

Health and Wellbeing Boards



Briefing for: Macmillan Service Development Teams and any Macmillan staff interested in the changes to local commissioning of health services

Purpose: To share information and advice on the new Health and Wellbeing Boards, to enable Macmillan to ensure that cancer is a part of local commissioning strategies

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Executive Summary

This six page briefing is a follow-up to an earlier introduction to the new local commissioning landscape in England. While the first briefing introduced the key players in the new system, this briefing goes into more detail about what is likely to be one of the most important innovations of the NHS Reforms - Health and Wellbeing Boards (HWBs).

HWBs will bring together GP commissioners, local councillors, adult social care, children's services, public health, and patients and the public as represented by Healthwatch. Their mission is to assess population needs, develop shared visions for change, and encourage integration of care.

The key tools for HWBs will be Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS). These will set out the needs of the local population and provide a strategic approach for how commissioners will address those needs. They will be continually revised and Local Authorities and Clinical Commissioning Groups are expected to take account of them.

The success of HWBs will come down to their ability to develop relationships and influence various budget holders. HWBs are not obliged to include the voluntary sector, the NHS Commissioning Board or providers in their membership, which may limit their impact. However, there is huge potential for the voluntary sector to positively impact their work.

There is a risk that HWBs will only focus on cancer prevention and early diagnosis. So it will be crucial that Macmillan continues to be a voice for cancer survivorship. There is a role for Macmillan to provide local data and evidence across the whole cancer pathway. We may at times need to address cancer through more generic priorities such as inequalities, prevention (primary and secondary), patient and public feedback, end of life care, the Marmot Framework,¹ and the life stage approach.

¹The 2010 Marmot Review looked at why most people in England aren't living as long as the best off in society and spend longer in ill-health. The report, *Fair Society, Healthy Lives*, recognises that disadvantage starts before birth and accumulates throughout life. This is reflected in the 6 policy objectives, with the highest priority being given to the first: 1. giving every child the best start in life; 2. enabling all children, young people and adults to maximize their capabilities and have control over their lives; 3. creating fair employment and good work for all; 4. ensuring a healthy standard of living for all; 5. creating and developing sustainable places and communities; 6. strengthening the role and impact of ill-health prevention.

Macmillan is currently in the process of commissioning the development of a JSNA tool. But in the mean time, now is the ideal time to be developing relationships with HWBs, and understanding what their priorities are. It is crucial that HWBs have Macmillan on their radar as an authoritative voice on cancer survivorship and a useful potential contributor to their area's strategic approach to commissioning.

The main recommendations from this briefing have been summarised in a Top Tips one pager for SDTs for your convenience - this can be found at the end of this briefing.

Health and Wellbeing Boards – What are they? What will they do?

Health and Wellbeing Boards (HWBs) are at the centre of the government's plans to transform health and care, and achieve better population health and wellbeing. They will bring together GP commissioners, local councillors, adult social care, children's services, public health, and patients and the public as represented by Healthwatch. Every upper tier and unitary local authority will have a HWB – 152 at last count.

Their mission is to assess population needs, develop shared visions for change, and encourage integration of care. Their three main functions are to:

- assess local population needs through a Joint Strategic Needs Assessment (JSNA)
- produce a Joint Health and Wellbeing Strategy (JHWS)
- promote greater integration by way of joint commissioning, integrated provision, and pooled budgets.

Pooled budgets currently represent less than 5% of total NHS and social care expenditure, but the potential is great. HWBs bring together the holders of two separate funding streams – Local Authority (LA) budgets with £14.5 billion for social care and £2.2 billion for public health, and Clinical Commissioning Groups (CCGs) with £64.7 billion for secondary care services.²

There are high expectations about what HWBs will be able to achieve.

“There is real risk that early hopes for the new bodies could collapse under the sheer weight of expectations placed on their shoulders. Cynics would not be surprised if their remit is extended to achieving world peace on the grounds that this is a slightly less challenging task than the remit in their own backyard.”³

But it will be crucial to engage with them.

“We will get a lot of the smarter single national issue charities lobbying health and wellbeing boards, lobbying councillors. The place at which a lot of those decisions about priorities will be taken is the health and wellbeing boards.”⁴

² Richard Humpries and Claire Mundle, 'Delivering integrated services', *Getting started: prospects for health and wellbeing boards*, December 2012.

