

A guide to governance for health and wellbeing boards

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Key points

- Many of the critical success factors for health and wellbeing boards (HWBs) hinge on the governance arrangements that members establish early on.
- A variety of ‘hard’ governance mechanisms exist to give board members a framework for working together.
- To be effective, HWBs will need to concentrate on developing strong ‘soft’ governance too. This includes aligning priorities where possible and developing collaborative leadership styles built on trust and shared values.
- Early implementer HWBs are developing a range of solutions to issues such as how broad their membership should be and how they relate to other local partnerships.

Health and wellbeing boards will give oversight and strategic leadership across many complex organisations and systems. To do this, they will need clear frameworks for accountability and action. Although they won’t necessarily be commissioning or providing services themselves, governance will be as important an issue to the boards as it is already to their member organisations.

This guide was developed by the governance health and wellbeing board learning set, part of the National Learning Network for health and wellbeing boards.

Many of the critical success factors for health and wellbeing boards hinge on the governance arrangements that members establish early on.

- Will the right local organisations engage?
- Will the health and wellbeing board’s decisions carry real weight?
- How can genuine partnerships be developed?

At a glance

Audience: This guide is aimed at all health and wellbeing board (HWB) members and stakeholders.

Purpose: To strengthen understanding and application of formal and informal mechanisms for holding HWBs and their members to account.

Background: This document was developed by the governance health and wellbeing board learning set, which is part of the National Learning Network (see back cover) and is supported by the Department of Health, NHS Confederation, the Local Government Association and the NHS Institute for Innovation and Improvement.

Supported by

‘It is just as important to have good governance between organisations as within organisations. A service that stops at the doors of the hospital or when a partner fails to deliver is not really a service, it’s a broken link in the chain of care.’ – Good Governance Institute and Institute of Healthcare Management (2008), *Integrated Governance II*.

- How will the health and wellbeing board itself be held to account?

This document sets out some of the main points that boards need to bear in mind when considering these issues. In addition, the appendix sets out some responses from early implementers to practical problems, such as whether the health and wellbeing board should replace the local strategic partnership and how broad the core membership of a board should be.

Holding members to account: ‘hard’ mechanisms

Health and wellbeing boards do not exist to performance manage their members, nor can they ‘veto’ any of their members’ commissioning plans. However, the Health and Social Care Act (2012) does place various responsibilities on members to ensure that the board’s decisions are taken seriously. Of these, the most important mechanism is the joint health and wellbeing strategy, which local authorities, clinical commissioning groups (CCGs) and the NHS Commissioning Board must have regard to when carrying out their functions, including the commissioning decisions they make. In particular, this means the following.

- Clinical commissioning groups must give each relevant health and wellbeing board a draft of their commissioning plan. They must consult the board as to whether it considers the commissioning plan to have taken proper account of their joint health and wellbeing strategy.
- The health and wellbeing board must provide its opinion on each clinical commissioning group’s commissioning plan – this should be included in the final published version of each plan.
- If the health and wellbeing board feels that the commissioning plan has not taken account of the joint health and wellbeing strategy, it can express its opinion to the NHS Commissioning Board.
- As part of their annual report, clinical commissioning groups must review the extent of their contribution to the delivery of the joint health and wellbeing strategy for their locality. They need to consult the health and wellbeing board when doing this.
- In undertaking its annual performance assessment of clinical commissioning groups, the NHS Commissioning Board must assess how well each one has met the duty to ‘have regard’ to its Joint Strategic Needs Assessment (JSNA) and joint health and wellbeing strategy.
- If the health and wellbeing board does not believe that a local authority has had regard to the relevant

Definition: The members of this learning set defined governance as both how the board ensures its priorities are delivered and how others ensure the board has appropriate priorities. This includes both ‘hard’ accountability (such as terms of reference and statutory duties) and ‘soft’ accountability (the culture of how members behave and relate to one another).

joint health and wellbeing strategy, it will be free to raise its concerns with the local authority.

Other relevant powers held by health and wellbeing boards include the right to request information from certain members to assist it in performing its duties. They also have a power to encourage joint working between commissioners of services related to, or having an effect on, health and care.

