*. Research for the Joseph Rowntree Foundation (Hastings et al., 2015) found that the most deprived upper-tier and unitary authorities saw cuts of more than £220 per head compared with under £40 per head for the least deprived. They also found social care spending had fallen in

real terms in the most deprived communities by 14% or £65 per head. Conversely, it had risen in real terms in the least deprived communities by 8% or £28 per head. More recently, the National Audit Office (2018: 4) found a 49.1% real-terms reduction in government funding for local authorities, 2010-11 to 2017-18. It also noted that: *‘Alongside reductions in funding, local authorities have had to deal with growth in demand for key services, as well as absorbing other cost pressures. Demand has increased for homelessness services and adult and children’s social care. From 2010-11 to 2016-17 the number of households assessed as homeless and entitled to temporary accommodation under the statutory homeless duty increased by 33.9%; the number of looked-after children grew by 10.9%; and the estimated number of people in need of care aged 65 and over increased by 14.3%. Local authorities have also faced other cost pressures, such as higher national insurance contributions, the apprenticeship levy and the National Living Wage’*. As our study respondents acknowledged, this fiscal constraint has had a significant impact on local government, the NHS and the various other partner organisations to a greater or lesser degree. While there was a view amongst some interviewees that austerity could provide the trigger to encourage agencies to work together more effectively, including by pooling resources, conversely, there was also the opposite view, namely, that pressure on resources would encourage agencies to retreat into silo working and adopt a protectionist stance.

Another contextual factor, and one of some concern for study participants, was that national priorities invariably took precedence over local HWB priorities; policies such as the BCF and latterly STPs were most often cited in this regard. Indeed, more recently, STPs were cited as a major concern. In the four study sites which had STPs, three viewed them as an initiative which risked side-lining HWBs. Despite attempts by HWBs to exercise an oversight role, the influence they were able to exert in the development of STPs was largely minimal. A recent survey by the LGA of 68 councils found that, overall, most perceived there to be low engagement in the STP, with 69% stating that councillors have not been sufficiently engaged in their STP and 71% believing that councillors were not sufficiently involved in the governance of the local STP (LGA, 2017). Over three-quarters reported that the HWBs (79%) were successful, at least to some extent, in providing an effective forum for engaging councillors in the STP process. However, only 25% reported the STP boards themselves to be successful in engaging councillors. The most recent study by Shared Intelligence (2017: 2) on HWBs also found that:

‘Many members of HWBs are involved in the STP process, but a fundamental concern expressed by our interviewees is the lack of any substantial local political input to STPs. Our interviewees pointed to a lack of respect for and understanding of the local political process in the DH and NHS England’.

Furthermore Black and Mays (2016: 1), in a report for the King’s Fund, note that:

‘[STP] leaders feel there is insufficient know-how, both locally and at the centre, on how to shift from a formally competitive system to a collaborative one’.

The findings of a survey conducted amongst the VCF sector by the National Association for Voluntary and Community Action (NAVCA, 2017: 8) also noted the lack of engagement in the STP process by the VCF sector: *'Involvement has largely been poor or 'non-existent'*. 21.1% characterised involvement as 'poor' and 31.0% as 'non-existent'. Only 1.4% viewed their involvement in the STP process as 'excellent'.

Given the role of HWBs as place-based collaborative bodies it might be hoped that STPs would have tapped into such a reservoir of knowledge, but according to our study participants, for the most part this had not occurred. One reason for such a finding is also highlighted in the research – organisations were still in some respects working in silos and, to varying degrees, there remained a divide between the NHS, local government, VCF sector and other local partners.

The move of public health into local government was generally welcomed although there was a perception that HWBs could do more to focus on the wider determinants of health and health inequalities. There was a view held by interviewees that there was too much focus on health and social care integration to the detriment of a focus on these wider determinants. There was also a view that public health specialists could do more to support HWBs to deliver on health inequalities, and in some circumstances their work was not always aligned with the boards' activities. As mentioned above, there is a need for boards to have clearly defined priorities shaped by place, although, as we have observed, national priorities could too often distract and side-track boards with the result that an emphasis on integration and the BCF may be the product of national priorities taking precedence over local ones.

Decision making: facilitators and barriers

Boards experienced difficulty with decision-making, and decisions were seen to be taking place elsewhere in the system by partner organisations, at different levels and not at the HWB. Boards tended to ratify or 'rubber stamp' decisions and, with HWBs having no executive power, they relied on 'soft power' to exert influence, although this had variable impact. It was suggested that HWBs could not hold partners adequately to account and there was a lack of scrutiny and challenge in general from partners (with sometimes Healthwatch being the exception). It was agreed that the lack of monitoring of policies and agencies being held to account for policy outcomes was problematic and not an area in which the HWBs in our study sites had excelled. In addition, although HWBs may be building relationships, and putting in place processes and structures, these do not necessarily lead to effective decision-making and outcomes. As our study found, having the right people on, or at, the HWB does not necessarily translate into effective decision-making or outcomes. Robust relationships and networks built on trust and goodwill and the capacity for organisations to work together effectively, not just meeting formally at board level but more frequently and perhaps informally through networks, may improve the quality of decision-making.

