Health and Wellbeing Boards: a new dawn for public health partnerships?

Abstract

Purpose – This article considers the effectiveness of partnership working in public health and draws on a systematic review of public health partnerships and original research conducted by the authors. It then considers in the light of research evidence whether the recently established Health and Wellbeing Boards (HWBs) under the 2012 Health and Social Care Act will help agencies to work together more effectively to improve population health or will go the way of previous initiatives and fall short of their original promise.

Design/methodology/approach – The paper is based on a systematic literature review conducted by the authors and empirical research focusing upon the ability of public health partnerships to reduce health inequalities and improve population health outcomes. It also draws on recent studies evaluating HWBs.

Findings – The paper finds that, hitherto, public health partnerships have had limited impact on improving population health and reducing health inequalities and that there is a danger that HWBs will follow the same path dependent manner of previous partnership initiatives with limited impact in improving population health outcomes and reducing health inequalities.

Originality/value – The paper draws on a comprehensive research study of the effectiveness of public health partnerships on improving health outcomes and a systematic literature review, in addition to recent research evaluating HWBs to inform the discussion on their future prospects in regard to partnership working in public health.

Keywords Public health, Partnership working, Health and Wellbeing Boards, Local Government.

Paper type Research paper.

The allure of partnership working

Partnership working has become an essential component of British public policy, especially since the late 1990s. New Labour partnerships were characterised by a 'top down' approach involving policy and guidance and statutory bodies, rather than a pure network approach, which is characterised by bottom-up delivery mechanisms, with multiple organisations coming together informally, based on shared outlook or priorities or interpersonal relationships (Glasby and Dickinson, 2008).

Partnership working thus embraced public health issues, requiring the NHS to work with other agencies in order to achieve the government's wider policy objectives (Secretary of State for Health, 1999; Wanless, 2004). Partnerships were deemed necessary to address the 'wicked issues' faced in public health (Hunter, Marks and Smith, 2010). Ling (2002: 622) describes 'wicked issues 'as: '…a class of problems whose causes are so complex, and whose solutions are so multi-factorial, that they require a multi-agency response'.

With the then Labour government seeing partnerships as the potential solution to these 'wicked issues' and their role and scope becoming more encompassing, concerns in the academic community and elsewhere were being raised as to efficacy and effectiveness of such partnerships (see Dowling et al, 2004; Cameron and Lart, 2003; Wanless, 2004). As Glasby et al (2008: 67) note: '…the assumption that partnerships lead to better outcomes is at best unproven and much existing partnership working remains essentially faith-based…'

This 'faith-based' view retains strong currency, and the view that partnerships are an essential feature of the policy landscape has in some instances prevailed. The current coalition government has, in particular, seen partnership working as the preferred policy mechanism to address the 'wicked issues' evident in public health. As Turner et al (2013:2) note: 'The current Conservative led Coalition Government has indicated that it will retain… [the] focus on health inequalities, and has confirmed its intention to act on the findings of a wide-ranging review commissioned by the previous Labour government – Fair Society, Healthy Lives…[The Marmot Review].

Thus, policy commitment to addressing health inequalities now appears to be an accepted part of the UK political mainstream'. Indeed, the Marmot Review consistently stresses the need for effective partnership working to tackle health inequalities. The introduction of multi agency Health and Wellbeing Boards as a forum in which key leaders from the health and care system and other sectors come together to promote health and wellbeing and tackle health inequalities is evidence of this (Marmot, 2010; Humphries and Galea 2013).

The efficacy of public health partnerships – faith-based or fact-based?

As part of a public health partnerships research study conducted by the authors, a systematic literature review of public health partnerships under New Labour (1997 – 2010) was conducted, with an emphasis on partnership outcomes. A further scoping review was conducted in 2012, in which a review of the literature was undertaken from 2010 for studies on public health partnerships (see Hunter and Perkins, 2014). Both reviews found no clear evidence of the effects of public health partnerships on health outcomes. In spite of enthusiasm for partnerships and a firm belief that they were essential, it was difficult to discern their precise impact on local policy or practice. Being able to establish with any degree of assuredness what outcomes have resulted from partnerships was almost impossible as was trying to track in what ways partnerships may have led to perceived outcomes or impact. Most of the success reported factors remained largely process-based, inasmuch as success was seen to lie in creating partnership structures, policies and processes, and not in the impact on public health outcomes or reducing health inequalities. Namely, there was no discernible impact of the partnerships themselves on delivering better public health outcomes, either through strategies or a range of programmes and no evidence of their actual impact on reducing health inequalities (Perkins et al, 2010; Hunter and Perkins, 2014; Smith et al, 2009).

