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Health and Wellbeing Boards: The new System stewards?

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Introduction

Health and Wellbeing Boards (HWBs) emerged from debates about the Health and Social Care Bill (2011) as a key co-ordinating mechanism or steward for local health and social care systems (House of Commons CLG Committee, 2013 :14). For many this is yet a further attempt to improve co-ordination between health and social care services which historically has been a mixed experience (Lewis, 2001; Glendinning and Means, 2004). However, the rationale for HWBs includes a broader co-ordinating function across local authority (LA) services with a role in addressing the wider social determinants of health such as housing, education and planning, as well as social care. This wider context of joint-working is generally unexplored despite the emergence in some areas of joint public health directors pre-dating the formal shift of Primary Care Trust public health responsibilities to local government in 2013 (Marks et al 2011).

Whilst partnerships are seen to be a prerequisite for tackling 'wicked issues' (issues so complex that their solution lies with a multi-agency response), historically they seem unable to break free from the 'silo-based' structures which govern how many UK public services are organised and delivered (Coleman 2014). Past initiatives to achieve joined up, well-co-ordinated and jointly planned services have previously had limited success.

Various approaches to local authority and NHS partnerships have been introduced since the 1970s with varied success (Hunter and Perkins 2014). Funding structures remained a key barrier partially addressed by the 1999 Health Act which introduced new "flexibilities" allowing health bodies and LAs to:

- Set up pooled budgets
- Delegate function, by nominating a lead commissioner or integrating provision, and
- Transfer funds between bodies.

The aim was that services should become far more co-ordinated, designed around users and potentially a cost saving. For example, keeping an elderly person in hospital can be more expensive than the more appropriate package of social care needed to allow the patient to be discharged. With pooled budgets, funds would no longer be tagged as belonging to health or social services, and managers would be able to take more sensible, holistic decisions. However, issues remained such as non-compatibility of budgetary cycles, audit and governance arrangements and non-coterminous boundaries[1].

In addition, a reduction of health inequalities and desire to integrate health and social care were prominent objectives in many Local Area Agreements, also reflected in the 2007 Local Government and Public Involvement Act. Health inequalities were also identified as an issue for HWBs to tackle locally.

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[1] Section 31 of the Health Act 1999 has now been repealed and replaced, for England, by section 75 of the National Health Service Act 2006, which consolidated NHS legislation.

Faced with complex organisational change under the Health and Social Care Act 2012 (HSCA12), unprecedented financial constraints (austerity and cuts) and increasing demand for services, we look at whether HWBs can do any better than previous initiatives? This chapter examines the development of HWBs and draws on the findings of studies conducted by the authors (Coleman et al 2014, Dhesi 2014, Jenkins et al 2015, Peckham et al 2015) and considers whether or not HWBs are emerging as system stewards. By this we mean HWBs acting at a strategic level to co-ordinate and set the direction of health and social care developments at the local level, as well as encouraging integrated working (Department of Health 2013)

Health and Wellbeing Boards
Addressing 'wicked issues' such as increasing costs of health and social care, poorer health outcomes for some groups and the persistence of health inequalities requires a multi-agency approach (Murphy 2013). The Coalition Government (2010 – 2015) introduced many new organisations and structures resulting in whole system change across health, public health and social care settings which led to greater fragmentation. This in turn led to an increased interest in the wider strategic and co-ordination role of HWBs and initiatives encouraging increased integration around common objectives articulated in common strategies and plans, often based on community or population outcomes, have been used as the foundations for their development.

The concept of HWBs was initially proposed in the 'Healthy Lives, Healthy People: Our Strategy for Public Health' White Paper (Department of Health 2010) and the White Paper 'Equity and Excellence' (Department of Health 2010b). Moves were made to create and develop HWBs locally as the Health and Social Care Bill was published in 2011. However the passage of the bill was troubled (Timmins 2012) and the HSCA12 was not passed until March 2012, with HWBs expected to be set up in shadow form from April 2012. All LAs were expected to have HWBs fully operational 12 months after this (April 2013) under section 194 of the Act.

