April 2014

GREAT EXPECTATIONS

A review of the Health and Wellbeing System Improvement Programme

Executive Summary

This report sets out the conclusions of our review of the impact of the Health and Wellbeing System Improvement Programme (the Programme), our recommendations for future support and our conclusions on the state of the health and wellbeing system, particularly health and wellbeing boards. The report draws on the conclusions of our earlier review of the four pilot Health and Wellbeing Peer Challenges.

The report draws on:

- Our review of the outcome of 13 of the 17 peer challenges undertaken in 2013/14;
- 18 stakeholder interviews;
- An on-line survey of health and wellbeing board chairs and co-ordinators and directors of public health;
- A series of discussions with the LGA and its partners.

The context for this report is one of great expectations: great expectations for the impact of health and wellbeing boards as an example of localism; and great expectations of the Programme as an example of sector-led improvement.

The title of our first report, Change Gear, reflected the fact that each of the early peer challenges made some reference to the need for health and wellbeing boards to "change gear", "pick up pace" or "become a driver of change". The fact that five months later peer challenges are reaching a similar conclusion means that the message to health and wellbeing boards now is "step up to the plate" or "get a grip". This reflects a frustration voiced by many of the stakeholders we interviewed that too many boards are still in a settling in phase and are not yet driving change in their areas.

But what does changing gear involve for a health and wellbeing board? On the basis of our work, we identify three tasks:

- Tighter prioritisation;
- More effective engagement; and
- Driving change on the big issues.

It is imperative that boards develop the capacity to visibly and effectively drive the immediate tasks of health and social care integration and health service reconfiguration while sustaining focus and momentum on the longer term priorities around, for example, public health and health inequalities.

We have identified five areas in which boards must develop if they are to change gear. They are to:

- Have difficult conversations when necessary;
- Use a variety of meeting formats outside formal board meetings;

- Apply lessons from other change programmes board members have led;
- Create the time and space to think;
- Establish greater clarity of purpose.

The final point is particularly important. It is key to achieving the shift from managing a period of transition to effective system leadership. This report sets out two roles which boards may find useful in any discussion on their role and functions. They are:

- to mutually hold the health and wellbeing system to account through its membership and in doing so to generate a shared responsibility for its impact;
- to empower its individual members in driving delivery and change, something we have described as a providing a collective 'power to their elbow'.

Our over-riding conclusion is that in its first year the Programme has worked well in bringing together key national partners, has been well received across the system and is helping places to implement the new arrangements. The health and wellbeing peer challenges have been particularly well received and offer a rich source of wider learning.

In considering the shape of any future support we explored three key issues:

- The future role and shape of peer challenge in the Programme;
- The extent to which the Programme should focus on areas in particular need of support;
- The role of the regional element of the Programme.

We recommend that:

- The existing health and wellbeing peer challenges should be supplemented with a new less resource intensive peer process which would enable more places to benefit from a peer review over the next two to three years;
- More priority should be given to places in most need of support, with a bespoke menu of support including the broader peer offer;
- The regional offer should be strengthened and given an explicit remit to identify places in particular need of support.

We also recommend:

- The provision of support for health and wellbeing board chairs in the form of mentoring, a bespoke leadership academy and action learning;
- Support for those boards which are struggling with the task of defining their purpose, roles and ways of working.

1 Introduction

1.1 Shared Intelligence (Si) was commissioned by the Local Government Association (LGA) to carry out a review of the Health and Wellbeing System Improvement Programme (the Programme). The primary purpose of the review is to provide the LGA and its partners with an understanding of the impact of the improvement support offered during its first year and, in doing so, to offer insight into the learning themes emerging for the health and wellbeing system in the first fully functioning year of the health and wellbeing boards. We were also asked to identify the future support needs of health and wellbeing boards and recommend how those needs could best be met. The main elements of the Programme are set out in the box below.

The health and wellbeing system improvement programme
• Health and wellbeing peer challenges - 17 in total in 2013/14; • Localised support through regional resources and partnerships; • A Healthwatch Implementation Team (HIT) to offer advice and assistance to local authorities and health and wellbeing boards,; • Opportunities for learning and sharing using the LGA's Knowledge Hub, social media, direct correspondence and national learning events; • A self-assessment tool designed to help health and wellbeing boards chart their own development; and • A single point of access to a range of data utilising the LGA's LG Inform and LG Inform Plus online tools.

1.2 In an earlier piece of work, also commissioned by the LGA, we carried out a rapid review of the first four health and wellbeing peer challenges, focussing in particular on the learning for other health and wellbeing boards and the sector as a whole. The results of that work were reported in Change Gear, published in October 2013. We also produced an interim report on our review of the impact of the Programme which was completed in January 2014. Key findings from both reports are included in this report, but we have not repeated them in full and the reports are available on

"http://www.local.gov.uk/documents/10180/49968/Change+Gear+-+learning+from+the+pilot+health+and+wellbeing+peer+challenges/06577543-1be0-4207-bb42-6214f931ac90."

1.3 The main focus of this report is on the picture of the health and wellbeing system that emerges from the first year of the Programme, our conclusions in relation to future support needs and our recommendations on how those needs should be met. It includes:

- A summary of our methodology;
- A description of the context in which health and wellbeing boards are working and in which in this Programme was commissioned and delivered;

- Our conclusions about the current picture of health and wellbeing boards and the wider system and the challenges they face;
- Our conclusions about the areas in which health and wellbeing boards need to develop and their future support needs and our recommendations about the form that support should take.

1.4 The report also includes:

- A set of questions health and wellbeing boards should ask themselves in the light of the conclusions of the issues raised by the health and wellbeing peer challenges;
- Some scenarios we developed to explore future support needs which may be of use in board development events.

2 Methodology

2.1 Our approach to this review comprised three core activities:

- We reviewed a total of 13 health and wellbeing peer challenges from the 17 undertaken in 2013/14;
- We carried out around 18 stakeholder interviews;
- We carried out an on-line survey of health and wellbeing board chairs and co-ordinators and directors of public health.