³ Richard Humpries, The King's Fund, [How are health and wellbeing boards shaping up to their new responsibilities?](#) 20 March 2013.

⁴ Jo Webber, NHS Confederation deputy policy director, [Will health and wellbeing boards be more than talking shops?](#) *GP Online*, 18 July 2012.

HWBs officially took on their formal roles and responsibilities on 1 April 2013. However 93% of Councils became early implementers, so have been in practice over the past year. This means it is already possible to make contact with most HWBs – the King’s Fund provides a useful [directory](#) for getting in touch with them.

The size and coverage of HWBs will vary greatly. See Appendix One for examples of just how different HWBs may look.

This time it’s different, I promise...

JSNAs have already been around for five years, but have traditionally been prepared for commissioning audiences and have often been problem-oriented, specific to acute care and clinically focused. In their new role as a tool for HWBs, JSNAs will need to be accessible to a wider audience including members of the public and democratically elected members. Traditionally they have primarily covered just health care, but they will now need to include public health and social care, and education, housing and transport where appropriate.

The original JSNAs had no formal levers to incentivise implementation – PCTs had little incentive to transfer them into their plans. Placement within HWBs, which brings together various commissioners and their associated budgets, now gives the JSNA and JHWS more weight. There are still no sanctions to ensure that commissioning decisions reflect the JSNA/JHWS, but CCGs and LAs are expected to consider JHWSs in their plans. If a HWB thinks that a CCG has *not* taken proper account of the relevant JHWS it can make this known to the CCG and the NHS Commissioning Board (NHSCB). The CCG must be able to justify any parts of their plans which are not consistent with the JHWS - otherwise the NHSCB can take action.

So what makes a good JSNA or JHWS?

JSNAs should identify the current and future health and wellbeing needs of the local population – looking at the wider determinants of health such as employment, housing and the environment. HWB members will need to be able to explain what the JSNA means to the local population, for example how it will address local concerns such as particularly high rates of youth unemployment or particular long term conditions.

JHWSs should then set a strategic approach to addressing the needs identified in the JSNA. They should be a concise summary of the key health and wellbeing challenges for the area, prioritising issues to be addressed through service changes. JHWSs should also map and take account of local assets and resources, including available budgets, human resources, and **third sector activities and capacity**. They should then assess how best to make use of these and identify gaps that require new services. Strategies that are action-focused are likely to be more impactful than those that just describe the region’s circumstances.⁵

Both JSNAs and JHWSs should be living documents, continually revised to reflect the changing needs of the population as services develop. Since the content of JSNAs and JHWSs will inform local commissioning plans, HWBs will want to ensure they are kept up to date. Annual CCG commissioning plans must be in place before the start of each financial

⁵ Madeleine Knight, British Medical Association, ‘Development of the joint strategic needs assessment’, *Getting started: prospects for health and wellbeing boards*, December 2012.

year, and must also be informed by the relevant JHWS. This does not mean full JSNAs and JHWSs necessarily need to be undertaken annually, but HWBs will want to agree how they will refresh or update them to inform annual commissioning plans. Local authority commissioning cycles should also be informed by the relevant JHWS, although the exact timing of these cycles is a decision for the local authority.⁶

Potential issues to be aware of

Membership of HWBs may prove an issue on three fronts. HWBs are not required to have representation from the NHSCB, the voluntary sector or providers. It is therefore unclear the influence HWBs will have over the NHSCB budget of £20 billion for commissioning primary care, dentistry and pharmacy.

However HWBs are free to extend their membership beyond what is compulsory, and in fact an Autumn 2011 King's Fund survey found that the voluntary and third sector was already represented on 57% of HWBs.⁷ Hopefully engagement with the voluntary sector will extend beyond merely having one representative on the board, as the scale of change for NHS structures has made many established relationships between the voluntary sector and decision makers in PCTs and LAs obsolete.

Many boards are choosing not to involve providers at all. Research shows that integrated care partnerships are likely to be led by providers, so this could be detrimental.⁸ Also providers are central to planning and developing the healthcare workforce, and it does not make sense to keep commissioners and providers separate.