Reviews by Dowling et al, (2004) and Cameron and Lart, (2003) reached similar conclusions, in that there is a lack of sound evidence to show that working in partnership will improve outcomes

Public health partnerships - messages from the Research

With a paucity of evidence on the impact of partnerships in achieving public health outcomes, a study of public health partnerships was conducted with the intention of addressing this gap.

Although the three year research project covered the pre 2012 Health and Social Care Act period (2007-2010), as will be shown, the findings remain highly relevant. For the research, nine case study sites were selected across England based on Primary Care Trusts (now replaced by Clinical Commissioning Groups – CCGs), boundaries with matching local authorities. There were three phases to the research. First, 53 face-to-face semi-structured interviews were conducted with senior managers (DPH, Director's of Commissioning etc.) and elected members (Health Scrutiny Chairs etc.). Second, follow-up telephone interviews were conducted with eight out of the nine directors of public health Finally, four tracer issues (smoking cessation, obesity, alcohol misuse and teenage pregnancy) were identified from four of the study sites involving semi-structured interviews with 32 frontline practitioners, and four focus groups with service users in three of the locations to establish how far strategic level partnerships impacted on their work and outcomes (Hunter et al, 2010).

The research showed that partnerships had no discernible impact on public health outcomes (Hunter and Perkins, 2014), and five lessons, or pointers for policy, have been drawn from the study, which may be particularly relevant for the relatively new HWBs and their approaches to partnership working as they mature and embed themselves:

1. Policy and procedures need to be more streamlined with an emphasis on outcomes rather than process and structure. Partnerships deemed a success by our interviewees were ones in which the policy processes were outcomes focused, with clear joint delivery mechanisms, lines of accountability, careful monitoring and the full engagement of partners.

2. In contrast to approaches at a higher strategic level where the emphasis was much more formal and focused on target-setting and delivering on key goals, frontline partnerships responded more flexibly to service users' needs and operated in a more organic, holistic and integrated way. These two approaches - meeting targets on the one hand and addressing actual service users' needs on the other - need to be rebalanced.

3. Partnerships are over-engineered. Although structures are important, this should not be, but all too often, is at the expense of being clear about purpose and achievement. Furthermore, not all partnerships need be permanent or semi-permanent.

4. Structures are less important than relational factors such as trust and goodwill. More effort needs to be placed on developing robust and sustainable relationships than on structures and process.

5. A new type of leadership is required for working in multi-agency contexts. Such leaders are commonly known as 'boundary spanners' (Long et al, 2013). They can operate horizontally and vertically across organisations and have the skill set to bring key people and organisations together in a nurturing and constructive manner. Boundary-spanning leaders remain the exception.

Health and Wellbeing Boards – messages from the past, lessons for the future.

Following its emergence in May 2010, the coalition government in May 2010 moved quickly to announce its proposals for major changes in the NHS and public health with two white papers appearing in 2010 (Secretary of State for Health (2010a); Secretary of State for Health, (2010b). These set the scene for arguably the biggest bang change agenda in the history of both the NHS and public health (Hunter, 2011).

Little of the NHS was left untouched by the proposed changes. Primary Care Trusts were to be abolished and replaced by CCGs and public health was to be returned to local authorities. Furthermore, new semi-independent bodies, NHS England and Public Health England were created with regional and local arrangements put in place beneath them. Further complexity is added with the creation of Commissioning

Support Units to support CCGs, and CCG boundaries not necessarily co-terminous with local authority boundaries (Tomlinson et al, 2013). As Tomlinson et al note: 'The degree of complexity that this introduces into linking public health and spatial planning makes it even more difficult to focus on the wider determinants of health…' (2013:258). To assess the impact of HWBs we conducted a literature search of 11 electronic databases for research studies on the emerging HWBs. In addition, the bibliographies of all included studies were hand-searched.