2.2 We began by carrying out a detailed analysis of the Programme's core documentation including the memorandum of understanding, regional papers, feedback from national learning events and minutes from national meetings.

2.3 Our reviews of the peer challenges included an analysis of the feedback presentations and letters for all 13 challenges, and interviews with key stakeholders in the case of 7 peer challenges. The areas covered were: Merton, Coventry, Cornwall and the Isles of Scilly, East Riding, West Sussex, Sefton, Bristol, Doncaster, Southend-on-Sea, Bath and North East Somerset, Leicester City, Solihull and Sunderland.

2.4 The stakeholder interviews were carried out at the start and the end of the review and included a mix of face to face and telephone interviews. The people interviewed included four local authority chief executives, the chair of a health and wellbeing board, a CCG Chair and representatives from Healthwatch England, NHS England, Public Health England, the Department of Health and the Association of Directors of Public Health. A number of the people we interviewed are involved in the regional arrangements that have been put in place as part of the Programme.

2.5 We carried out an online survey of over 400 HWB chairs, HWB coordinators and Directors of Public Health to understand the awareness and impact of support offered through the 'self-service' aspects of the Programme - the self-assessment tool, the health and wellbeing board bulletin, the national events and the Knowledge Hub. The survey response rate was around 25%, of which approximately one-third were chairs of health and wellbeing boards.

2.6 Our work also included:

- An external scenario based workshop with key national and local stakeholders to test out key challenges and support needs;
- Presenting and discussing our findings at a number of key LGA and partner learning events;
- Attending a series of six LGA team sessions, two Programme Steering Group meetings and the LGA Community and Wellbeing Board meeting to test our emerging findings.

3 The context

3.1 Local government's role in relation to health and wellbeing was significantly enhanced by the Health and Social Care Act 2012. Of particular importance was the creation of health and wellbeing boards, the transfer of responsibility for public health to local councils and the establishment of local healthwatch.

3.2 It is evident from the stakeholders we interviewed that these new arrangements are jointly owned by central and local government and that there are high expectations about what they can deliver. How local councils and their partners take on these roles is perceived to be important in relation to the health and wellbeing of local communities, the reputation of local government and the broader case for localism and devolution.

3.3 In terms of the Programme it is significant that these new responsibilities have been introduced at the same time as local government and its partners are promoting the notion of sector led improvement and development - in the context of the abolition of the Audit Commission and the changing roles and remits of other public service inspectors and regulators.

3.4 To support the implementation of these roles and functions during their first year, the Department of Health grant funded the LGA around £1.9m to develop a Health and Wellbeing System Improvement Programme. The Programme was designed in collaboration with the Department of Health, NHE England, Public Health England and the NHS Confederation.

3.5 The expectations about the impact of the Programme are also high. It is widely perceived to provide an important test of the robustness of sector-led improvement, and there is undoubtedly a tension between this approach and the Department of Health's more directive approach.

3.6 A final contextual point is that these changes are being introduced during a period of reductions in public expenditure and an intense focus on the performance of health and care services, the impact on them of our ageing society, the financial pressures on the health service, the move towards health and social care integration and the sensitivity of any significant changes to health service provision.

3.7 This has been reflected in developments such as the role of health and wellbeing boards in relation to the Better Care Fund. This £3.8bn Better Care Fund - formerly the Integration Transformation Fund - was announced by the Government in June 2013 and plans on how the money is to be spent locally had to be formally agreed and signed off by the health and wellbeing boards for submission in April 2014.

3.8 This reflects a widespread view that health and wellbeing boards should play a leadership role in relation to health and social care integration and health service reconfiguration. But there is also evidence that boards are becoming the victim of 'mission creep' as national partners see the boards as vehicles to validate and secure local delivery of a number of

specific national policies and initiatives. At one recent national learning event a senior DH official listed five topics he said he would like to see boards address in the coming year, on top of the big strategic challenges.

3.9 Some of these additional ambitions might well be legitimate and that is for local negotiation and decision but, particularly at a time where clarity of purpose and direction of the health and wellbeing boards feels crucial, it is important to recognise the significant risks attached to letting the boards' role and functions grow exponentially in an unstructured way. This 'mission creep' is arguably reminiscent of local strategic partnerships which, often as a result of a lack of specific purpose and focus, became seen in some places as ineffectual 'talking shops'. We return to the importance of clarity of purpose of the boards later in this report.

4 The current state of play

4.1 In Change Gear! we concluded that "On the basis of the four pilot peer challenges, health and wellbeing boards have made a solid and enthusiastic start, but are at a key stage in their development. The peer challenge reports use different analogies – "pick up the pace", "change gear", "become a driver of change" – but the overall message is a consistent one: health and wellbeing boards need to focus more, drive delivery more effectively and address a series of challenging issues in relation to the future of health and social care and the integration of the two."

4.2 At the time this was felt to be a reasonable position for health and wellbeing boards to be in. Five months later, however, most peer challenges are reaching a similar conclusion, and our stakeholder interviews reveal a frustration at the pace of board development. Our strong sense is that many boards are still in a settling in phase. If Change Gear! was a fair reflection of the message to boards in October 2013, our conclusion is that now it should be Step up to the Plate! or Get a Grip!.

4.3 This section of our report:

- Summarises the strengths of the settling in period;
- Sets out our reflections on the current position;
- Outlines the challenges facing health and wellbeing boards and the action they need to take to address them.

Settling in successes

4.4 The health and wellbeing peer challenges consistently suggest that health and wellbeing boards have made a good start in tackling their agendas with their commitment and enthusiasm and the quality of local leadership particularly notable. Within the peer challenges and in stakeholder discussions much has been made of the progress health and wellbeing boards have made in establishing close and collaborative working between all partners on the boards and the effective bringing together of partners from across organisations, each with very different cultures, values and ways of working.