HWBs' impact on integrated service provision

The context of the development of partnerships historically was seen as an important factor in sites 3 and 5 in regard to the success of integration. Here, as noted earlier, we saw evidence of efforts to promote good partnership working and develop joint arrangements and pooled budgets. In one site this precluded the HWB as these arrangements had started to be put in place before its formation. In regard to the integration of health and social care, a lack of trust and development of relationships could impede any discussion of meaningful pooled provision. For instance, in site 1 we saw the HWB not being viewed as a decision-maker with the strength of robust governance arrangements to undertake meaningful health and social care integration. Where those governance arrangements were in place and time was taken to build those relationships and trust then the pooling of budgets – the real test for integration – could become possible. HWBs were found to be more effective where good relationships were purposively built upon. However, as an earlier report by the National Audit Office on health and social care integration (2017: 7) cautions: *'The Departments...[of Health and Department for Communities and Local Government] have not yet established a robust evidence base to show that integration leads to better outcomes for patients... There is no compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity. While there are some positive examples of integration at the local level, evaluations of initiatives to date have found no evidence of systematic, sustainable reductions in the cost of care arising from integration'*.

Citizen involvement

It was noted that HWBs had generally done little in the way of public and patient involvement with the public not generally attending board meetings. There may be ways for HWBs to hold events and workshops on particular issues and themes of concern locally to not only highlight the work and role of the board but also to provide an opportunity for HWBs to listen and learn. Although there were some good examples of consultation undertaken by boards, it was evident that much more could be done. Healthwatch had made effective contributions to boards and challenged them on occasion, but it was contested that it was not Healthwatch's role to conduct public engagement on behalf of the HWB.

There is much that could be done between partner organisations to align public engagement strategies, with the HWB exercising a strategic overview in order to reduce any duplication, and to ensure clear consistent messages across the health and social care local landscape. Our focus groups noted that although the VCF sector was willing to act as a conduit for HWBs into local communities, and vice versa, the sector did not have the resource and hence the capacity to do this adequately. Again, task and finish groups could be a way to ensure that there is little duplication on the ground between the goals of the HWB and what is being delivered in communities. They could also enable HWBs to carry out an informal mapping and updating of community provision and need, and encourage boards

and the VCF sector to share information and evidence. There was concern expressed in some sites that the VCF sector was not harnessed effectively or their views sufficiently taken into account by HWBs. As a guide to community-centred approaches for health and wellbeing produced by Public Health England argued: *'When preparing their joint strategic needs assessment (JSNA), Health and Wellbeing Boards should ensure that it is a comprehensive assessment of assets as well as needs based on thorough engagement with local VCSE organisations and all groups experiencing health inequalities'* (Public Health England, 2015: 10, 11). Indeed a report by the National Association for Voluntary and Community Action (NAVCA, 2017: 7) found that: *'NAVCA membership involvement with JSNAs is not so good, with nearly a half saying it is poor (23 per cent) or non-existent (25 per cent)'*.

Strengths and limitations of the evaluation

Strengths of this evaluation include the use of a mixed methods approach, involving: multiple data collection techniques (allowing for the generation of data of sufficient depth to address the evaluation objectives); multiple samples (enabling us to capture diverse perspectives); and multiple investigators (thereby enhancing the rigour of our analyses). Our chosen evaluation design was informed by both realist evaluation principles and complex systems thinking, providing additional depth to our findings and conclusions.

Limitations include the low response rate to our national survey in WP2 and the relatively small number of case study sites in WP3. Instead of achieving our target sample of six local authority study sites we had to settle on five in the end. Several local authorities declined the invitation to take part for unknown reasons and others reported having competing demands, which included mergers, other types of restructuring and having recently taken part in the LGA peer review process. In spite of our sustained efforts over a period of 12 months, we were unable to recruit a London-based site or a Conservative-led authority. Nevertheless, we did manage to obtain a relatively heterogeneous sample, and prolonged engagement with the case study sites enabled us to capture and explore changes over time, particularly the impact of the STP process on HWBs. However, there were some changes in key personnel (e.g. HWB chairs and DsPH) between the initial and follow-up interviews. Furthermore, there was a low response rate to invitations to take part in the VCF focus groups despite repeated attempts to increase participation. The rapid and constant pace of change within the health and social care system, a reality to which we have drawn attention already, means that our findings can only be seen as a 'snapshot' of particular points in time.

Such factors were inevitably beyond our control and, indeed, are evident in all such studies and not just the one reported here. However, they do raise broader issues about how best to conduct policy research in such dynamic and ever-shifting contexts so that emerging insights and findings can still provide useful learning to policy-makers and others.

In what follows below, and to conclude this report, we have attempted to distil from the study findings a set of key insights which may be useful in informing future policy and practice.