HWBs are tasked with creating a forum of relevant professional groups, local elected members and others, and carrying out a joint strategic needs assessment (JSNA) for the local population - described as "the means by which local leaders work together to understand and agree the needs of all local people, with the joint health and wellbeing strategy setting the priorities for collective action" (Department of Health 2011:7). HWBs are also responsible for developing a joint health and wellbeing strategy (JHWBS) for their area with a 'core purpose …to improve local health and social care and to reduce health inequalities' (Local Government Improvement and Development 2011:7). The JHWBS is the overarching framework within which commissioning plans are developed for health services, social care, public health and other services which the board agrees are relevant.

HWBs are also expected to promote greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate and are described as "sitting at the heart of local commissioning decisions, underpinning improved health, social care and public health outcomes for the whole community" (Department of Health 2011:7). These will be the pillars of local decision-making, focussing leaders on priorities for action and providing the evidence base for decisions about local services. There was thus a clear emphasis on joint working and integrated care with HWBs being given responsibility for oversight of their local area's Better Care

Fund (BCF)[2], set up with the intention to increase the scale and pace of integrated working with a particular focus on reducing hospital admissions and length of hospital stay.

Although the passage of the HSCA12 was somewhat fraught, the idea and introduction of HWBs was generally welcomed by public health professionals and LAs and was seen as the least controversial part of the reforms, with over 90% of LAs volunteering to become early implementers. Nevertheless, some critics dismissed claims that HWBs would improve the democratic legitimacy of the NHS (Fitzpatrick 2011) and others felt that they "will not be sufficient to ensure a partnership approach to improving health and wellbeing" (Kingsnorth 2013:73). Their mandated membership (see below) necessitates that a diverse mix of stakeholders are consulted in the strategic and policy tasks of key commissioners in the HWBs (Coleman et al 2014).

Established as sub-committees[3] of upper tier/unitary LAs, the exact membership of HWBs was not defined, and subject to a minimum core membership, HWBs could choose how they wished to work. However, the Department of Health emphasised the role of local elected members to provide greater local democratic legitimacy of commissioning decisions (Department of Health 2011). The core membership should consist of:
- at least one nominated councillor of the LA
- the director of adult social services for the LA
- the director of children's services for the LA
- the director of public health for the LA
- a representative of the local HealthWatch organisation
- a representative of each relevant commissioning group
- such other persons, or representatives of such other persons, as the LA deems appropriate.

All members have equal voting rights on HWBs – unusual for an LA (sub)committee including non-elected members. Dhesi (2014) and Coleman et al (2014) found that LAs were conscious of the need for balance in the number of LA and CCG members, where the view was either that the democratic voice of the LA should have the greatest weight or that health and LA representatives should be evenly balanced.

Upper-tier/unitary LAs are the authorities responsible for HWBs and, unlike in previous joint health and social care initiatives, there is no duty or requirement for district and borough councils to have a seat at the board, to be consulted or to be otherwise involved, (with the exception of the drafting of the JSNA, Chartered Institute of Environmental Health 2010), an omission for which the government was criticised by the Health Select Committee (Williams 2012). LAs are free to determine the number of elected members on HWBs, though this has promoted concerns about the politicisation of decision-making and the need to ensure that the most suitable members are present (Calkin and

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[2] The August 2013 Spending Review established the £3.8 billion BCF "to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people." The total pooled budget is now £5.3 billion and is to be used to integrate health and social care.
[3] Most LA committees allow only elected members to vote, having taken guidance from officers. However, on HWBs elected members, officers and others who are full members all have an equal entitlement to vote on decisions taken.

Ford 2011). There is also the option for HWBs of using co-option to increase variety and suitability of membership.

Given the variety of potential representatives on HWBs, this gives opportunities for cross-organisational work at a strategic level, and being able to co-opt enables variation suited to local needs/context to be developed. Other potential representatives, include the fire service, police, voluntary organisations and housing associations, all of whom can influence the wider determinants of health. It is important that representatives are senior enough to make decisions on behalf of their organisations, and to attend meetings regularly in order to maintain the position of the HWB as a respected forum (Coleman et al 2014, Dhesi 2014).