4.5 This encouraging settling in period has been universally seen as vital. During the course of the review stakeholders frequently observed that the levers to make things happen available to health and wellbeing boards are more about persuading and influencing across the system rather than through the use of formal powers. Many felt this is particularly important when working across organisational boundaries. All stakeholders we spoke to recognise that these powers of persuasion and influence take time to develop, depend upon mutual trust and respect between board members and non-members and therefore cannot be expected to develop overnight.

4.6 Many stakeholders also pointed out that there is still much legitimate learning going on relating to individuals' roles and organisations' systems. This is because the boards bring together health and wellbeing system leaders from across the different sectors, often for the

first time, and the boards form part of the not well understood democratic, legal and cultural environment of local government. One interviewee powerfully expressed the scale of the learning necessary on all sides in understanding each other's role, ethos and working environments suggesting that "it would be naive to think that all the learning had already taken place". This chimes with the messages from the early peer challenges about boards needing a better understanding of the working constraints of their members.

4.7 As well as taking time to build strong and sustainable relationships between board members, the peer challenges refer to boards making good progress with the mapping of priorities and aligning of planning processes and strategies. The peer challenges consistently highlight the quality of the health and wellbeing strategies and the robust evidence based approaches adopted to inform them.

4.8 The evidence we have seen, from peer challenges and our stakeholder interviews, shows that the transition of public health to local government has been well-managed and is beginning to have an impact. This is still work in progress, but the peer challenge reports suggest that public health teams have been well received by their new colleagues. Although their positions in the organisational structures differ the directors of public health seem to be in influential positions and they and their senior colleagues are taking advantage of opportunities to play wider leadership roles.

4.9 It is also clear that some boards are now getting to grips with the leadership challenges associated with health and social care integration. Their involvement in programmes such as the health and social care Pioneers and the Better Care Fund has facilitated this shift. It will be important that this focus and momentum is sustained through the delivery period and that boards establish robust mechanisms for enabling them to monitor progress and to secure the necessary follow up action.

Slow to change gear

4.10 Our most recent stakeholder interviews confirm that there remains a large body of support and goodwill for the potential of health and wellbeing boards in adding real value to the system. The peer challenges make the point that the boards' progress is all the more notable as it has been made in the context of the very high expectations nationally and locally about what health and wellbeing boards can and should deliver. However, our interviewees have also expressed frustration at the speed of progress and impact of many boards.

4.11 The stakeholders we interviewed talked about the challenge and "enormity" of the agenda. Many of them referred to a lack of clarity of role and some ambiguity about the task - "what is the purpose of the board?", "what is the board going to put its stamp of influence on?", "what is the job to be done?", "there is a lack of clarity on accountability for delivery".

4.12 Some stakeholders questioned whether the boards yet yield genuine influence, describing situations in which boards have had relevant discussions but have not, in practice been listened to. One interviewee described how boards are "rubber stamping" rather than driving initiatives and attributed this primarily to either a lack of focus and/or a lack of clout.

In too many areas stakeholders perceive that the real action is taking place outside the board.

4.13 In Change Gear we noted that the boards could be placed on a spectrum in relation to the robustness of their prioritisation processes and their ability to secure effective delivery. On the basis of the work we have done since it is evident that boards are in fact on a spectrum in terms of their maturity and development and that this development is happening at different rates and in different ways. Some boards therefore are better placed than others to grasp the big issues and to make progress on delivery, but for others big challenges remain.

The challenge of changing gear

4.14 There is an appetite in central and local government and in the wider health and social care system to see HWBs move on from the 'settling in' period and 'step up to the plate', and tackle the big issues of health reconfiguration, the integration of health and social care, and the delivery of longer term public health priorities.

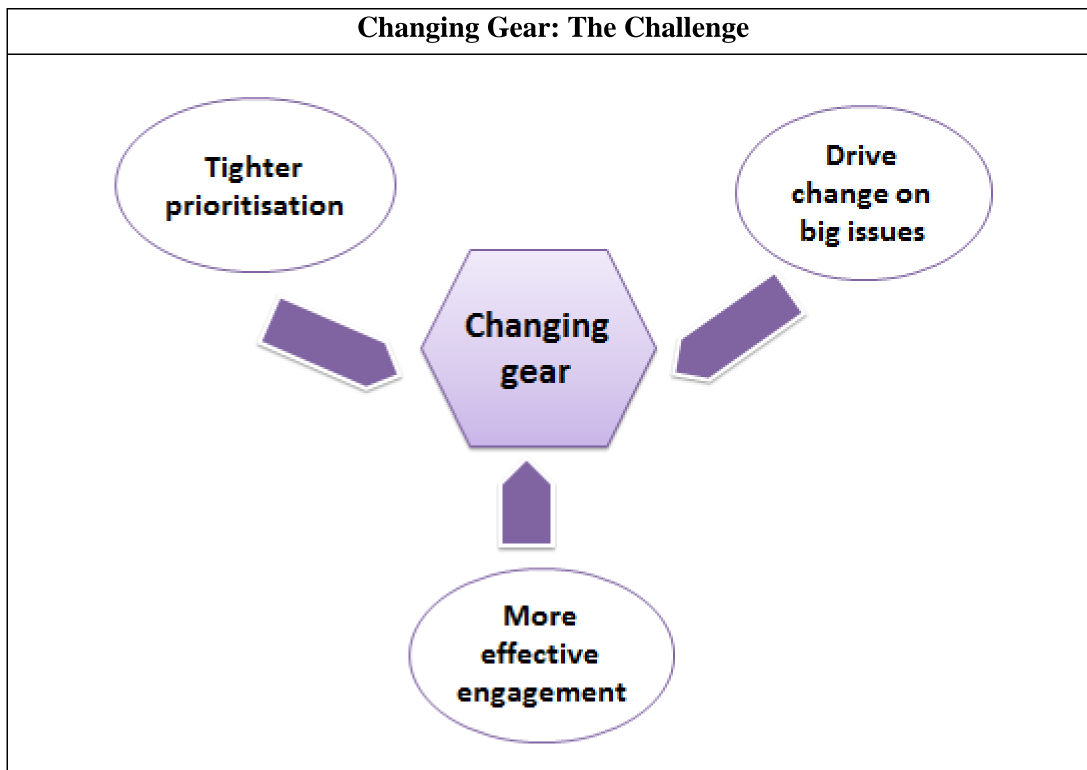
4.15 The requirement for boards to be involved in the Better Care process has given this shift a fresh impetus. However, the evidence from recent peer challenges and the stakeholders we interviewed is that HWBs must move on from the transition phase more quickly than is evident in many places. Unless they do so there is a risk of the boards becoming side-lined, being used to validate rather than drive change, or, worse, becoming a distraction.