An important mechanism for holding the commissioner members of a health and wellbeing board to account is the independent local authority scrutiny function. Health scrutiny exists to ensure that the health and social care needs of the local population are understood, that health inequalities are being reduced and that health and social care services are integrated around the needs of people who use services and other vulnerable groups. The powers given to local authorities to undertake this function require some adaptation to take account of the new NHS architecture, but currently allow them to:

- require all commissioners and providers of NHS-funded services to provide information within a specified timeframe
- require all commissioners and providers of NHS-funded services to attend meetings and answer questions
- require all commissioners and providers of NHS-funded services to respond to recommendations from council scrutiny
- refer contested proposals for reconfigurations of health services for independent review.

Local authorities will be able to choose how they exercise their health scrutiny powers in future. Many will opt to keep existing an health overview and scrutiny committee (OSC).

Holding members to account: 'soft' mechanisms

The formal governance mechanisms outlined above help to give a foundation to local partnerships, but are far from sufficient to achieve coordinated health and social care. To do this, health and wellbeing boards will also

Working across multiple tiers

One area of debate among shadow health and wellbeing boards is how they should involve district councils (where there is more than one tier) and/or engage with multiple clinical commissioning groups within their boundary.

These are issues where each board has the freedom to decide its own solution. In doing this, an important principle to remember is that membership of a health and wellbeing board should be about forming the right local relationships, not attending meetings.

For district councils in particular, there are significant advantages to having their involvement in issues around housing, public space, leisure and sport. Boards might consider involving them through:

- having district councillors represented on the health and wellbeing board
- having a designated health lead in each district, for example the officer for leisure and sport
- co-locating public health staff with district staff in district locations.

Building links between clinical commissioning groups will also be important where they share the same health and wellbeing board. All of the clinical commissioning groups must be engaged, but on some issues it will be more efficient for them to develop shared representation.

‘Transparency, involvement and accountability need to be a central part of planning and delivering healthcare alongside quality, safety and financial management.’ – Centre for Public Scrutiny and British Medical Association (2011), *Accountability and the new structures: A discussion paper*.

need to develop their ‘soft’ governance mechanisms of shared culture, common purpose and trust.

Leadership behaviours will be key to creating strong ‘soft’ governance. These behaviours will need to be based on cross-organisational, collaborative styles, rather than ‘traditional’ models of hierarchical authority. One example of a development tool specifically designed for building system-wide leadership is Leading as Peers from the Centre for Innovation in Health Management at the University of Leeds, which identifies priority areas as follows.

- Developing a shared identity and ambition for the team. This includes understanding each other’s perspectives, constraints, needs, assumptions and identity.
- Exploring the differing uses of language used by leaders from different sectors.
- Getting agreement about system accountability (eg, local vs. national pressures on each member), in particular how people behave during periods of uncertainty and instability.

New leadership styles will also be required in local government, as health and wellbeing boards present the unusual situation of giving local authority officers voting rights alongside elected members.

Many organisations that health and wellbeing boards will need to work with are not subject to statutory obligations, but will engage with the peer-leadership approach above. Local partners in housing, education, community safety and business are not held by any legal duties to the health and wellbeing board, but are likely to engage in an informal ‘web of accountability’.

Soft accountabilities hinge on an understanding of the different constraints, pressures and cultures of the board’s members – and how these might sometimes conflict. A commitment to finding accommodation where necessary is crucial to overcoming such tensions.

Duties on providers

One of the early decisions facing health and wellbeing boards is the extent to which they wish to involve local providers of health and social care services. As this is an area where boards have been given a high degree of autonomy, different geographical areas are likely to arrive at different arrangements.

Some localities may decide to limit the board’s membership and only hold providers to account through their commissioners, or by including them in a wider stakeholder reference group. Other areas may choose to offer providers membership of the board and involve them directly in its decisions – this will give the board a wider reach, but as there are few legal duties on providers’ involvement, the board’s governance of these organisations will largely rely on ‘soft’ mechanisms.

Where providers are part of the health and wellbeing board, members will need to discuss how to address potential conflicts of interest that might arise.

Some boards are developing shared sets of values and/or codes of conduct to cement this commitment. These include the board members reaching an agreed position on things like transparency, inclusion and innovation.

Holding the health and wellbeing board to account

As well as the governance of individual members, the health and wellbeing board itself will be held account both nationally and to its local population. As a statutory council committee, health and wellbeing boards will be accountable to the full council and ultimately, through this, the public. They can also be subject to the local authority's overview and scrutiny functions as described above.