As our systematic literature review on public health partnerships found, the most effective 'partnership killer' is re-organisation, due to established networks being broken up and personnel relocated (Perkins et al, 2010). Recent qualitative research looking at the prospects for progress on health inequalities within the new policy landscape conducted with 42 professionals in health and social care commissioning at national and local levels, confirms what we found in our study that: 'the general feeling was that restructuring presented significant risks to partnership working. Several respondents emphasised that partnerships between organisations are fundamentally based on personal relationships and that these take time to establish' (Turner et al, 2013:9).

HWBs were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the health and care system could work together to improve the health and wellbeing of their local population and to promote integrated services. They operated on a shadow basis for the first year, and the 152 HWBs in England became fully operational on 1 April 2013 (Murphy, 2013).

The overall purpose of the boards is to bring together bodies from the NHS, public health and local government, including Healthwatch as the patient's voice, jointly to plan how best to meet local health and care needs.

In practice, HWBs are expected to join up commissioning of local NHS services, social care and health improvement strategies, through the mechanisms of consultation and partnership in local communities. They will lead on health and well-being improvement and prevention measures. HWBs will be responsible for the Joint Strategic Needs Assessment, (JSNA) and this will be used to agree combined action

at the local level with a Joint Health and Wellbeing Strategy (JHWS). The 2012 Act contains provisions to ensure that JSNAs have authority to inform local commissioning decisions by local authorities, Clinical Commissioning Groups, and NHS England (La Placa and Knight, 2014; Mumford, 2013).

With such a pivotal role for the JSNA, it is somewhat disconcerting that our research on public health partnerships found that JSNAs were not regarded as terribly effective in driving the partnership agenda or local priorities prior to the current changes. Indeed, research by Turner et al (2013:7) found that: 'Many respondents also highlighted the failure of Joint Strategic Needs Assessments…to really have an influence on mainstream commissioning action in relation to inequalities. While there was awareness of the intended function of these documents/exercises, there was general agreement that they were not used systematically and had little impact on commissioning practice'.

A great deal rests on HWBs being successful. The House of Commons Communities and Local Government Committee concluded that they have a pivotal role and their success 'is crucial to the new arrangements'. But it also warned of the danger 'that the initial optimism surrounding their establishment and first year or two in operation will falter and go the way of previous attempts at partnership working that failed and became no more than expensive talking shops' (House of Commons CLG Committee, 2013 paragraph 22, 14). Reaffirming findings from our own research on the key importance of trust and relational factors being more important than structures and processes, the Committee maintained that success would be contingent on HWBs working 'on the basis of relationships and influence' which would depend on both people and structures.

Certainly, an early assessment of HWBs, conducted through a survey of 50 local authority areas covering all regions of England to assess the implementation of the boards, warned about the danger of them becoming another 'talking shop' and of failing to ensure that their strategic vision was fulfilled (Humphries et al, 2012). And that is the crux of the issue: will HWBs be the system leaders their supporters hope for, or will they become mere talking shops which risk becoming marginalised as decisions get taken elsewhere? Again, our own research warned of the danger of

partnerships getting bogged down in process and structure and not focusing upon outcomes. As Allen and Rowse (2013:20) argue: 'No amount of structural change or legislation can create the strength of a good working relationship...' Coleman et al (2014) argue that given HWBs' lack of statutory powers, only through developing good local relationships will strategies be realised. They also argue that there is as yet little clarity around the role of HWBs and setting the strategic agenda may prove difficult as other organisations also have their own agendas. Given the lack of statutory powers they also argue that it will be difficult for HWBs to hold partners to account (ibid).