Humphries (2013) suggested several features of HWBs which could set them apart from previous partnership initiatives. These included: involvement and engagement of GPs; better governance and accountability (due to being sub-committee of the LA); encouragement of wider relations between the NHS and broader LA (not just Social Services); and opportunities afforded by the move of Public Health functions to local government (Coleman and Glendinning 2015). However, as we have noted, similar initiatives had historically fallen short of expectations.

Following publication of the White Paper (Department of Health 2010), the idea of HWBs developed - including potentially having a lead commissioning role (Behan 2011). However, HWBs have no direct commissioning responsibilities, but instead are expected to influence the commissioning decisions of LAs and CCGs by providing local strategic oversight (stewardship). They are the single element in a fragmented system with a specific mandate to promote integration between local services. CCGs and LAs, together with other key stakeholders, are members of these pivotal joint local fora (Coleman and Glendinning 2015).

A recent publication (LGA, NHSCC 2015:2) suggests that "HWBs provide a genuine opportunity to develop a place-based, preventive approach to the commissioning of health and care services, improving health and tackling health inequalities and the wider determinants of health". However, since HWBs have no formal powers, their ability to influence others will depend upon their success in building relationships (Coleman 2014).

In the following section we use empirical evidence from research, with which we have been involved looking at changes in the system following the implementation of the HSCA12 (Coleman et al 2014, Dhesi 2014, Jenkins et al 2015, Peckham et al 2015), to illustrate some of the issues faced by HWBs as they developed.

Implementation and impact of reform 2010-2015: Membership, Structures and Relationships

Dhesi (2014) found that the matter of HWB membership was a thorny issue for many, with Chairs and support officers attempting to achieve a balance between inclusion of all relevant parties and creating an unwieldy board with too many members for effective decision-making. HWB

membership numbers varied considerably, ranging from little more than the statutory minimum (6), to around 40 members at one authority in a largely rural two-tier system.

Many HWBs faced challenges when deciding which, if any, non-statutory members should be included. The following comment gives a HWB member's opinion on the lack of representation of district council based services in a two-tier area;

> *'..my specific suggestion was that the seats, however many, given to the District Council should go to the key roles, because, I think, it's really damaging not to have Environmental Health and not to have Housing represented around the table, that, I think, is a real disadvantage for us.' (HWB member, Dhesi 2014)*

Our studies suggest that in some two-tier areas, due to the large number of district councils, not all were directly represented on the county-level HWB. However, there were representative district councils on these HWBs, and in several areas there were also local versions of HWBs. To illustrate, in one area (Peckham et al 2015:17) the local HWB matched CCG boundaries, so all district councils sit on at least one local HWB, and in another site, there was one local HWB for each district council. In another site, each local HWB had an integrated commissioning board, which was attended by a member of the public health team (e.g. business manager or commissioning manager). This was to ensure commissioning was aligned and integrated where possible. The District Council's Network highlighted the issue of adequate district council representation 'it seems contradictory... given the prominence of the prevention agenda -that whilst CCGs have a statutory role, there is no obligation to involve districts beyond the production of JSNAs' and the committee recognised the issue as a concern (House of Commons Select Committee on Health. 2013:32).

The existence of sub-structures did not appear to be related to the size of the HWB, and sub-structures changed over time during the developmental stages. In many areas the HWB and sub-structures had been developed from existing groups (Dhesi 2014, Coleman et al 2014). Others have also observed that in some areas there was an existing system of close collaboration (Tudor Jones 2013). An environmental health manager noted this trend and described the need to change the people and not just recycle the previous arrangements;

> *'... I'll look back in a year's time and think, well, it's just the same old, same old, nothing has really changed, because I've been involved with the NHS for a couple of decades now and I've seen restructures, I've seen different GP structures, to the PCT's, they come and go with just the different names, and it's the same people pop up in different structures... You need to change the people sometimes, not just the structure and I'm seeing it happen now'. (EH manager, Dhesi 2014)*

In other areas of the country, an administrative layer has been created above the statutory HWB (often where there was a history of joint working at this scale). This shows that the imposition of LA-wide HWBs does not always sit comfortably with existing partnerships and that different areas have created local arrangements to accommodate this.