Another potential issue regards boundaries. LAs and CCGs will have coterminous boundaries – an improvement from when LAs and PCTs had differing boundaries. But in most areas CCGs outnumber HWBs, so CCGs will need to form agreements between themselves – adding a layer of complexity to relationships.

Cost is a further concern – LAs are expected to establish HWBs as formal statutory committees, but have not received any additional resource to do so. Costs are estimated to vary from £150,000 for small boards of 10 people meeting six times a year, to over £300,000 for large boards who meet more frequently.⁹ This will be a significant challenge for LAs dealing with squeezed budgets.

The role of the voluntary sector

While there is no statutory role for the voluntary sector on HWBs, there are plenty of opportunities for influencing.

One of the main aims of the NHS Reforms is to give responsibility for commissioning to GPs rather than bureaucrats, with the assumption that GPs are better placed to understand patient needs. However, not even GPs can know the needs of everyone in a community –

⁶ [JSNAs and joint health and wellbeing strategies – draft guidance](#), Department of Health, January 2012.

⁷ [Health and wellbeing Boards: System leaders or talking shops?](#) Richard Humphries et al, King's Fund, April 2012.

⁸ Supra footnote 1.

⁹ Derek Miller, 'Achieving cost-effectiveness for health and wellbeing boards', *Getting started: prospects for health and wellbeing boards*, December 2012.

particularly those of disadvantaged or vulnerable people. Therefore, GPs will need to work closely with the voluntary sector in their role as advocates and representatives.

HWBs will provide an ideal means of supporting engagement between commissioners and the voluntary sector. Charities such as Macmillan are well placed to map out the needs of local populations. Some HWBs are intending to engage with the voluntary sector solely through their Healthwatch representative.¹⁰ It is unlikely one representative will understand the needs of the local community as well as the wider voluntary sector. Therefore sensible HWBs will be keen to engage with the voluntary sector when developing JSNAs/JHWSs.

How will cancer fit into JSNAs and JHWSs?

Some HWBs are intending to evaluate their performance against specific outcomes like health inequalities, emergency admissions to hospital, A&E waiting times, admissions of over-75s and patient user satisfaction. Others intend to develop their own set of outcome indicators, choosing those that align across the NHS, Public Health, and Social Care Outcomes Frameworks.¹¹ Some boards seem to be lifting their indicators exclusively from the Public Health Outcomes Framework – perhaps because Public Health Directors are currently the most confident members of HWBs.

HWBs are free to decide how they will measure their own success, but recommendations do exist for how cancer should be included in JSNAs. The All Party Parliamentary Group on Cancer has recommended that,

“Each JSNA should include a section on the local population’s public health needs with regards to cancer. This should consist of information about cancer prevalence, Cancer Awareness Measure scores for the area, and information on the metrics in the Public Health Outcomes Framework – screening uptake rates, smoking prevalence for those over and under 18, and stage of cancer at diagnosis.”¹²

It is important that HWBs cover prevention and early diagnosis, and this will support progress on achieving the Government’s goal of saving an additional 5,000 lives by 2014/15. However, it is also crucial that commissioners understand the need to commission services that support people right throughout their cancer journey. This is likely to be the area they are less familiar with, **and which Macmillan could provide most support on.**

In order to include cancer in their plans, HWBs will require access to high quality cancer information. Some of this will come from Public Health England, whose role includes:

- being a source of information, advice and support for local authorities and clinical commissioning groups as they develop local approaches to improve health and wellbeing

¹⁰ Sir Stephen Bubb, CE of the Association of Chief Executives of Voluntary Organisations, ‘Engagement with the voluntary sector’, *Getting started: prospects for health and wellbeing boards*, December 2012.

¹¹ Note that the King’s Fund has suggested HWBs won’t achieve their goal of integrated care without integrated Outcomes Frameworks to promote joint accountability. Supra footnote 6.

¹² APPG on Cancer, [Effective Cancer Commissioning in the New NHS](#), Dec 2011

- generating information on the state of public health in England to support the development of local JSNAs.¹³

There is a role for Macmillan to provide local data and evidence across the whole cancer pathway. Scoping work by the National Cancer Action Team found that even JSNAs cited as early examples of best practice were found to contain out of date and inaccurate cancer information.¹⁴ Given the wide range of issues and conditions HWBs will need to cover, the easier we can make it for HWBs to access good data, the more robust their plans will be.