Implications for policy

- There needs to be a clear role and purpose for HWBs in terms of how they are perceived and situated as a place-based mechanism for the development of health and wellbeing. This reassessment takes on an added urgency in the light of STPs and, more recently, ACS/Os. There needs to be a clear definition of the role of HWBs and STPs and attention given to how they can best work together to improve the health and wellbeing of local populations (particularly in regard to the focus on the wider determinants of health, prevention and health inequalities) as well as the promotion of integrated services
- The overall health system is fragmented with accountabilities for population health also dispersed. In an effort to transform the system, STPs/ACSs have been introduced as attempts to overcome such fragmentation and move from a system where competitive behaviour has been privileged to one where collaborative approaches are to be encouraged and nurtured. But the arrival of STPs/ACSs risks creating multiple accountabilities with resources and programmes being duplicated. As the only statutory place-based bodies currently in existence, HWBs are ideally placed to join together at an STP level to provide strategic oversight (with the Greater Manchester Health and Social Care Strategic Partnership Board being the basis of such a model); at a local authority level, boards could ensure policy is implemented and organisations held to account.
- There is an argument for having a clearer role definition for HWBs and one that is set out in terms of their role in, and the scope for, promoting health and wellbeing, commissioning, integration and how these duties can be discharged in the context of STPs/ACSs while bearing in mind the need to balance central prescription on the one hand and local flexibility on the other hand. Allied to this, the power base of boards needs to be clearer together with their decision-making functions, especially with respect to local government and CCG decision-making.
- HWBs do not exercise any formal power to compel agencies to work together and be accountable for delivery of JHWS outcomes – ‘soft power’ only goes so far in most instances; a case can be made for HWBs to have executive powers to ensure accountability for their actions and the delivery of outcomes. This might include the plans and priorities produced by other place-based partnerships or organisations (such as STPs/ACSs) having to be formally agreed by HWBs, while ensuring that local policies and priorities align with JHWSs with a clear line of accountability to HWBs in terms of policy implementation. Consideration might be given to the formation of sub-groups of HWBs in order to performance manage policy implementation.

- HWBs should undergo formal scrutiny and have a duty placed on them to involve citizens, including holding meetings enabling proper public involvement.
- Healthwatch's role should be clarified to establish whether they are to be partners with HWBs rather than watchdogs; this would mean adopting other measure to ensure HWBs are held to account.

Implications for practice

- HWBs need to have a clear vision of the role, purpose and mechanisms for the delivery of outcomes with an emphasis on system leadership through the coming together of partners to determine the role and direction of the HWB and perhaps an annual evaluation and regular monitoring by HWBs to evaluate progress.
- Ownership and accountability are key ingredients for a successful HWB. Too often partners were seen as having their own (sometimes conflicting) priorities and not being held account for JHWS priorities. Workshops, development sessions and more informal events (which were seen as valuable and productive) may go some way towards improving relationships and collaborative working.
- The role of sub-groups and 'task and finish' groups merits exploration, particularly in terms of ensuring that policy agendas are moving forward given the general infrequency of HWB meetings and as a way of measuring progress and holding partners to account; such groups should involve all appropriate stakeholders, from the frontline to executive officer level, so that accountability is delivered across the system thereby engendering system ownership. It is only through working from the bottom-up and across partner organisations in a clear strategic framework that there exists an opportunity to overcome silo working whereby agencies remain too focused on their own particular priorities to the exclusion of everything else.
- Robust monitoring and evaluation is needed by HWBs to ensure targets and priorities are met.
- There is an argument for HWBs to identify a few key themes from their JHWSs and do them well, since many strategies risk trying to be all-encompassing and therefore of failing.
- Ensuring that the talents and attributes of all partners are utilised requires some investment; this would include the VCF sector and providers with a view to harnessing their knowledge and expertise as appropriate.
- Identifying ways for HWBs to engage with, or even lead, the STP/ACS process is a matter in need of urgent attention if boards are to have a future; making HWBs the accountable body for population health would go some way towards this.
- In regard to the issue of integration, a lack of trust and development of relationships can preclude any discussion of meaningful pooled provision with CCGs; HWBs need to have the strength of governance arrangements to undertake meaningful health and social care integration. Only then are pooled budgets – the real test for integration – likely to become possible.

- HWBs lack effective public engagement; they need to focus on how to engage with the public and, more importantly, why. Such engagement cannot be tokenistic but should be centred on a pressing local health priority.

Conclusions

Our research has demonstrated that, by and large, respondents valued HWBs and were only too well aware that they are the only place where the system can come together. Boards have the potential to act, as one participant put it, as ‘the beating heart’ of health in the local landscape. Unfortunately, HWBs in their current form are for the most part unable to occupy this pivotal role or to function accordingly. They have little power to hold partners and organisations to account, and other place-based mechanisms, notably STPs/ACs, have a larger geographical footprint and arguably more traction on the system because of the investment in, and expectations of, them. It is hardly surprising, therefore, that STPs were viewed by study participants as potentially eclipsing HWBs. With the advent of ACs, the eclipse risks becoming total.