Despite concerns expressed that HWBs might be mere "talking shops" as they did not have statutory powers (HCLGC 2012, Humphries and Gelea 2013) public health staff, LA staff and councillors interviewed by Peckham et al (2015:18) were generally positive about the future role of HWBs and who was involved, despite some feelings that HWBs were still developing their roles.

It is clear both from policy documents and from our research data that HWBs have an important role to play in cross-system coordination. When interviewees in Peckham et al's (2015) study talked about HWBs, it was usually with a sense of optimism. HWBs were seen to play a key part in (potentially) pushing ahead system change, particularly around the integration agenda. Their position in the council, and their membership - often chaired by a senior councillor , was seen to give the HWB the opportunity to progress on the whole redesign of the system, taking the public with them as they do. In a survey of Directors of Public Health (DsPH) (Jenkins et al 2015) respondents reported that the main benefit of the HWB was that it was 'definitely' instrumental in identifying main health & wellbeing priorities (61%), although as many as 63% of DsPH felt that the HWB was 'not really' making difficult decisions. One senior manager described it as *"the place to come to"*, given its high profile and membership. As figure 1 shows, the responses for elected members were slightly more positive, with more saying that membership of the HWB allowed them to influence decision-making in the authority (73%) and to engage with the development of the Better Care Fund (73%).

Figure 1: Role on Health and Wellbeing Board (Peckham et al 2015:27)

How do you see your role on the Health & Wellbeing Board? (% of N=93 DsPH and N=52 elected members)
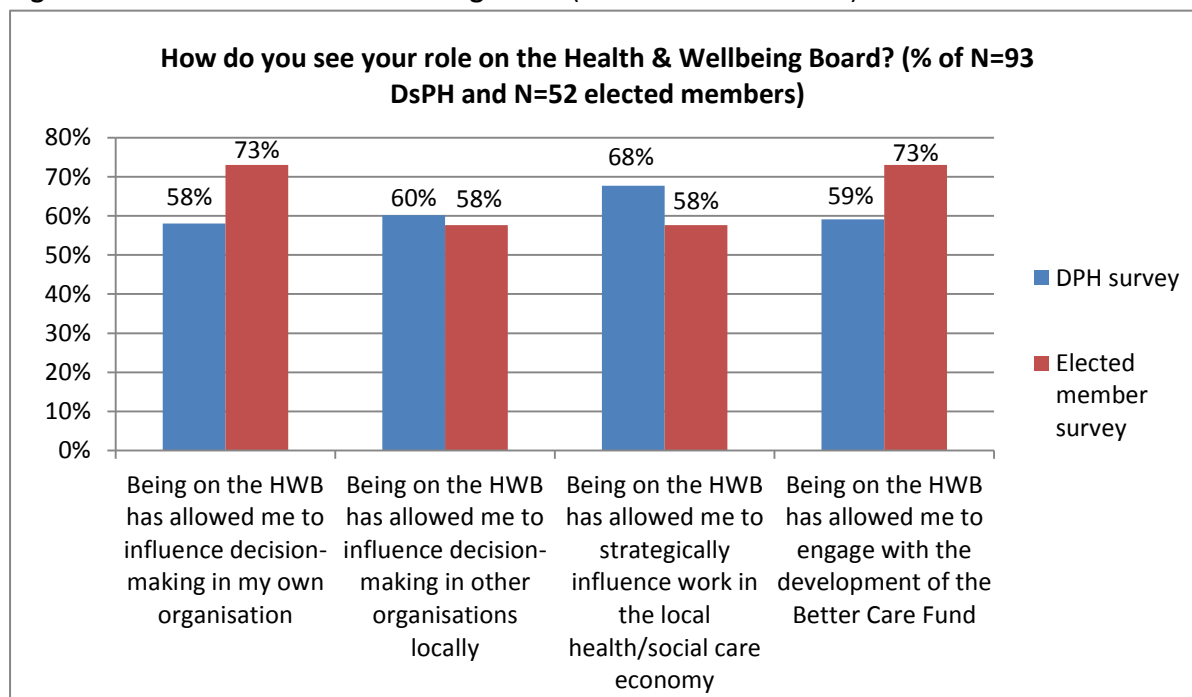
Peckham et al (2015:27/28), highlighted the HWB role in forging new or better relationships between different actors within the system – in particular between elected members and clinicians, which in turn offers opportunities for change and improvement:

'… we insisted … that the one relationship we had to get right was between elected members and clinicians, because they were the only two new entrants into the health and wellbeing

board as far as we were concerned, everybody else had been there before' (Senior strategy manager).