JSNAs may or may not have a section dedicated to cancer, but this is not the only place cancer can be covered. Organisations supporting LAs have advised addressing cancer through more generic priorities such as inequalities, prevention (primary and secondary), patient and public feedback, the Marmot Framework, and the life stage approach.

Macmillan priorities like work and cancer/ vocational rehabilitation, and physical activity, are likely to sit well with HWB priorities. HWBs will be interested in,

“creating jobs to improve wealth and to improve people’s mental and physical health through work and the workplace.”

And a survey of over half of HWBs in November 2012 found,

“most had health improvement and/or public health, or some aspect of these, as their main priority.”¹⁵

So, what next?

Macmillan is currently in the process of commissioning the development of a JSNA tool. What the tool will look like will be based on interviews with HWBs to establish what would work best for them. It might be an example best practice guide of how cancer survivorship should or could look in JSNAs. Or it might be a checklist for SDTs to evaluate existing JSNAs, with examples of what they might suggest that HWBs add in. We plan to have this tool ready to use by Autumn 2013 – in time to influence the 2014 commissioning round.

But in the mean time, now is the ideal time to be developing relationships with HWBs and understanding what their priorities are. As JSNAs and JHWSs will be developed iteratively, opportunities to influence their content could arise at any time. It is crucial that HWBs have Macmillan on their radar as an authoritative voice on cancer survivorship and a useful potential contributor to their area’s strategic approach to commissioning.¹⁶

Contacting HWBs through their formal channels (as per the directory linked above) is certainly one option, but you may already have relationships with some of the individual members, and this will be another key way to influence. Individual GPs or Local Councillors may be able to present your messages to the wider HWB if you cannot get around the table yourself – especially if you can present them with useful data and evidence, and suggestions for action that sit well with their priorities.

¹³ DH/NCAT, [An Intelligence Framework for Cancer](#), December 2011,

¹⁴ Kathy Elliott, National Lead - prevention, early diagnosis and inequalities, National Cancer Action Team, April 2012.

¹⁵ Georgina Owen, ‘Exploring how new NHS organisations will collaborate’, *HSJ*, 12 March 2013.

¹⁶ For the most recent messaging and evidence on cancer survivorship, see [Living with and beyond cancer: taking action to improve outcomes](#), DH, Macmillan, NHS Improvement, March 2013.

Health and Wellbeing Board case studies¹⁷

Case study: Lambeth

Lambeth covers a population of 274,000. The organisational landscape is straightforward, with one coterminous CCG. Following initial discussions between the council and the PCT, it was agreed to adopt a phased approach to developing the HWB. The process involved identifying the outcomes that partners want to achieve through the board, rather than rushing to establish its governance, membership and way of working.

A series of workshops were held from spring 2011, attended by 25 participants from a wide range of statutory health, social care and local government organisations, including the Local Involvement Network. New conversations were able to take place for the first time between organisations and clinical disciplines, notably GPs. The active and committed involvement of providers has been a distinctive feature of Lambeth's approach; it reflects the presence of King's Health Partners, an Academic Health Sciences Centre that brings together three major acute foundation trusts with an annual spend of £2 billion (compared with the combined NHS Lambeth and council spend of just over £1.6 billion).

The workshops focused on revising the JSNA, taking into account the current priorities and plans of existing organisations, and how the HWB could add value. This has helped the organisations involved to understand each other's agendas and concerns. A mapping of existing spend showed that the total public resource that falls within the remit of the board is more than £1 billion, and that its core mission will be to consider its overall deployment and what outcomes will be achieved in terms of the JSNA and JHWS.

The board's role is seen as strategic, with no direct involvement in detailed commissioning. This understanding has helped to frame initial priorities; workstreams have been agreed on and work has begun on citizen involvement, public health, integrated care and early intervention.

Case study: Surrey

Surrey is a large and complex health and care system, covering a population of 1.1 million. There are more than 20 statutory organisations, including 11 district councils, and 12 developing CCGs.