It is no exaggeration to conclude, as speakers at the project national event held in September 2017 did, that HWBs are currently at a crossroads with two possible future scenarios ahead of them. The first scenario involves HWBs being revisited and reconstituted to assume responsibility as the accountable organisation for the delivery of place-based population health in an area, with STPs/ACs and CCGs being held accountable to boards.

An alternative scenario would see HWBs merely becoming, or continuing to be on the basis of the evidence from our study, talking shops which are effectively left to wither on the vine as STPs/ACs effectively take over their role and function.

We suggest this second scenario would be regrettable for a number of reasons notably the following: HWBs enjoy member participation from the highest levels in partner organisations; they are the only body with a democratic accountability and the only body able to connect with, and respond to, local communities. They are, therefore, well placed to act as ‘the beating heart’ in coordinating population health. Unfortunately, in their present form they do not have the power to hold partners to account and act as a binding decision-making body. Consequently, JHWSs are not adhered to, and plans and strategies are not always co-ordinated or followed up to ensure they are implemented. This can only be regarded as a waste in terms of the potential of HWBs to reduce duplication in the system and ensure scarce resources are used wisely and to best effect.

HWBs could have a very bright future, reasserting their focus on their place leadership role and being ‘the anchors of place in a sea of new initiatives’ (Councillor Izzi Secombe, Chair, LGA Community and Wellbeing Board, speaking at the project national event in September 2017). They just require the means to do so and to be given the support to enable them to realise what remains, by and large, their untapped potential.

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APPENDICES

Appendix A: Relevant sections of the Health and Social Care Act 2012

HEALTH AND WELLBEING BOARDS: ESTABLISHMENT

194. Establishment of Health and Wellbeing Boards

- (1) A local authority must establish a Health and Wellbeing Board for its area.
- (2) The Health and Wellbeing Board is to consist of—
 - (a) subject to subsection (4), at least one councillor of the local authority, nominated in accordance with subsection (3),
 - (b) the director of adult social services for the local authority,
 - (c) the director of children’s services for the local authority,
 - d) the director of public health for the local authority,
 - (e) a representative of the Local Healthwatch organisation for the area of the local authority,
 - (f) a representative of each relevant clinical commissioning group, and
 - (g) such other persons, or representatives of such other persons, as the local authority thinks appropriate.
- (3) A nomination for the purposes of subsection 2a) must be made—
 - (a) in the case of a local authority operating executive arrangements, by the elected mayor or the executive leader of the local authority;
 - (b) in any other case, by the local authority.
- (4) In the case of a local authority operating executive arrangements, the elected mayor or the executive leader of the local authority may, instead of or in addition to making a nomination under subsection (2)(a), be a member of the Board.
- (5) The Local Healthwatch organisation for the area of the local authority must appoint one person to represent it on the Health and Wellbeing Board.
- (6) A relevant clinical commissioning group must appoint a person to represent it on the Health and Wellbeing Board.

(7) A person may, with the agreement of the Health and Wellbeing Board, represent more than one clinical commissioning group on the Board.

(8) The Health and Wellbeing Board may appoint such additional persons to be members of the Board as it thinks appropriate.

(9) At any time after a Health and Wellbeing Board is established, a local authority must, before appointing another person to be a member of the Board under subsection (2)(g), consult the Health and Wellbeing Board.

(10) A relevant clinical commissioning group must co-operate with the Health and Wellbeing Board in the exercise of the functions of the Board.

(11) A Health and Wellbeing Board is a committee of the local authority which established it and, for the purposes of any enactment, is to be treated as if it were a committee appointed by that authority under section 102 of the Local Government Act 1972.

(12) But regulations may provide that any enactment relating to a committee appointed under section 102 of that Act of 1972—

(a) does not apply in relation to a Health and Wellbeing Board, or

(b) applies in relation to it with such modifications as may be prescribed in the regulations.

(13) In this section—

(a) “enactment” includes an enactment contained in subordinate legislation (within the meaning of the Interpretation Act 1978);

(b) “elected mayor”, “executive arrangements” and “executive leader”, in relation to a local authority, have the same meaning as in Part 1A of the Local Government Act 2000;

(c) “relevant clinical commissioning group”, in relation to a local authority, means any clinical commissioning group whose area coincides with or falls wholly or partly within the area of the local authority.

(14) In this section and in sections 195 to 199, “local authority” means—

(a) a county council in England;

(b) a district council in England, other than a council for a district in a county for which there is a county council;

(c) a London borough council;

(d) the Council of the Isles of Scilly;

(e) the Common Council of the City of London in its capacity as a local authority.

HEALTH AND WELLBEING BOARDS: FUNCTIONS

195. Duty to encourage integrated working

(1) A Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.

(2) A Health and Wellbeing Board must, in particular, provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services.

(3) A Health and Wellbeing Board may encourage persons who arrange for the provision of any health-related services in its area to work closely with the Health and Wellbeing Board.

(4) A Health and Wellbeing Board may encourage persons who arrange for the provision of any health or social care services in its area and persons who arrange for the provision of any health-related services in its area to work closely together.