The local healthwatch organisation will play a key role in representing the views of patients, service users and

the wider local population. It is required to appoint one person to represent it as a member of each health and wellbeing board.

Some of the most important outputs through which health and wellbeing boards will be held accountable are the Joint Strategic Needs Assessment and joint health and wellbeing strategy. From April 2013 local authorities and clinical commissioning groups will have equal and explicit responsibility for the quality of these documents.

Local Healthwatch

Starting from April 2013, each local authority must have in place a local Healthwatch organisation to undertake the following functions.

- To advise the public about accessing health and social care services.
- To listen to the views and experiences of people about local health and care services, and represent those views to commissioners, providers, OSCs and Healthwatch England.
- To recommend improvements to services.
- To report areas of serious concern to Healthwatch England or, in urgent cases, the Care Quality Commission.
- To promote the involvement of local citizens in monitoring, commissioning and providing health and care services.

Some local authorities have already commissioned a local Healthwatch to run in shadow form.

For more information see Department of Health (2012), *Local Healthwatch: a strong voice for people – the policy explained*.

Influencing commissioning members

By far the most effective way for health and wellbeing boards to influence the commissioning plans of their members will be to align the pressures and priorities of each organisation. At a national level, the Department of Health is working to align the outcomes frameworks it sets for the NHS, adult social care and public health systems to allow local partners to work together while keeping lines of accountability clear. A separate outcomes strategy for children's health and wellbeing is currently in development. While this work continues, a valuable exercise for local health and wellbeing boards may be to go through each member organisation's understanding of its local priorities and the outcomes by which it is measured, to see which issues are the most relevant and promising candidates for joint working.

Health and wellbeing boards should also consider the ‘soft’ governance mechanisms that they should submit themselves to. Self-evaluation of the board’s operations will be one part of this. Boards should also plan for how they can work with their district councils in two-tier areas and neighbouring health and wellbeing boards.

Appendix: What are other areas doing?

The following matrix shows the decisions that some health and wellbeing boards involved in producing this product have made about particular aspects of their governance structures, as well as short explanations as to why. Their approaches may be helpful to other

localities considering questions such as the following.

What is the right level of political involvement in the health and wellbeing board?

The respondents recognise the balance that needs to be struck between getting buy-in from the cabinet and keeping the board lean and free from some of the instability that can come with having too many elected members (for example, instability around local elections). Most have prioritised keeping a small and focused board, but see the inclusion of two portfolio holders as consistent with this. Two respondents have the leader of the council as a member – one of whom

1. Political involvement in health and wellbeing boards in different areas

Approach	Rationale
Just two portfolio holders initially	Keep the board small and focused
Two portfolio holders, independent chair	Keep the board small and focused, unitary authority almost co-terminous with CCG so can get all players in the room within a small group
Two portfolio holders initially	Small and focused – commissioners
Chaired by council leader and including two portfolio holders (children and adult social care, housing and community safety)	HWB is a subcommittee of cabinet and is a commissioning activity therefore should be led by cabinet and as the brief is broad it is appropriate that the leader chairs it
Leader and relevant cabinet lead on the HWB	Signifies the importance of the board whilst keeping political membership to a minimum

is the board's chair. No boards have yet identified any challenges arising from council officers having full membership alongside elected members.

Should the board be a subset of or replacement for the Local Strategic Partnership?

Of the five respondents, three were replacing the Local Strategic Partnership (LSP) with the health and wellbeing board, and two were not. The biggest factor influencing this appears to be how well the LSP is currently felt to work – the boards seem to be reluctant to disrupt something that is seen as functioning well. Those that are merging the two bodies see it as a way of

broadening the agenda of the health and wellbeing board to include more social determinants of health.

How broad should membership of the health and wellbeing board be?

The respondents make a distinction between the board's membership and its stakeholder reference group. The latter allows them to access expertise where it is needed without making the board an unwieldy size. One respondent within a two-tier council has opted to allow each district to nominate a representative to sit on the board.