In addition, HWBs have a role in encouraging new ways of working for health improvement, perhaps by focusing on a particular health issue and tasking others across the system with looking at how they might be able to assist, or by 'shaking things up' and putting pressure on system actors, or by system actors putting pressure on each other, asking what more they can do, or what they can do differently. This role of applying pressure has a performance management/scrutiny aspect to it, which one senior manager described as *'hold[ing] public health activity to account'* (Peckham et al 2015).

Priority Setting

The influence of the Marmot review (2010), where two policy objectives relate specifically to children and young people, can be seen in the prioritisation of children in many locally developed JHWBS. A commitment to addressing the social determinants of health was notable during shadow stage interviews with HWB members and support officers, although observations at all case study sites noted a focus on healthcare and social care during many HWB meetings, particularly at the CCG authorisation stage reflecting both internal and external policy pressures (Dhesi 2014). Dhesi's research (2014) found that many early agendas had the authorisation of CCGs[4] as standing items for some time and integrated care was also a regular feature on the agenda at meetings across the case study sites. There were two approaches to issue-based prioritisation; focussing on specific population groups, such as children or vulnerable people; and focussing on health issues, such as smoking, drugs and alcohol, dementia or obesity. Sites (Dhesi 2014) generally adopted a mixture of both issue-based approaches and there was little real support seen for geographical prioritisation other than in primary care, where the provision and quality of care were sometimes referred to as issues.

However, Dhesi (2014) highlighted differences in opinion about priorities, and in some cases uncertainty about the best course of action to take. This is illustrated by the views of an elected member of a HWB when asked how best to tackle health inequalities locally;

> *'What more can [LA] do to help [DPH] and CCGs in driving down health inequalities? I mean we all know what they are, you know, we live 10 years shorter in [area] than we do in [area] and you know, teenage pregnancies, obesity, it's all worse in the North than it is in the South... think we've got to see what we can do about [it], I'm not sure we actually know.'* (HWB member Dhesi 2014)

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[4] In order to become a statutory body each CCG had to go through an authorisation process. This was a set of checks and balances set against 6 domains set out by the NHS Commissioning Board (later known as NHSE). Within each domain, aspirant CCGs would be expected to produce a range of evidence, including documents such as plans and proposals, examples of work undertaken and feedback from local stakeholders. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130293

Several interviewees noted the impact of wider policy initiatives, and the limited scope of the HWB in tackling an issue with structural causes. Concerns were raised around central government welfare policy exacerbating health inequalities, whilst others emphasised the impacts of other policy areas *'...so it's really to do with economics, war, housing, education, all these big things...' (EH practitioner, Dhesi 2014).* Another interviewee considered that expectations on what was possible in tackling health inequalities locally needed to be managed, but felt that improvements in certain specific areas were possible.

In contrast to the majority of other sites in Dhesi' study (2014) an EH manager explained that the existing strategies did not include priorities relating to the social determinants of health, but that this was based on previous initiatives and likely to change as they were reviewed;

> *'..when you go back to the JSNA, those wider determinants aren't really in there, it's very much around the legacy of what was the local area agreement and the [area] Strategic Partnership and the priorities that were there got carried over and the strategy, you know, everybody will admit, was put together in a hurry really, so that the board had something to work to and could launch and that was it, but they've also recognised that in the next 12 months, we do need to refresh that...' (EH manager, Dhesi 2014)*

In some areas there were reports of health inequalities being seen as low priority or as in one case being unacknowledged. There were some indications that a commitment to prevention and focus on the social determinants of health were starting to result in changes in local arrangements. An elected member described what they viewed as a change under the new system;

> *… It can't be just about treating ill people. But it never had the chance, I don't think, under the old regime, to have a proper prevention agenda.' (HWB member, Dhesi 2014))*

However, others raised concerns about the level of funding available for preventative services, and also the need for priorities to work in practice, within the sphere of HWB influence, if they were to have some meaning and impact.