(5) Any reference in this section to the area of a Health and Wellbeing Board is a reference to the area of the local authority that established it.

(6) In this section—

“the health service” has the same meaning as in the National Health Service Act 2006;

“health services” means services that are provided as part of the health service in England;

“health-related services” means services that may have an effect on the health of individuals but are not health services or social care services;

“social care services” means services that are provided in pursuance of the social services functions of local authorities (within the meaning of the Local Authority Social Services Act 1970).

196. Other functions of Health and Wellbeing Boards

(1) The functions of a local authority and its partner clinical commissioning groups under sections 116 and 116A of the Local Government and Public Involvement in Health Act 2007 (“the 2007 Act”) are to be exercised by the Health and Wellbeing Board established by the local authority.

(2) A local authority may arrange for a Health and Wellbeing Board established by it to exercise any functions that are exercisable by the authority.

(3) A Health and Wellbeing Board may give the local authority that established it its opinion on whether the authority is discharging its duty under section 116B of the 2007 Act.

(4) The power conferred by subsection (2) does not apply to the functions of the authority by virtue of section 244 of the National Health Service Act 2006.

HEALTH AND WELLBEING BOARDS: SUPPLEMENTARY

197. Participation of NHS Commissioning Board

(1) Subsection (2) applies where a Health and Wellbeing Board is (by virtue of section 196(1)) preparing—

(a) an assessment of relevant needs under section 116 of the Local Government and Public Involvement in Health Act 2007, or

(b) a strategy under section 116A of that Act.

(2) The National Health Service Commissioning Board must appoint a representative to join the Health and Wellbeing Board for the purpose of participating in its preparation of the assessment or (as the case may be) the strategy.

(3) Subsection (4) applies where a Health and Wellbeing Board is considering a matter that relates to the exercise or proposed exercise of the commissioning functions of the National Health Service Commissioning Board in relation to the area of the authority that established the Health and Wellbeing Board.

(4) If the Health and Wellbeing Board so requests, the National Health Service Commissioning Board must appoint a representative to join the Health and Wellbeing Board for the purpose of participating in its consideration of the matter.

(5) The person appointed under subsection (2) or (4) may, with the agreement of the Health and Wellbeing Board, be a person who is not a member or employee of the National Health Service Commissioning Board.

(6) In this section—

“commissioning functions”, in relation to the National Health Service Commissioning Board, means the functions of the Board in arranging for the provision of services as part of the health service in England;

“the health service” has the same meaning as in the National Health Service Act 2006.

198. Discharge of functions of Health and Wellbeing Boards

Two or more Health and Wellbeing Boards may make arrangements for—

(a) any of their functions to be exercisable jointly;

(b) any of their functions to be exercisable by a joint sub-committee of the Boards;

(c) a joint sub-committee of the Boards to advise them on any matter related to the exercise of their functions.

199. Supply of information to Health and Wellbeing Boards

(1) A Health and Wellbeing Board may, for the purpose of enabling or assisting it to perform its functions, request any of the following persons to supply it with such information as may be specified in the request—

(a) the local authority that established the Health and Wellbeing Board;

(b) any person who is represented on the Health and Wellbeing Board by virtue of section 194(2)(e) to (g) or (8);

(c) any person who is a member of a Health and Wellbeing Board by virtue of section 194(2)(g) or (8) but is not acting as a representative.

(2) A person who is requested to supply information under subsection (1) must comply with the request.

(3) Information supplied to a Health and Wellbeing Board under this section may be used by the Board only for the purpose of enabling or assisting it to perform its functions.

(4) Information requested under subsection (1) must be information that relates to—

(a) a function of the person to whom the request is made, or

(b) a person in respect of whom a function is exercisable by that person.

Appendix B: National online survey questionnaire

PART 1: COMPOSITION AND ORGANISATION

1. **How many** members are there on your local Health and Wellbeing Board?

2. How many members, on average, regularly **attend Board meetings**?

3. In your opinion, is the size of the Board...?

Too big Too small Just right

4. Do you think the **right people** are around the table?

Yes No Not sure

If you have answered no, who/which organisations do you think is missing?

5. Who **chairs** your local Health and Wellbeing Board?

Elected lead member for health Leader of the council
Executive mayor
Clinical commissioning group (CCG) chair Other (please specify)

6. **How often** does the board meet?

More than once a month Every month
Every 6 to 8 weeks Quarterly
Less often

7. In your opinion, is this...?

Too often Not often enough Just right

8. In your opinion, does the board have the necessary support (eg human and financial resources) to do its job?

Yes No Not sure

9. What **sub-structures** (e.g. delivery partnerships, working groups, etc) exist to support the Board?

9a. Please feel free to comment on these structures here and/or include a weblink to further information (e.g. an organisational diagram).

9b. How do these sub-structures feed into the decisions of the Health and Wellbeing Board? Please select all that apply.

a) Regular report b) Report by exception
c) Presentations at Board meetings d) Other (please specify)

10. Please use the space below if there is anything else you would like to add here [OPTIONAL]

.....