As Checkland et al (2013: 7) note in their study of CCGs and accountability, which involved in-depth case studies in eight emerging CCGs and national web surveys carried out at two points: 'In some sites, the CCGs appeared to see themselves as an integral and important part of the development of the HWB, seeing themselves as 'co-owners' of the HWB with the LA. In other areas, we saw HWBs developing separately, with the CCG representatives present at meetings but apparently seeing themselves as representing the CCG rather than as partners in the HWB process. It remains to be seen how these differing approaches develop over time, and how HWBs will react should CCGs decide to disregard their concerns'.

Our own study found partnership goals may get sidelined when an agency's own priorities or imposed targets become pressing and assume priority. Indeed this was regarded as one of the key reasons why partnerships failed. In short, for the new HWBs to succeed, they must be different (Humphries, 2013; Kingsnorth, 2013).

However, as Turner et al (2013) note, there are concerns raised by the King's Fund research that CCGs need adequately to understand the value and scale of local community and voluntary organisations and how to work with them to address health inequalities. Their research, conducted as the new arrangements were being put in place, also found that their study respondents believed that HWBs would not have the 'teeth' to hold CCGs to account. They also argue that because responsibility for tackling health inequalities is divided amongst several different agencies, incentives to tackle such inequalities lack specificity, relevance and leverage. Furthermore their research found study respondents worried that CCGs would not commit resources to

public health because they did not view it as lying within their remit, public health having been moved out of the NHS.

The neglect of public health issues is also a concern for HWBs. If HWBs become preoccupied by the integrated care agenda then their impact on public health could be lost with the emphasis placed almost solely on the social care agenda. It is all too easy to foresee this danger occurring. The provision of social care occupies around 80 per cent of local government spending and many local authorities predict that with severe cuts affecting their services, within a few years local government may be providing little else but social care (Churchill (ed), 2012). Also, the NHS and local authorities are under heavy political pressure to move care into the community and out of hospitals through the aegis of the Better Care Fund (BCF) which is a national £3.8 billion pooled budget. However, this is not new or additional money but NHS money. The funding is for the purposes of improving out of hospital health services for people who are the clients of social care and heavy users of the NHS (Bennett and Humphries, 2014). To date, this issue has occupied much of the time and energy of HWBs with the government not satisfied with the BCF plans submitted by HWBs (Cooper, 2014).

Further research by the King's Fund through an online survey in May 2013 with 152 local authority areas, with a 46 per cent response rate examined the state of play with HWBs after their first year found that when asking what will help or hinder boards in achieving their objectives strong working relationships was considered by far the most important, with 70 per cent of their 60 respondents citing this as the factor that would best help them to achieve their objectives (Humphries and Galea, 2013:13). Again, the importance of relational factors cannot be stressed highly enough and, as our research noted, policies and processes will not have an impact if relational factors are poor between partners.

The King's Fund survey sought to investigate what was perceived to be the single biggest challenge facing HWBs. Forty-five per cent reported that their main concern was delivering on their priorities. As one respondent put it: 'Turning positive relationships and high level strategy into tangible outcomes and benefits for people' (Humphries and Galea, 2013:15). As we stressed in our lessons for partnerships,

policy and procedures need to be streamlined with the emphasis on outcomes not process issues. As noted, successful partnerships were ones with clear lines of joint delivery, accountability and monitoring arrangements to ensure their goals were being achieved. The King's Fund study concludes that partnership working is very hard to achieve in practice and highlights three possible scenarios for HWBs in which they believe the most likely is:

'…based on their current trajectory of development, most boards will default to a limited role of information-sharing and high level co-ordination of plans and strategies. They will react to proposals and plans from partners, and some boards will make progress in overseeing specific public health programmes, but few, if any, will initiate or lead system-wide change' (Humphries and Galea, 2013:18).

In short, HWBs face the danger of becoming ineffective talking shops with little traction on the public health agenda. We argued in our study that effective partnerships are built from the bottom-up, not imposed from above. HWBs are in danger of following their predecessors in having high level strategic goals with little or no ownership or input from those partner organisations' staff on the frontline tasked with delivering the goals and strategies of HWBs. Research by Regional Voices (Regional Voices, 2013:7), focusing upon how the voluntary and community sector is engaging with HWBs through a 2013 survey of 434 respondents across England found that: '…overall it looks like in just over 50% of local authorities there is a clear route for influence in health and wellbeing boards. This looks improved where there is a VCS [voluntary and community sector] rep, but even some VCS reps say there's not a clear route for influence for the sector. The fact 45% of respondents didn't know whether there was a voluntary sector representative or not showed there is definitely a communications job to be done, both in areas with a representative and where there isn't- to highlight the routes to influence'.