4.16 But what does changing gear involve for a health and wellbeing board? On the basis of the pilot peer challenges we identified three actions boards should take (see diagram): tighter prioritisation; driving change on the big issues and more effective engagement. Our subsequent work has validated that analysis. The following paragraphs explore what is involved in each of those actions.

Tighter prioritisation

4.17 A common recommendation in the peer challenge feedback is that boards must focus on a small number of priorities and tasks. They must avoid over-load and focus on outcomes. This is particularly important – and challenging – in the context of the mission creep we referred to earlier (para3.8).

4.18 More recent peer challenges have pointed out that while a board's overall strategy is often convincing, many boards need to develop a stronger narrative and road map to set out how the system can move from where it is now to where it needs or wants to be. A road map of this type could encourage all services to consider their role and contribution and offers some sort of evaluative framework for the boards to monitor progress towards this vision. The need for a means by which boards can understand progress and impact has been consistently flagged.



Changing Gear: The Challenge

To become drivers of change and secure effective delivery of priorities

4.19 The most common point made by the stakeholders we interviewed was the importance of boards playing a leadership role in relation to health and social care integration and the reconfiguration of health services. One litmus test of whether a board is doing so is whether or not its plans are fully integrated with the council's medium term financial plans and those of the CCG's. The Better Care Fund processes have catalysed the integration agenda and a key challenge for boards will be to sustain this momentum.

4.20 It is important to understand that the task of grappling with major organisational change at the same time as seeking to achieve long term public health objectives is not easy. This is reflected in the mood music in which health and wellbeing boards operate. Some observers have criticised boards for being distracted by the public health agenda and not taking a lead role on integration. While others accuse them of short termism and avoiding longer term challenges.

To engage more effectively with key stakeholders

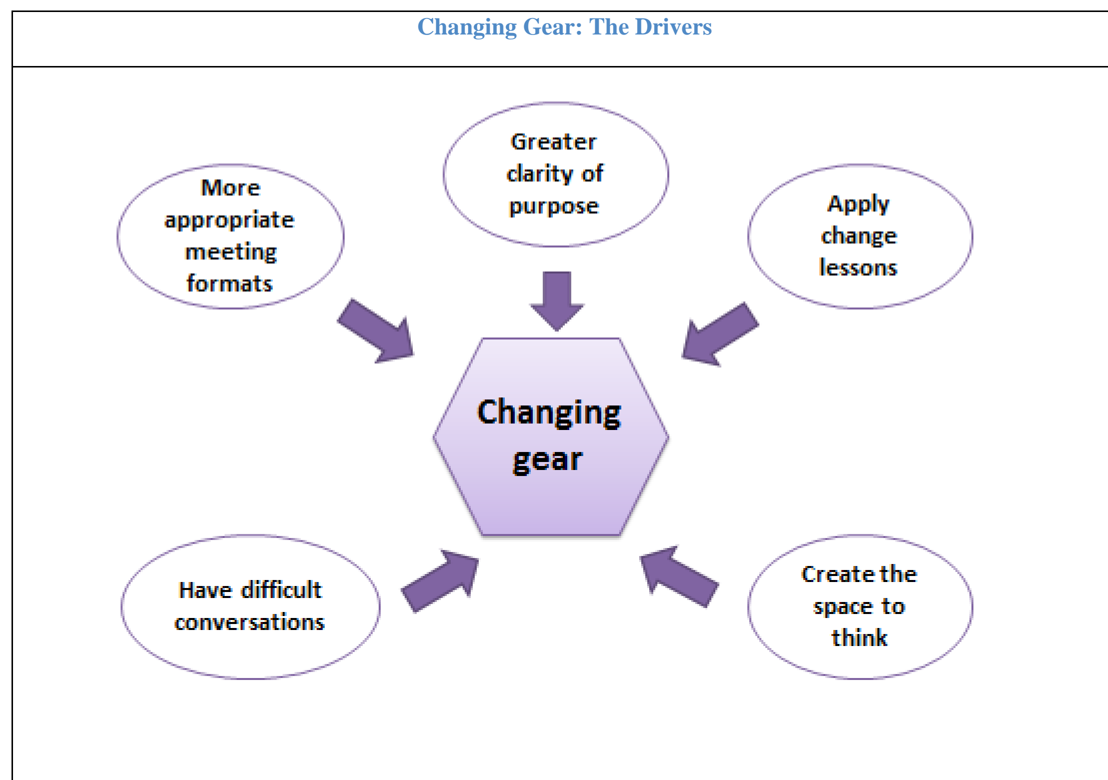
4.21 The quality of communication between health and wellbeing boards and the organisations not represented on them has been raised as an issue by many peer challenges. This is particularly so in relation to health care providers and in two tier areas with district councils. There is a legitimate debate about whether or not providers should be represented on the boards. But whatever the outcome of that debate locally, it is crucial that relations between the board and providers are effective. This is particularly significant in relation to the boards' role in integration and reconfiguration. In two-tier areas relations with district councils are also important as district councils often play a significant role in influencing health behaviours and addressing wider determinants.