PART 2: PRIORITIES

11. What are the **priorities** of your local Health and Wellbeing Board, in terms of improving the health and wellbeing of local communities?

12. How is the board working towards delivering against these priorities?

13. In your opinion, how relevant is the local **Health and Wellbeing Strategy** to current priorities?

Not at all relevant

Somewhat relevant

Quite relevant

Very relevant

Not sure

14. Was the Health and Wellbeing Strategy developed in line with:

- | | |
|---|---------------------|
| i) The local Joint Strategic Needs Assessment | Yes / No / Not sure |
| ii) Local CCG commissioning intentions | Yes / No / Not sure |
| iii) NHS England commissioning intentions | Yes / No / Not sure |
| iv) Public Health England priorities | Yes / No / Not sure |
| v) Local political priorities | Yes / No / Not sure |
| vi) The public health outcomes framework | Yes / No / Not sure |
| vii) Other (please specify) | Yes / No / Not sure |

15. Please use the space below if there is anything else you would like to add here [OPTIONAL]

PART 3: RELATIONSHIPS

16. How would you describe your chair's **leadership style**?

17. What is the **quality of the relationships** between the Board and the following partners:

- | | |
|--|---|
| a) Healthwatch | Very good / Good / Neutral / Bad / Very bad |
| b) Clinical commissioning group(s) | Very good / Good / Neutral / Bad / Very bad |
| c) Service providers | Very good / Good / Neutral / Bad / Very bad |
| d) Voluntary, community and faith sector | Very good / Good / Neutral / Bad / Very bad |
| e) Local government | Very good / Good / Neutral / Bad / Very bad |
| f) NHS England | Very good / Good / Neutral / Bad / Very bad |
| g) Public Health England | Very good / Good / Neutral / Bad / Very bad |
| h) Other (please specify) | Very good / Good / Neutral / Bad / Very bad |

18. How does the board hold these partners **accountable** in pursuit of its objectives as set out in the Health Wellbeing Strategy or elsewhere?

19. How does **scrutiny** of the Board take place? Please give examples.

20. Does the Board have a **public engagement strategy**?

Yes

No

Not sure

Please include a weblink to a copy of the strategy if possible.

21. How does the Board ensure **public engagement**, particularly with groups that are typically marginalised or excluded?

22. In your opinion, is public engagement in the Board adequate?

Yes

No

Not sure

23. Please use the space below if there is anything else you would like to add here [OPTIONAL]

PART 4: BARRIERS AND ENABLING FACTORS

24. In the context of your local Health and Wellbeing Board, what are the **three main barriers** to success?

25. What efforts are being taken to **overcome these barriers**?

26. In the context of your local Board, what are the **three main factors that support or enable** success?

27. Please use the space below if there is anything else you would like to add here [OPTIONAL]

PART 5: PROGRESS

28. What have been the main **successes, highlights or achievements** of the Board to date?

29. How is success **measured** by your Health and Wellbeing Board?

30. What have been the **main challenges, failures or disappointments** of the Board to date?

31. What is likely to be the **impact** of the Board in the:
a) Short-term b) Medium-term c) Long-term

32. What plans does the Board currently have for the **future**?

33. Please use the space below if there is anything else you would like to add here [OPTIONAL]

PART 6: YOUR DETAILS [OPTIONAL; TREATED AS CONFIDENTIAL]

35. Please provide the name of your authority:

36. Where are you based?

North East

North West

Yorkshire and Humber

West Midlands

East Midlands

South East

South West

East

London

37. What is your role within the local authority?

Elected lead member for health

Elected member – other

Executive mayor

Leader of the council

Chief executive

Director of public health

Head of Policy

Other (please specify)

Appendix C: National stakeholder initial interview schedule

- Please describe your background/role in developing/implementing introduction of Health and Wellbeing Boards and their role in health, social care and public health.
- What were the key drivers for the introduction of HWBs?
- What was the policy to move public health responsibilities to HWBs intended to achieve?
- How are HWBs as a policy instrument intended to achieve these objectives?
- What challenges are HWBs facing in achieving their objectives? Did these challenges influence/taken into account in policy design? How?
- What unintended consequences might arise, or are arising, from HWBs?
- What does a successful HWB look like? (Prompts: leadership, partnership, strategy, mechanisms for collective decision-making, enhanced democracy/engagement, etc)
- What factors or conditions impact on differences in the configuration and operation of HWBs across the country?
- Examples of successful HWBs we should visit? Examples of more challenging HWBs?
- What change(s) in future for HWBs would you like to see happen? How do you see them evolving?
- What change(s) in future for HWBs do you think is/are likely to take place?
- Three key issues to discuss in more depth – partnership, leadership and strategy
- Anything further you would like to add? Questions for interviewer?