Pros	Cons
Easy to manage the board as relationships develop with new partners such as CCG	Risk that cabinet feel excluded Change of administration could cause problems
At only the second meeting group already beginning to gel despite obvious cultural difficulties	Non-elected members need to understand the democratic decision-making process and the repercussions of the representative role that councillors have
Shared understanding of the territory	Need to engage wider membership through health and social care economy
Buy in at cabinet level so potential for tie in to wider council activities Involvement of leader reflects the cross-cutting nature of the agenda and demonstrates importance of HWB	Ensuring wider political ownership of the agenda through scrutiny panels
Allows broader partnership engagement	

2. How health and wellbeing boards work with other local partnerships

Approach	Rationale
Replace the LSP with the HWB	Wider determinants of health give the HWB a broad remit
Close down LSP and incorporate Community Safety Partnership then formally recognise link to Local Economic Partnership (LEP)	<p>This extends the agenda beyond health and social care</p> <p>The LSP had lost impetus and with the creation of HWBs and LEPs there is an opportunity for a fresh start</p>
Keep the LSP as overarching body with HWB leading on health and wellbeing	Don't get rid of things that are working and have taken time to develop
Building on existing strong partnership. The police sit on the HWB. They are aware that the community safety partnership needs further consideration	The LSP arrangements reviewed last year and the HWB will use joint assembly arrangements as part of engagement processes
The LSP is discontinued but lines of accountability with adults and children's boards and Scrutiny Committee remain and a representative from the Safer City Partnership sits on the HWB	Needs to add value to existing mainstream work which continues and to have connections with existing partnerships
Keep the LSP	LSP is working well and includes a wider group, whilst the HWB is still grappling with their role in relation to emerging responsibilities

Pros

Means the board has representatives from the breadth of organisations and sectors needed, for example, police

The important thing is influencing what partners do, not how the board operates, so you want as many levers to pull as possible

Working with new players particularly CCGs and on the economic agenda, the opportunity to start again re-energised, was seen as a good approach

There is still a forum for getting wider buy-in, for example, for the joint health and wellbeing strategy

Aligning the planning cycles gives momentum and generates goals and creativity for the HWB partnership

Focus on areas of expertise

Cons

All the factors that led to the LSP becoming moribund are still potential risks to the HWB unless actively managed

A risk that merging the HWB and LSP might broaden the agenda too much, and miss out on some issues, for example, the environment and economy from the LSP's function

Need to work hard and a clear rationale for priority setting in order to keep partners on board

3. How health and wellbeing boards work with other tiers/organisations

Approach	Rationale
District councils have been asked to choose one representative to sit on the county-wide HWB	Important to have districts involved as they provide services that affect health and wellbeing but also keeping board numbers manageable
Use a wide reference group of stakeholders, members include: housing, employment, the voluntary sector and Healthwatch as well as key statutory bodies	Need breadth of stakeholders engaged but keep board focused The reference group is a model the PCT has used to engage clinicians and is an idea that could be taken forward by the HWB
Use a reference group made up of a broad set of stakeholders	Focus on getting the right things done at the right time, but still need flexibility and innovation
Are a unitary authority so this is not a problem	
Looking to use innovative approaches to engage with communities to build up citizen ownership of the joint health and wellbeing strategy	If community know and care about the joint health and wellbeing strategy it may prevent it dropping off the radar We want to encourage community responsibility and not just what public services do for people

Pros	Cons
<p>Gives districts a voice</p> <p>Keeps numbers down</p> <p>Keeps people focussed on their 'corporate' or 'representative' role, i.e. focused on the needs of the whole population not just one group</p>	<p>Those districts without a seat may not feel their local issues are represented</p> <p>How do you get non-elected organisations to perform a 'representative' role, for example, one college representing other higher and further education providers?</p>
<p>Gives access to wide range of expertise and different perspectives</p>	
<p>Gives access to wide range of expertise and different perspectives</p>	<p>Need to understand commissioning activity that goes on beyond the HWB</p>
<p>Strengthening involvement in local democratic processes plus better decision-making</p> <p>Positioning the joint health and wellbeing strategy as something important for all</p>	<p>Risk that communities do not engage or determine alternative priorities to 'professionals'</p> <p>The new approach is seen as a back door method to reduce public services</p>

This document was developed as part of the National Learning Network for health and wellbeing boards, a programme funded by the Department of Health and supported by the NHS Confederation, the Local Government Association and the NHS Institute for Innovation and Improvement. Each health and wellbeing board learning set has focused on a theme that early implementers have said is of most interest and importance – this one looks at how health and wellbeing boards will hold their members to account and be held accountable themselves.

It aims to provide health and wellbeing board members with an accessible and helpful resource and does not necessarily showcase best practice but represents key learning on the issues. For further information, or to comment, please email hwb@nhsconfed.org.

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