4.22 In the later phase of our work two other issues have been raised more frequently: the need for greater clarity about the role of health overview and scrutiny and its relationship with the board; and the need for more attention to be paid to capturing the user voice and in using the board's relationship with local Healthwatch to strengthen public accountability. We say more on the public accountability of the boards later in the report (para 4.36).

The drivers of change

4.23 Drawing on our review of health and wellbeing peer challenges and stakeholder interviews we have identified five key areas for development that health and wellbeing boards may wish to consider to help them 'change gear'. These are: ensuring the boards have the capacity to have difficult conversations; ensuring more appropriate meeting formats and creating the space to think; applying change lessons by exploiting fully the experience of organisational change and service redesign processes of board members; and ensuring greater clarity of focus. It is imperative that boards develop the capacity to visibly and effectively drive the immediate tasks of health and social care integration and health service reconfiguration while sustaining focus and momentum on the longer term priorities around, for example, public health and health inequalities.

Changing Gear: The Drivers



The capacity to have difficult conversations

4.24 On the basis of our review of the pilot peer challenges we concluded that if boards are to tackle the big issues effectively they must develop the capacity to have difficult conversations that will take them beyond the collaborative relations that have now been put in place. The fact that recent peer challenges include comments such as "tensions...are bizarrely absent" and "cosy so far....useful to have crunch points" suggest this is still the case despite recent reports of more challenging discussions around the Better Care Fund negotiations. One stakeholder encapsulated this by saying that "all being in it together will

not do". It is also important that boards are comfortable with constructive challenge and the type of feedback and evidence that will be generated if they become more open to the public voice.

More appropriate meeting formats and creating the space to think

4.25 Many of the peer challenges we reviewed refer to the fact that the formally constituted meetings of the boards as council committees are not conducive to the types of conversation that boards need to have. It is important that boards meet in different settings, formal and informal, to create the space for these difficult conversations. This is crucial if boards are to revisit their role and of ways of working.

4.26 One of the benefits that places point to in having had a pilot peer challenge is that the process gave them the space to think with the benefit of external challenge. Given the limited resources available to deliver peer challenges, an issue for all boards to consider is how they can create this space to think and stimulate constructive challenge as part of their work and meeting programme.

Apply change lessons

4.27 Many councils have extensive experience of managing substantive organisational change and service re-design. A number of peer challenge reports recommended that health and wellbeing boards, and the people who support them, should apply this wider learning to the challenge of driving change in health and social care and health and wellbeing. One challenge team went on to suggest that the use of action plans to deliver the health and wellbeing strategy could support the wider change process and drive cultural change.

Clarity of purpose

4.28 The single most important theme in our stakeholder interviews has been the need for a board to be clear about its purpose and confident that its membership, the roles each member plays and its sub structures are fit for purpose. One interviewee described his board as needing a "cause to rally round". For many the Better Care Fund has offered some of this focus but this not gone far enough and the lack of clarity is seen to hinder the boards in having real impact. The danger of mission creep (see para 3.8) means that this issue is more important than ever.

4.29 Our review suggests that this lack of clarity has two distinct aspects:

- a lack of clarity of vision and ambition - what do the boards see the local health and wellbeing system looking like in 5-10 years and are they clear on the steps to take to get there?
- a lack of clarity of role - what is the health and wellbeing board's distinctive role in securing and driving this vision?

4.30 A consistent theme emerging from the peer challenges is the recommendation for boards to tell a more powerful narrative about what local health and wellbeing services will look like, how and where delivered in five, ten or twenty years' time and to develop a 'road map' to getting there. The key point being made is that boards should do this from a user not an organisational perspective. The peer challenges suggest that this framework can then be used to embed a shared sense of the task and to crystallise expectations and roles of

stakeholders and partners as well as the unique contributions of the health and wellbeing board.

4.31 This should be done within the context of a broader understanding of the role of the board. While the constitution, core membership and core functions of health and wellbeing boards are relatively fixed, their focus, priorities, wider membership and ways of working are determined locally. While this must be right, it is also important that the role of the boards is unambiguous and widely accepted and understood by stakeholders. Most people we spoke with felt that there was some way to go here and that many boards had not yet defined their role with sufficient clarity.

4.32 Early descriptions by stakeholders of the role of their boards included sitting somewhere in the middle "on a spectrum ranging from an LSP-type influencing body to a hard-nosed body heavily involved in the commissioning process", a position the stakeholder considered unsustainable in the longer term. More recent descriptions include the board "is used to explain things not resolve things", also considered unsustainable by the describer. The notion of sitting somewhere 'in the middle' of listening and directing is not uncommon and one stakeholder was keen to point out that simply feeling that we are "all in it together" won't deliver.

4.33 We have formulated two key roles which boards may wish to consider in any discussion on their role and functions. They are:

- to mutually hold the health and wellbeing system to account through its membership and in doing so to generate a shared responsibility for its impact;
- to empower its individual members in driving delivery and change, something we have described as a providing a collective 'power to their elbow'.

4.34 Taking this a step further, stakeholders expressed support for the example we offered of a board's CCG member(s) and its Director of Adult Social Care needing to answer to the board as individual system leaders on issues relating to progress on delivery of the integration agenda. The individuals and their organisations remain responsible for doing what is in effect their job. However they must be accountable as board members to the board for ensuring that the changes are effected in accordance with the board's agreed strategy and plans. The board's role is to secure system wide buy-in, to understand, support and challenge progress, and to secure any system changes which enable progress to be made. In doing this the board must use its collective influence and authority, and that of all of its individual members, to good effect and create a supportive system-wide environment.

4.35 One related and we believe unresolved issue raised during our review concerned the public accountability of the boards. Certainly there seems no question that the boards have a clear role in ensuring the public accountability of the health and wellbeing system. Their establishment in local government and the democratic legitimacy that accompanies this, the system leadership role they play joining up governance across the system, and the formal membership of local Healthwatch all point to this. But it should be a matter for agreement locally whether this accountability is via the board itself or is achieved through the individual

organisations represented on the boards and through the nature of debate and challenge the board prompts. The importance of this distinction is that, if accepted, the latter approach frees the boards up from developing their own separate channels of public engagement and communications and instead places more emphasis on the boards encouraging the individual organisations, and notably local Healthwatch, to undertake this role effectively.