Looking at perceptions of the role of HWBs, a survey found that while DsPH and elected members were very similar in the way they ranked the benefits of being on the HWB (Jenkins et al 2015, Peckham et al 2015 p27/28), Councillors were more positive about the powers of the HWB on every aspect. For example, they rated identifying the main health and wellbeing priorities most highly (86% said 'definitely' compared to 61% of DsPH). At the other end of the rankings, 35% of Councillors compared to only 6% of DsPH felt that the HWB was 'definitely' making difficult decisions (see table 1, Peckham et al 2015:28).

Table 1: In your opinion is the Health and Wellbeing Board… (% of replies in DPH and elected member surveys)		Definitely	To some extent	Not really	N
Instrumental in identifying the main health and wellbeing priorities?	DPH	60.5	33.3	6.2	81
	EM	86.0	14.0	0.0	43
Strengthening relationships between commissioning organisations?	DPH	39.5	51.9	8.6	81
	EM	77.3	18.2	4.5	44
Beginning to address the wider determinants of health?	DPH	23.5	49.4	27.2	81
	EM	59.1	36.4	4.5	44
Influencing cross-sector decisions and services to have positive impacts on health and wellbeing	DPH	14.8	64.2	21.0	81
	EM	50.0	43.2	6.8	44
Facilitating the greater use of collective budgets?	DPH	12.3	55.6	32.1	81
	EM	43.2	50.0	6.8	44
Helping to foster a collective responsibility for the use of budgets?	DPH	9.9	63.0	27.2	81
	EM	40.9	45.5	13.6	44
Making difficult decisions?	DPH	6.2	30.9	63.0	81
	EM	34.9	51.2	14.0	43

EM – Member

Operational Matters

The tone of HWB meetings and decision-making processes varied considerably, with some chairs permitting much debate, whilst others felt that discussion and any disagreement should take place outside HWB meetings. Research (Dhesi 2014, Coleman et al 2014) indicated that there was variation in how decisions were made at HWBs, but there was a significant level of work which was, or was planned to be, carried out outside the HWB. This is interesting due to the requirement of HWBs to meet in public from April 2013. However observations have revealed that the content and level of debate heard in public at some sites was minimal, with a clear intention at some sites that disagreements will be debated privately. One site (Dhesi 2014) in particular held very little debate during meetings and this approach was explained by the chair;

> *'I'm determined that we will never have a vote on the board. We'll do it all by consensus. And if there is a danger of falling out over something we'll take it away and sort it, but not in public at the board.' (HWB member, Dhesi 2014)*

Public access to the work of sub-structures appeared to be an area of development. In addition, it was clear that at many sites, officers rather than elected HWB members (with the exception of some chairs) were driving the agendas of HWBs, although HWB members did feel able to add agenda items if they wished.

Both Dhesi (2014) and Coleman et al (2014) showed clearly that there were differing views about the role of party politics, with some members feeling that there was no role for it in HWBs. Officers involved in HWB often expressed the need to gain cross-party support, although it was evident that people with different political persuasions could take different views on health decisions for their local areas. As sub-committees of the council, HWBs operate with equal voting rights for all Board members, including the LA officers – which is different to any other LA committee where officers advise and councillors vote.

Humphries (2013) identified key factors for HWB success. These were the role of local government, the role of national government, strategy vision and purpose, promoting integration, beyond the meetings and establishing relationships. Early evidence from work by Peckham et al (2015) suggests that public health is an integral part of HWBs and with PH now being located in LAs rather than health (PCTs) there are many more opportunities for better work across traditional professional boundaries. Despite some tensions identified in case study work (Peckham et al 2015), Jenkins et al's (2015) survey of DsPH indicated that the overwhelming majority (82%) of respondents felt more able to influence the work of the LA as a whole than they could prior to the reforms.

HWBs were seen as important for public health despite their broader function and current strong focus on integrated care. The DPH is a statutory member of the HWB but there were different expectations about how engaged HWBs actually were, or should be, with the wider public health agenda:

> *'We have a very strong focus on integration, Better Care Fund – all that side of things. I'm conscious sometimes of an element of criticism. Well I mean when I say criticism it's probably a bit strong; there's always a challenge to say, 'Are you actually thinking enough about long term determinants and all the sort of public health agenda' …'*(Councillor, Peckham et al 2015 p17).