Appendix D: National stakeholder follow-up interview schedule

- Please describe your role and how this has changed in the last 12 months (if at all), particularly in relation to HWBs
- From your perspective, what were HWBs set up to achieve? Have the key drivers for their introduction remained valid? Has their role or significance changed in the last 12 months? If so, in what way(s)?
- What challenges are HWBs currently facing in achieving their objectives? Have these challenges changed in the last 12 months? If so, in what way(s)?
- What factors or conditions currently impact on differences in the configuration and operation of HWBs across the country? (Prompts: differences in membership)
- What does a successful HWB look like? Are you aware of any particular examples of good practice? (Prompts: systems leadership, partnership, strategy, mechanisms for collective decision-making, enhanced democracy/public engagement, etc)
- What level of influence do HWBs have on the health and social care agenda in their communities?
- How far is the wider policy landscape presenting any challenges or opportunities for HWBs (e.g. STPs, integration of services)?
- How do you see HWBs evolving in future? (Prompts: impact of STPs, devolution, etc)
- What change(s) in future would you like to see for HWBs? (NB: Becoming more or less important? And explain any difference between this and answer to previous question)
- Anything we haven't covered? Anything further you would like to add. Questions for interviewer?

Appendix E: Case study initial interview schedule

- Describe your background and role with regards to the Health and Wellbeing Board
- Describe area's previous experience of partnership working in health and social care and public health. Has it made a difference/had a positive effect? If so, how and why? Have lessons been drawn from this and applied to HWB?
- Describe the mechanisms by which the board has/plans to engage and involve the public
- What are the main opportunities and challenges faced locally?
- What is the board trying to achieve? Has it succeeded/is it likely to succeed? If so, why? If not, why? Provide example of success?
- Describe leadership and leadership style of the board and by the board
- How are decisions made?
- Has the HWB changed the way in which its partner organisations work? If so, in what ways?
- What are the key local barriers to effectiveness? What are the key success factors?
- What if there was no HWB – would anyone notice? Would it be missed? Would things still get done?
- Anything we haven't covered? Anything further you would like to add? Questions for interviewer?

Appendix F: Case study follow-up interview schedule

Opening questions

- How long have you been in post?
- If not new in post, has your role changed in the last 12 months?

Context

- Have there been any changes in the local or national context over the past year that have impacted on the work of the board?
- What impact has the STP process had on the board in the last year?
- What impact has the devolution agenda had on the HWB in the last year?
- Have austerity and fiscal pressures influenced or constrained the work of the board in the last year? If so, in what way(s)?

Mechanisms

Board composition and partnerships

- Has the membership of the board changed over the past year?
- Are there organisations who have recently expressed a wish to be represented on the board? Are there other organisations that you think should be at the table?
- Are all members of the board engaged and has this changed in the last year?

Leadership

- Has the leadership of the board changed at all? If so, what has been the impact?
- How influential is the board in the local health and social care landscape? Is it viewed as a system leader and, if so, what is your understanding of this term?
- Has this system leadership changed in the last year? If yes or no, what are the factors accounting for the change?

Decision-making

- Have the priorities of the board changed in the last 12 months? If so, in what ways and why?
- Has there been any change in the way the board makes decisions in the last year?
- Has the nature or composition of any sub-groups of the board changed in the last year or have any new sub-groups been created? What are the reasons for this?
- Are the JSNA and JHWS factored into the decision-making process at all levels? If yes or no, what are the reasons for this?
- Has the JSNA or JHWS been refreshed in the last year?

- What impacts do national agendas have on the board? Have these changed over the last year?
- Has there been any change over the last year in the ability of board members to have 'honest conversations' around 'difficult decisions'?

Integration of health and social care

- What, if any, developments have there been in the integration of health and social care agenda in the last year, specifically in relation to the work of the HWB?
- What are the opportunities and challenges in the future in terms of integration?

Public, patient and service user engagement

- Have there been any changes in the last year in terms of how the public has been engaged by the board? If so, what is the nature of these and what has their impact been?
- Are there any plans for wider engagement? If so, what are these? If not, why not?
- Has the role, scope and impact of Healthwatch changed in the last 12 months and what are the reasons for this? Has this affected public engagement in any way?
- Has the role, scope and impact of the VCSE changed in the last 12 months and what are the reasons for this? Has this affected public engagement in any way?

Outcomes

- Have any of the JHWS priorities been translated into outcomes in the last year?
- Are there other examples of successful outcomes in the health and social care arena which have been influenced by the board in the last year?
- Have there been any changes in the mechanisms in place to monitor or evaluate the success of programmes and policy?
- Are there regular reports from sub-groups and other bodies? Are there any examples of progress by these bodies that you believe has been influenced by the board?

Closing questions

- What are the key challenges you see facing the HWB in the next 12 months?
- What are the key opportunities you see facing the HWB in the next 12 months?
- If there was no HWB, would it be missed? Would anyone notice? Is there anything that would not get done?
- If you were in charge of deciding the future of HWBs nationally, what would you do differently?
- Anything you would like to say or add that has not been covered? Any questions for the interviewer?