4.36 During the course of this work we have developed two tools that may be of use to boards in exploring the issues highlighted in this section:

- A list of questions for boards to consider based on our review of health and wellbeing peer challenges (appendix 1);
- A number of scenarios of issues that boards may face which could be a useful tool for board development days (appendix 2).

5 Future support

5.1 Our interim report completed in January 2014 set out the conclusions of our review of the impact of the Health and Wellbeing System Improvement Programme. This section briefly restates our overall conclusions on the impact of the Programme, but it concentrates on our recommendations on future support. It highlights three key, linked issues:

- The future role and shape of peer challenge in the Programme;
- The extent to which the Programme should focus on areas in particular need of support;
- The role of the regional element of the Programme.

5.2 The executive summary of our interim report summed up our conclusions on the impact of the Programme as follows:

> "In summary, our over-riding conclusion from this phase of our review is that in its first year the Programme has worked well in bringing together key national partners, has been well received across the system and is helping places to implement the new arrangements. The health and wellbeing peer challenges have been particularly well received and offer a rich source of wider learning.
>
> In future priority should be given to capturing and disseminating the learning more systematically and rapidly, using the many channels already in place. In addition, a new peer 'snapshot' or 'facilitation plus', combined with a refreshed self-assessment, would supplement the fuller peer challenge and enable more places to benefit from peer input.
>
> The Programme has not yet addressed the question of how to identify and support the places in most need of assistance, and does not claim to have done so. This needs to be a priority focus for the Programme's second year and we believe requires a better funded regional element of the Programme with lead chief executives and their colleagues given an explicit remit to identify areas most in need of support and the fuller peer challenges focussed on helping those places."

5.3 In relation to the peer challenges we concluded:

> "If we were asked to sum up the impact of the peer challenges in a single word, it would be "galvanising". By this we mean that their impact has been a combination of deepening the priority given to this area and accelerating the actions that health and wellbeing boards are taking".

5.4 Our subsequent work has highlighted the central role of the chairs of health and wellbeing boards in ensuring that boards address the issues highlighted in this report. They have a particular role to play in ensuring that the board is clear about its role, focusses on key issues and, when necessary, has difficult conversations. The chairs are also key players in establishing effective relationships between the board and other organisations, including health and care providers. In the light of this, specific support for the chairs of boards must be part of any future support programme.

5.5 On the basis of our work we recommend that the main elements of future support for health and wellbeing boards should be:

For the board chairs:

- Access to mentoring and bespoke leadership academies;
- Action learning sets bringing together chairs from boards dealing with similar issues at the same time.

For boards as a whole:

- Support for board development to help boards which are struggling with the task of clarifying their purpose, role and ways of working;
- A programme of peer challenges;
- A programme of bespoke support for boards in most need;
- Exposure to wider learning through dissemination events, networks, web tools etc.

Health and wellbeing peer challenges

5.6 Peer challenges are a particularly well-received element of the support programme and are having a demonstrable impact locally. They are resource intensive, however. Over 20% of the budget for the Programme in 2013-14 was used to fund peer challenges which were delivered in 17 areas. This means that only a small number of places can benefit from them in any one year. It is clear from our work, however, that:

- More boards would benefit from a peer challenge than can be delivered over the next two years using the current format;
- There is considerable learning from peer challenges for the sector as a whole if it is captured in a way similar to the approach we adopted in Change Gear!

5.7 The LGA is very strongly of the view that peer challenges should not be targeted at places most in need of support. They argue that this would damage the integrity of the process, penalise high performers (by denying them access to development support) and limit the scope of learning from the peer process. We accept the strength of this position, but believe that key features of a new approach to the part that peer challenge plays in this process must include:

- A robust and rapid dissemination of the learning from this peer work to ensure that the wider sector benefits from the peer processes and satisfy the appetite for real time learning;
- A spread of peer challenge across the spectrum of health and wellbeing board performance in a way which both targets places in most need of support and support the continued development of 'high performers';
- Requires a commitment from those receiving a peer challenge to undertake an initial self-assessment to ensure that they get maximum benefit from the process.

5.8 In our interim report we recommended that the LGA should consider developing a peer tool which is less resource intensive than the existing peer challenge, and enable every health and wellbeing board to have an opportunity to benefit from some form of peer process within the next two/three years. We have in mind some form of 'peer snapshot' combined with a refreshed self-assessment to prepare the health and wellbeing board for the peer visit

and help to ensure that the process prompts genuine follow up action. We understand that this idea is being considered by the LGA through some form of bespoke peer support.

5.9 There are two further important points to be made in relation to this proposition. First, what we are suggesting is not simply a slimmed down version of the current model. It is not possible to under-estimate the value of a four day process, with sufficient lead-in time, particularly when dealing with a complex and complicated system. What we are suggesting is the design of a new process. Second we are not suggesting that this new 'offer' replace the existing peer challenges. It would be a less resource intensive supplementary offer. Combined with a further programme of health and wellbeing challenges it should enable priority to be given to meeting the needs of places in most need of support, while ensuring that boards at all points on the development spectrum have access to some form of peer challenge.

Areas in most need of support

5.10 It is also important to note that the Memorandum of Understanding between the DH and the LGA specifically refers to the importance of the Programme in identifying risks of underperformance and managing those risks effectively. To date the Programme has not specifically targeted areas in most need of support (and does not claim to have done so), yet the importance of it doing so has been raised by many of the national stakeholders we have interviewed.