Evidence from a Regional Voices (2015) survey asked representatives about their engagement with HWBs and their success in influencing it. The results suggested that over a three-year period the voluntary and community sector found it easier to influence the JSNA than the JHWS and consequently commissioning. Two further findings were that organisations working with equality groups highlighted how difficult and resource intensive it can be to engage with HWBs resulting in issues considered to be important being omitted from strategic agendas. Where voluntary bodies span geographical boundaries and end up working with multiple HWBs, they particularly struggle to engage and influence adequately.

Health and Wellbeing Boards: developing their roles

Findings from our research projects (Coleman et al 2014, Dhesi 2014, Peckham et al 2015) and the work of others (LGA / NHSCC 2015, Humphries et al 2013) suggests that the system within which HWBs are operating is still under development and given the scale of change (for organisations and individuals within these), this is not altogether surprising.

It has been noted that "In such a fragmented system, the HWB is crucial in ensuring local governance and stewardship. However, whilst the HWB was seen as having a role in 'holding public health activity to account', it did not have any inherent power to fulfil this role, and it was unclear how this might work" (Peckham et al 2015:38). In addition the dual roles held by HWBs – building partnerships across the local area and applying pressure and scrutiny may prove uneasy bedfellows. Given the broad remit of HWBs and that they were still very much in development "the dominant priorities were integrated care and the Better Care Fund (LGA 2014)" often at the expense of other roles / functions. Peckham et al (2015) found that councillors were more optimistic about the roles of HWBs than DsPH, which may reflect the institutional positions they hold. Also, HWBs have not developed an executive decision making role but remain information exchangers and focused on a co-ordination role – supporting the findings of other research (Humphries and Galea 2013).

HWBs are struggling in many cases to carry out all their roles and have focussed on selected areas such as integrated care or very locally specific issues. In addition other imposed national change such planning the use of the BCF need to be co-ordinated and overseen by the HWB. The BCF involves NHS funding being pooled with money from other funding streams and spent jointly by the NHS and LAs on promoting integrated care. The compulsory pooling of significant amounts of funding when budgets are already under huge strain will add to pressures facing NHS providers; furthermore, changes to the operation of the BCF have undermined support for it within local government (Kings Fund 2015). Some current disquiet about BCF and delays in announcing way forward for 2016/17 – planning time is being diminished (Peters 2015). Under the changes announced in July 2014 (Johnstone 2015), HWBs were to set a local target for reducing the number of unplanned hospital admissions by at least 3.5%, or 185,500 nationwide. All these changes have led, in many areas, to a lack of strategic oversight by HWBs and many questioning their role.

New arrangements are bedding in at a time of unprecedented austerity and budgetary pressures on both the NHS and LAs. Adult social care services have inevitably been adversely affected by cuts to LA budgets, both in the range of services they can fund and the organisational structures within which they operate. Funding constraints such as these do not provide an encouraging environment for new, robust collaborative relationships to develop (Coleman and Glendinning 2015). The announcement of a £200 million cut in public health funding, constitutes a 7.4% reduction in the public health budget (Barr and Robinson 2015) potentially costing the Treasury much more than £200 million in the long term (Owen et al 2012).

There are also more fundamental changes happening at a local and national level at different speeds around England. These include devolution of health/care budgets; new initiatives such as Devo-Manc; and new models of commissioning and care provision as set out in the Five Year Forward View (NHSE 2014). In addition the Care Act 2014 places new responsibilities on LAs responsible for adult social care with a particular emphasis on prevention and the need to develop greater health and social care integration (Department of Health 2012).