The concern over lack of ownership and the absence of any substantive powers for the Boards can only reinforce the outcome of boards being talking shops and lacking influence. Compounding the difficulties further are the unprecedented financial pressures on local authorities and the impact of welfare reforms on the public health agenda.

A further test of HWBs will be how far local authorities adopt a strategic approach. Buck and Frosini (2012) show that to date the government has sought to tackle unhealthy behaviours in vertical silos, that is, producing separate strategies for obesity, smoking and alcohol that do not link to each other or to policies on health inequalities. Truly joined up policy would acknowledge such connections across public health issues. But, as our research has shown, partnerships have tended to operate in a silo, target driven manner, and have failed to join up policy in a strategic manner.

Conclusions

How 'wicked issues' can best be tackled suggests the need for a different approach to partnership working that is looser, more flexible and responsive to rapidly changing contexts, and, above all, less engineered. Too often, if partnerships are not seen to be working, the temptation is to resort to yet more structure or to adopt a mechanistic response by proposing that the partnership should give greater emphasis to a more target-driven approach, to ensure that the partnership delivers what it promises. As Allen and Rowse (2013) argue, there is the need for HWBs to create space for contention and creativity and what Heifetz (2009) refers to as 'adaptive leadership'. As we noted earlier 'boundary spanner' leaders are those who can work with different agencies in an adaptive manner and allow room for creativity and innovation rather than being driven by a list of descriptive goals to be delivered in the traditional top-down, target- driven manner. As Kingsnorth argues, 'Health and wellbeing boards…will not be sufficient to ensure a partnership approach to improving health and wellbeing; a range of staff from the public health team, LA, CCG, and potentially voluntary sector and provider organisations…should be brought together to jointly define a vision for health and wellbeing' 2013:73).

Adopting a 'systems thinking' approach to partnership working does not magically make complex problems disappear. But through such a perspective, the process of designing, formulating and implementing policies is based more on facilitating improvements than on the control of the organization or system. The aim should be to provide a minimum specification and proceed from there.

Leadbeater (1999:206) maintains that the problem of sclerosis in public services can be put down to public organizations having been designed as bureaucracies and a feature of such organizations is their division into 'professionally dominated departments with activity concentrated into narrow specialisms, with little cross-fertilization of ideas or practices'. He describes, in other words, a silo- based approach. Generally, as a consequence, public organizations 'have heavy-handed management systems which provide limited autonomy or personal responsibility for front-line staff' (ibid). Wilderspin (2013:18) makes the very important point that 'Service transformation is a tough job; it requires a change in mind-set and behaviour from top-to-bottom…It will also require a new style of shared leadership, with a focus on the collective good, not the interests of particular organisations'.

The issue of trust, or its absence, seems to be a major part of the problem. As was noted earlier from our research on partnerships, trust and goodwill comprised the glue that made them work. Overall, strong trust is equated with long-term stable relationships which have become virtually impossible in public services which appear to be caught in a cycle of continuous re-organisation and change with new organisations formed and re-formed and networks dismantled all of which makes lasting connections difficult to achieve. With that lack of trust and continuity, there is a paradoxical need for HWBs to be given statutory powers in order to pursue and drive the policy agenda, given the transient nature of partner agencies and in the face of continuous policy churn and structural change. Without such powers and influence they may well become redundant. Partnership working is not going to disappear. The complex challenges facing those in public health are unlikely to disappear either or become less complex. Regardless of how we configure public health, there will always be a need to bring together a mix of skills and organizations which left to their own devices would probably not seek to work together. Partnerships need to be less engineered and driven from the bottom-up to be successful. The opportunities are there for HWBs to make a real difference through engagement in a different manner, but whether they can grasp this opportunity only time will tell.

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