5.11 In our interim report we recommended that this should be a priority for the next phase of the Programme and the work we have done since reinforces that view. The action required to do so includes the development of some less resource intensive peer process (see above) and the enhancement of the regional dimension of the Programme (see over)

Regional support

5.12 Our most recent stakeholder interviews have reinforced our view that it is at a regional1 level that places in need of support are most likely to be identified and the conversations held to prepare the ground for a support offer to be well received. As we recommended in our interim report, the key elements of a refreshed regional offer could be:

- To give lead chief executives and their colleagues an explicit remit to identify places in particular need of support at a regional level;
- To develop a menu of support which can be provided to those areas in the light of the other recommendations in this report (most notably the targeting of peer challenges).

5.13 We understand from LGA colleagues that this is now already part of the design for year two. We were struck by the model adopted in the East Midlands, where an individual is regionally funded on a day a week basis to go out and talk to all system stakeholders and in doing so get to understand their development needs.

[1] As we noted in our interim report we do not necessarily mean the 'standard' English regions.

5.14 Finally there are two further issues which have emerged during this phase of the review which we believe have implications for the future support offer.

5.15 The first is the ramping up of expectations around what the boards will deliver. This suggests that support for board members, particularly the chairs, as the boards move into real delivery phase is particularly important. The need for support for the chairs of boards was repeatedly flagged during the course of the review. Three suggestions in particular of ways to support chairs seemed to elicit strong support. The first two - some form of peer mentoring and a type of leadership academy programme - both offer a form of personal support and development for the chairs in undertaking their roles. The third suggestion - the development of some form of action learning sets, possibly regionally organised though some suggested membership might want to extend beyond regional boundaries - would offer the chairs opportunities to explore real challenges and actions with those facing similar issues.

5.16 The second issue relates to the need for many boards to clarify their purpose and distinctive contribution. This suggests that some immediate support to facilitate greater joint learning and understanding between all the individual system leaders on the boards including a revisiting of role, purpose and ways of working would be helpful.

Appendix I

Questions for health and wellbeing boards to consider

- Have you reviewed the fundamental purpose of your board and are its membership, sub-structures and ways of working fit for that purpose?
- Is the board playing a leadership and oversight role in relation to the big issues, notably health and social care integration and the reconfiguration of health care services?
- Do you need to improve engagement with key stakeholder who are not directly represented on the board, including: major providers, district councils and locality/neighbourhood structures?
- Is there a need to streamline the partnership structures in your area?
- Are you considering what action may be appropriate at a sub-regional level?
- Are you using the evidence available to you in the most effective way to set priorities, drive change and monitor progress?
- Are you giving due weight to qualitative evidence such as the personal stories of board members and the user, patient, carer and community voice?
- Do all councillors and GPs in your area have a shared understanding of the communities they serve and their roles in meeting local needs?
- Do you have a good understanding of the constraints and opportunities facing the major organisations in the health and social care system?
- Is the board in control of its agenda and work programme?
- Does the board have appropriate business and policy support?
- Do you have an appropriate mix of formal and informal meetings?
- Do you have the opportunity to think and reflect as a board and to explore questions such of those set out above?
- Are you applying lessons from other major change processes in your area?

Appendix II

Scenario 1

Acute reconfiguration - responding to change in face of local opposition

Exampleshire, a two tier local authority area, has two main acute hospitals - Mid Hospital and North Hospital - serving over 600k residents in the mid and north of the county. The two acute hospitals merged two years ago into a single foundation acute trust. Plans have recently been announced to transfer all trauma services in Mid Hospital to North Hospital - with the ambition of making North hospital one of two major trauma centres in the region. There is a risk that the major trauma centre could go elsewhere if these plans do not go ahead. A legitimate process has been followed to get to this point - the proposals are outlined within the CCG commissioning plans and the strategy has been signed off by the health and wellbeing board.

The consultation process has been initiated by the acute trust in discussion with the CCGs but some warning signs have emerged that progress will not be without challenges. While North DC has been openly supportive of the proposals, Mid DC has always expressed concerns and the leader of Mid DC represents district councils on the board. During the consultation 3000 copies of a letter distributed by a local newspaper campaigning to keep trauma services at Mid Hospital have been received from residents of Mid Council by Exampleshire County Council. The local MP supports the newspaper's campaign and there is evidence that some local councillors are trying to whip up support for the campaign also. Progress on the consultation is scheduled to be discussed at the next meeting of Exampleshire health and wellbeing board.

Key prompts for discussion:

- What, if anything, should the health and wellbeing board do in advance of its next meeting or at the meeting itself?
- What other opportunities, channels and relationships are there, other than the formal board meeting, that board members could use to resolve and progress issue?
- What role would/ should Exampleshire County play here?
- What role would the NHS local area team be expected to play? What about others?
- The scenario mentions a 'legitimate' process. What might a good process look like and could this scenario have been avoided?

Scenario 2

Change necessary - no plans yet
Example City Council's health and wellbeing board has made good early progress including establishing a clear set of priorities and making reasonable progress on the integration agenda with integrated commissioning arrangements for community health and social care for adults. The board has developed reasonable relationships system wide, including with its two CCGs. The council is fairly ambitious and is looking to make demonstrable progress in the next two years. The council is in a relatively healthy financial position (having introduced significant savings and efficiencies in recent years) but the same cannot be said of its main acute hospital provider, which serves a wide catchment area covering another health and wellbeing board too. Privately board members are worried about the impact of the financial position of the acute hospital on realising its ambitions. They understand that discussions on possible reconfiguration plans should be taking place sooner rather than later but the main health providers have yet to fully engage in any concrete board discussions and there is currently no established forum for enabling this. The financial risk has been identified within the draft Better Care Fund (integration) plans. The acute hospital has not been unsupportive of the integration plans but to date has not played a proactive role.