In 'Making it better together' the LGA and NHSCC (2015) call for action and set out proposals for strengthening the impact of HWBs. They stress the importance of developing a place-based preventative approach to commissioning health and care services and tackling health inequalities

and the wider determinants of health. In a time of developing new models of care they believe HWBs could play a bigger role as local system leaders, building on the good work they are already undertaking (p2). This they suggest can be facilitated, not by significant legislative change, but through the bold use of existing powers (p4). The report states that "in some areas members [of HWBs] have begun to make use of the powers and freedoms HWBs have to make a significant impact…. while others were more sceptical about the boards' capacity and have made only tentative steps so far" (p9). A plea is made for a balance between national accountability and local flexibility, the removal of barriers to integration and increased place-based leadership, enabling HWBs to look at both immediate priorities for integration and action for upstream prevention. They set out what a 'good' HWB would look like and include: shared leadership – equal partnership between local commissioners enabling a shared understanding to facilitate services which address the wider determinants of health; a strategic approach – shared ownership of problems and solutions, focussing on manageable local priorities and making change at a sensible local pace; engaging with communities – working with and accountable to local communities together; collaborative working – pooling and sharing risks, budgets, data and intelligence and developing good working relations throughout the local health economy (including providers).

This latter point is supported by the findings of Peckham et al (2015:26) where it was found that "*In influencing the system, participants often talked about using specific relationships as levers; key relationships would be used to help to smooth the process, understand what is required to get papers through the local authority and also to get political priorities agreed*".

Calls have long been made for aligning finance and budgets between the NHS and local government (for example Hudson 1998, Ling 2002) and this is now repeated (LGA, NHSCC 2015). Aligning finances and budgetary timetables would simplify integration and the creation of joint incentives could facilitate prevention and early intervention. To allow strategic planning and monitoring of outcomes facilitating an easier flow of information across health and local government would seem key, as would aligned accountability frameworks across local health systems. Co-ordinated workforce planning to include recruitment and training would also encourage better cross professional working.

Conclusions

As we demonstrate, HWBs display similarities and differences with previous partnership approaches. Distinct differences include equal membership rights of LA officers and external members on a local government committee, new governance forms in local government, problems regarding structures and patterning – especially in two-tier areas but also in areas where new structures (at regional level for example) are also present. The system surrounding HWBs and the Boards themselves are still developing, with national imposition of new responsibilities, local variations and establishing working relationships and appropriate agendas being challenging. There is an ongoing struggle between local agendas (e.g. tackling inequalities) and a central Government push (e.g. integration) where HWBs can only be a part of the solution suggesting they may be best focusing on their local system oversight and co-ordination role. The context of financial austerity in local government and recent additional public health cuts, does not facilitate joint working and can lead to suspicion locally

between organisations about potential budget raids although, conversely it may force different approaches to be examined – such as through devolution.

Given these challenging contexts it is perhaps not surprising that the role of HWBs remains unclear in practice. The HWB sits at the intersection of three broad movements. The first is that of developing local collaboration and co-ordination. To date this has been dominated by the integrated health and social care agenda to the detriment of broader health and wellbeing goals – particularly in the context of public health budget cuts. The mixed reception to devolved autonomy also suggests that this will continue to be an area of concern and complexity. Secondly, this is likely to be exacerbated by the need to address more substantial budget restrictions and reductions across both LAs and healthcare. While integration is seen as a response to this, structural constraints in terms of organisational, professional and accountability differences continue to create a complex arena within which the HWB has to operate. Given the complexity of "wicked issues" and the need for action not only across local organisations but also between local and national government does raise the question of whether the HWB can ever provide adequate strategic leadership and co-ordination. Finally, the key issue relating to internal governance and accountability, membership of HWBs is based on equality of membership with LA officers and non-LA representatives having voting rights with elected members. This makes HWBs unusual governance structures within local government. Achieving the potential of HWBs to deliver democratic accountability and "joined-up" solutions depends on how well local organisations can, not just manage these, but also shape the environment within which the HWB operates locally.

There is unlikely to be a single response given the extent of local variations in LA and health and social care systems, and the wider context of developments following the Five Year Forward View (NHSE 2014) and local progress on devolution. Pushing more and more onto HWBs is unlikely to help them develop their key strategic roles and enable them to take on a clear leadership and co-ordination role in the local health and social care system. There is likely to remain a tension between local determination and national policy - notwithstanding new approaches to devolution. In addition many of the social determinants of health rely on national policy initiatives rather than being solely amenable to local policy solutions.

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