Stakeholders from across the county were brought together in three development workshops in spring 2011 to develop a shared vision for the new HWB. The starting point was a strong focus on outcomes, seeking stakeholder views on three questions: what are the top three health and wellbeing priorities for local people?; what needs to be done to address them?; and what needs to be commissioned differently to achieve those outcomes?

Workshops involved at least 60 people drawn from across local government and the NHS, including the private and voluntary sectors and acute health providers. Early themes included: ensuring clarity of purpose; mapping existing spend and services across the

¹⁷ Case studies are excerpts taken from [Health and wellbeing Boards – System leaders or talking shops?](#) Richard Humphries et al, King's Fund, April 2012.

county; understanding the overall picture (and differences within the county); and building strong relationships, both within the board and externally.

Mapping work through the JSNA had shown that combined spending across the NHS, adult social care and children's services amounted to more than £2 billion.

A clear consensus emerging from the workshops was that the purpose of the board is to promote transformational change, recognising the need for fundamental changes in what services are commissioned and how this is done, rather than simply tinkering with or repackaging existing arrangements.

By the time of the final workshop, the county council was able to articulate some clear models for the board. These included: one main board and 11 local boards based on district/borough boundaries; and a two-tier model with a single board and four subgroups based on the PCT resource hubs or the CCG cluster areas. These models reflected the need to ensure the engagement of both district councils and CCGs, made difficult by the lack of coterminous geographical boundaries.

Chaired by the council's cabinet member for adult social care and health and co-chaired by a GP lead, the HWB has approximately 27 members (17 of whom are GP leads). There will be wider engagement activity with other key stakeholders who are not members of the board.

Health and Wellbeing Boards and cancer – Top Tips for SDTs

1. While they took on their official roles on 1 April 2013, most Health and Wellbeing Boards (HWBs) have been in practice mode over the past year. This means it is already possible to make contact with most HWBs – see the King's Fund [directory](#) for contact details.
2. If a HWB thinks that a CCG has *not* taken proper account of the relevant JHWS it can alert the CCG and the NHS Commissioning Board (NHSCB). The NHSCB can take action if the CCG can't justify why their plans are not consistent with the JHWS.
3. Both JSNAs and JHWSs should be continually revised, living documents. Since the content of JSNAs and JHWSs will inform local commissioning plans, HWBs will want to ensure they are kept up to date. As JSNAs and JHWSs will be developed iteratively, opportunities to influence their content could arise at any time.
4. GPs will need to work closely with the voluntary sector in their role as advocates and representatives to ensure they understand the needs of everyone in their community. Macmillan is well placed to map out the needs of local populations and HWBs will provide an ideal opportunity for commissioners and the voluntary sector to engage.
5. The APPG on Cancer has recommended that each JSNA should include a section on cancer. They advise this should cover cancer prevalence, Cancer Awareness Measure scores, and Public Health Outcomes Framework metrics such as screening uptake rates, smoking prevalence for those over and under 18, and stage of cancer at diagnosis.
6. It is crucial that commissioners also understand the need to commission services that support people right throughout their cancer journey. [Survivorship](#) is likely to be the area they are less familiar with, and which Macmillan could provide most support on.
7. JHWSs should also map and take account of local assets and resources - this includes third sector activities and capacity. Therefore sensible HWBs will be keen to engage with the voluntary sector when developing JSNAs/JHWSs.
8. Macmillan can provide local data and evidence across the whole cancer pathway. NCAT found that even JSNAs cited as best practice examples had outdated, inaccurate cancer information. Given the wide range of issues and conditions HWBs will need to cover, the easier we can make it for HWBs to access good data, the more robust their plans will be.
9. JSNAs may or may not have a section dedicated to cancer, but this is not the only place cancer can be covered. Consider addressing cancer through more generic priorities such as inequalities, prevention (primary and secondary), patient and public feedback, end of life care, the Marmot Framework, and the life stage approach.
10. Macmillan priorities like work and cancer/ vocational rehabilitation, and physical activity, are likely to sit well with HWB priorities of public health and improving health through work and the workplace.
11. Now is the ideal time to be developing relationships with HWBs, and understanding what their priorities are. It is crucial that HWBs have Macmillan on their radar as an authoritative voice on cancer survivorship and a useful potential contributor to their area's strategic approach to commissioning.