Appendix G: VCF focus group topic guide

- Are you aware of the local HWB and what it does?
- If aware, how do you hear about what it does?
- Did you have any involvement as it was being set up? Were you engaged in agenda-setting, looking at priorities for the Board, etc?
- Are you aware of news bulletins, website, fora, etc, relating to the HWB?
- Links with Healthwatch?
- What do you think works and does not work in relation to the HWB?
- Does HWB reach into all communities for engagement?
- What would good engagement look like to you?
- What would you like to see improve with regard to the local HWB?

Appendix H: Example of coding framework for follow up national interviews

Name of node: Role. **Description:** Please describe your role and how this has changed in the last 12 months (if at all) particularly in relation to HWBs.

Name of node: HWBs set up to achieve **Description:** What were HWBs set up to achieve?

Sub node name: Role and significance of HWBs **Description:** Has the role or significance of HWBs changed in the last 12 months and if so, in what ways?

Sub node name: Key stakeholders. **Description:** Bringing together key stakeholders into one forum.

Sub node name: Public health into local government. **Description:** Impact of move of public health into local government on HWBs

Sub node name: Prevention. **Description:** HWBs arena for promoting prevention

Sub node name: Wider determinants of health: **Description:** Addressing the wider determinants of health and health inequalities

Name of node: Drivers. **Description:** Have the key drivers for the introduction of HWBs remained valid?

Sub node name: Policy. Have the policy drivers for the introduction of HWBs remained valid?

Name of node: Challenges currently facing HWBs. **Description:** What challenges are HWBs currently facing in achieving their objectives?

Sub node name: Challenges - changes in last 12 months. **Description:** Have the challenges facing HWBs changed in the last 12 months?

Sub node name: Commissioning. **Description:** The level of influence on commissioning decisions by HWBs

Sub node name: Fragmented system. **Description:** the challenges facing HWBs in a fragmented health and social care system

Name of node: Configuration of HWBs. **Description:** What factors or conditions impact on in the configuration of HWBs across the country?

Sub node name: Providers. **Description:** The role and function of providers on HWBs.

Sub node name: Partners needed to be on HWB: **Description:** Partners who need to be included on HWBs

Name of node: What does a successful HWB look like? **Description:** What does a successful HWB look like in general terms?

Sub node name: Examples of good practice. **Description:** Examples of good practice in terms of a successful HWB

Sub node name: Decision Making. **Description:** What does a successful HWB look like? Mechanisms for collective decision making

Sub node name: Impact and outcomes. **Description:** What does a successful HWB look like? Impact and outcomes in terms of health improvement/inequalities/prevention?

Sub node name: Monitoring. **Description:** mechanisms for monitoring outcomes

Sub node name: Accountability. **Description:** Holding partners to account for outcomes

Sub node name: Partnership. **Description:** What does a successful HWB look like? Partnership Working

Sub node name: Relationships. **Description:** The importance of trust and good relationships in HWBs

Sub node name: Public, patient involvement. **Description:** The role of HealthWatch and the voluntary sector and methods for engaging the public

Sub node name: Public Engagement. **Description:** What does a successful HWB look like? Enhanced democracy and public engagement

Sub node name: Strategy. **Description:** What does a successful HWB look like? Strategy

Sub node name: Wider determinants. **Description:** The importance of focus on the wider determinants of health by HWBs.

Name of Node: Leadership. **Description:** leadership of the HWB

Name of Node: Level of influence in health and social care. **Description:** Level of influence HWBs have on health and social care in their local communities

Name of Node: Policy Landscape - challenges and opportunities. **Description:** How far the wider policy landscape presenting challenges and opportunities for HWBs generally

Sub node name: Devolution. **Description:** How the devolution agenda is presenting challenges and opportunities for HWBs

Sub node name: Co-terminosity. **Description:** the presence or lack of co-terminosity of footprints in regard to local authority, CCG, STP and devolution administrative areas and complex organisational geography.

Sub node name: Integration. **Description:** How the integration of health and social care is presenting challenges and opportunities for HWBs

Sub node name: Resources. **Description:** How austerity and fiscal constraint are presenting challenges and opportunities for HWBs

Sub node name: STPs. **Description:** How STPs are presenting challenges and opportunities for HWBs

Sub node name: CCGs. **Description:** level of engagement of CCGs with HWBs

Sub node name: Health and Wellbeing Strategy. **Description:** The scope and impact of the Health and Wellbeing Strategy.

Sub node name: JSNA. **Description:** The scope and impact of the JSNA.

Node name: HWBs evolving in the future. **Description:** How HWBs will evolve in the future

Sub node name: Executive Power. **Description:** HWBs need more executive power

Sub node name: Future of HWBs. **Description:** What changes would like to see in the future for HWBs

Sub node name: Significance. **Description:** HWBs become more or less important/significant in the future

Sub node name: integration: **Description:** the need for further integration of provision

Node name: Issues not covered. **Description:** Issues not covered in the interview

Node name: Questions for Interviewer. **Description:** Questions for the interviewer

This work was funded by the Policy Research Programme.

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