Key prompts for discussion:

- Views on the risks attached to this scenario e.g. how realistic/ambitious can the integration plans be without agreeing action to improve the financial situation of the main acute provider?
- Have the integration plans fully identified the impact of new models of delivery and support on the acute provider and other existing or potential providers?
- How should the health and wellbeing board go about kick-starting the debate which needs to happen? Should the board lead the debate?
- What would the first agenda of any provider discussion look like?
- What action should the board expect from the Council/ CCGs/ NHS local area team/others to drive forward these issues?
- To what extent does the BCF plans build on the evidence of future need in the JNSA, the priorities for improving health outcomes in the JHWS and the CCG commissioning plans?

Scenario 3

Integrated care - making it happen under severe financial pressures
Exampleshire is a rural county experiencing extreme financial pressures. It needs to make budget cuts equivalent to 20% of its budget in the next five years. All services need to make cost savings, including adult social care. The county's CCG is leading a pioneer BCF bid covering one area of the county. Early signs on progress are good. To date, the CCG has engaged the HWB in a 'rubber stamping' role but has not looked to the health and wellbeing board for any leadership of this agenda. Both the CCG and health providers are also under extreme financial pressures and success of the integration agenda more widely is recognised as necessary if ongoing financial viability of the system is to be ensured. The CCG has become increasingly concerned about the capacity and capability of the main community provider and the primary care system more widely in 'getting on board' and delivering on this agenda and is looking to the health and wellbeing board for some advice and assistance here. The next agenda of the board has already been committed to discussing other issues.

Key prompts for discussion: What has gone 'wrong' here? Follow up:

- Nature of relationships between those involved to have reached this point?
- What might have been happening/not happening between meetings?
- Existence of strategies to address 'no money' scenarios?
- How can the situation be addressed? What would be the immediate next steps?
- What is the board's specific role in moving this agenda on? What levers should the board be using/seeking to assist this role?
- What is the role the Council/ CCG/ LAT/others should have played/now need to play?

Scenario 4

HWB and CCG priorities - balancing national and local priorities

Exampleshire health and wellbeing board has set itself three clear priorities informed by what has been widely recognised locally as a well-informed JSNA - frail and elderly, children and family and workplace health. The health and wellbeing board has yet to put in place a set of clear delivery plans. There has been good engagement in the priority setting discussions by local commissioners and providers and no expressed disagreements.

Despite this, it has recently been brought to light that the local CCGs are still operating according to their 10 strategic priorities and commissioning plans from 2011. While there is some overlap between these plans and the health and wellbeing board strategy, there is no clear alignment, and indeed some clear disconnect. For example, the JNSA offers up no real evidence on childhood obesity being a priority but the CCGs have a fully developed commissioning strategy for this. Commissioning arrangements have been known to be agreed in bilateral discussions with the district councils and though there is some district council membership of the board, not all of the district councils have been engaged, and the board is unclear on the exact nature of some of these more recent discussions.

Key prompts for discussion:

- This scenario highlights issues around tensions between national ‘must dos’ and local priorities. In reality, how would these tensions be brought to light?
- What could/should the health and wellbeing board do to address these tensions and what support would it need to do so?
- Could these issues have been exposed/ tackled earlier in the process? if so, what preventative action could have been taken?
- What other local channels, structures and processes are there for the county and districts to discuss and align commissioning priorities?
- What other issues does this scenario raise and what steps, if any, need to be taken by the board or others to address these?

Scenario 5

Acute provider not performing well

A major hospital foundation trust with two acute hospitals serving three London Boroughs has been recommended to be put in special measures by the CQC following a recent inspection. Key issues highlighted by the inspection relate to a potentially ‘unsafe’ service in A&E with high mortality rates, poor patient experiences and poor trust leadership. The Chief Inspector of Hospitals said that the trust was being put in special measures to develop an action plan with other NHS bodies and the local authority.

A local newspaper serving one of the London boroughs has started a campaign asking what the Council’s new health and wellbeing board is doing to tackle and improve the situation. The campaign is also asking local residents to write to the Council Leader, the Chair of the local Healthwatch and their local MP demanding action.

Key prompts for discussion:

- How would/should the health and wellbeing board know about this (if not through a media campaign)? Is that a problem?
- How effective is the local health and care system in identifying risks of underperformance? For example, LHW, quality surveillance groups, overview and scrutiny etc?
- What ‘problems’ would this scenario expose? And for whom? Probe on issues around whether this scenario exposes wider system risks so it is not just about a provider failure in isolation but about wider issues of quality/safety/safeguarding etc
- What should the board do, if anything, on hearing the news/ receiving the residents’ letter? Probe on issues re public vs. private space for board discussions, public questions, petitions etc
- What, if anything, would this scenario expose about wider system relationships e.g. between boards and health scrutiny, between the board and CCGs, role of the LAT etc

Scenario 6

Delivery against Better Care Fund Plan

Anytown health and wellbeing board submitted its BCF plans in partnership with its CCG according to the national guidance and timescales in the Spring of 2014. In its progress report to the health and wellbeing board and Locality Team in September that year, Anytown established that it was making good progress across the sweep of national conditions and targets set out in their plan although it was recognised that that they were still some way off reaching final agreement on hospital reconfiguration plans and parallel investment in community services and social care. This work is critical to enabling their BCF's 10% reduction in acute hospital care for older people target to be achieved and needed to be prioritised. The board agreed that the formal consultation would need to be underway before April 2015 if their BCF 'pay for performance' was to be released.

It is now January 2015 and the Chair of the health and wellbeing board is concerned that while the consultation plans have moved forwards, the discussions have exposed concerns about a recent upwards trend in the monthly numbers of emergency admissions for those over 65 years which cannot simply be explained by seasonal trends. This is one of the key performance measures for their April 2015 progress report to release the first tranche of BCF monies. This forms the main agenda item for the January board meeting.

Key prompts for discussion:

- What sort of evidence would/should the health and wellbeing board seek to enable probing questions at the next meeting which expose the underlying issues? Where would this be sourced?
- How would the board go about in marshalling wider system resources to undertake any necessary 'recovery' action. Is this the board's role?
- What action would the board expect others to take?