Briefing
BwD: Health and Wellbeing Board
Early Implementers and the Transition
February 2011

Introduction

1. The communication below has been received by the Early Implementer Health and Wellbeing Boards from the Department of Health

2. The paper updates Early Implementer Health and Wellbeing Boards on the process of establishing a network of early implementers. It sets out Department of Health proposals on the following issues, seeking HwB agreement and any further comments;

    a. Focus of the network
    b. Approach to leading and supporting the network(s)

Recommendation

3. That you:

    a. Note progress to date; and
    b. Give agreement to and further comments on next steps

Timing

4. The Department of Health we intend to write to all local authorities inviting them to engage in the second wave of the early implementer network later this month, building on comments received as to how to take this work forward.

Background

5. The focus of the early implementer work is to support the objective of ensuring a shadow health and wellbeing board is in place in all 152 top tier local authority areas by March 2012. Through the early implementer network the DH will support the development of shadow health and wellbeing boards throughout 2011/12, with the aim that they develop the capacity they need to deliver their main functions including Joint Strategic

Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS) during 2012/13.

6. This is primarily about a cultural change, rather than the relatively straightforward process of establishing a committee. The aim is for the NHS, local authorities (including elected representatives), and representatives of patients and the public to genuinely collaborate throughout the commissioning process. It is about developing a shared understanding of the needs of the local population and agreeing the best strategy to meet those needs within the collective resources available to the local community. This joint work should be the foundation of both GP consortia and local authority commissioning plans.

7. The DH approach to establishing a network of early implementers to date has been based on four principles;

   (i) **Co-production;** working with a core group of areas to co-design and produce the approach and focus of a wider network of early implementers
   (ii) **Inclusivity;** all local authorities will be invited to engage regardless of current partnership arrangements in order to build momentum to support shadow health and wellbeing boards in all areas by 2012
   (iii) **Driven by local partnerships;** while there are a number of key policy questions that DH needs to resolve, the approach to answering those questions will be set by local areas, building on existing networks of local authorities
   (iv) **Supported by DH and SHAs;** DH and SHA colleagues will offer the practical support and co-ordination to enable the network to resolve issues and barriers to establishing shadow health and wellbeing boards by 2012

8. This approach means that DH will not issue central guidance on how Local Authorities should establish Health and Wellbeing Boards.

9. The Local Government Group (LGG) has been working closely with us throughout the process so far. We are now working with approximately 25 local areas (including the 10 unitary authorities within Greater Manchester) who have either approached or been suggested to us and have an interest in early implementation of the proposals. A list of these is at Annex A.

10. The focus of work since the summer has been working with these areas to co-produce the focus and approach to supporting a wider network of early implementers. The intention is for David Behan to write out to all local authorities in January inviting them to engage in a wider network. The DH intend to maintain the inclusive approach to establishing a wider network

of early implementers in order to maximise the scope for development and sharing of innovative ideas and practice. Local authorities will need to make a conscious decision to become an early implementer and to engage as active participants in the network, but we believe that any more formal selection process will inhibit rather than stimulate momentum. With this approach, we expect a great deal of ongoing interest in the wider network, and that up to half of the local authorities in the country will want to join by April.

11. Promoting at a national level the role of the early implementers will be important to communicate the importance or this work, continue engagement across key stakeholders and get across the key messages set out in *Equity and Excellence; Liberating the NHS, Healthy Lives, Healthy People,* and *A Vision for Adult Social Care: Capable Communities and Active Citizens*. The inclusive nature of the approach to identifying early implementers we have taken however will require a different approach to launching or promoting the work of the network, as opposed to announcing a specific list of places. We intend to provide you with options in the next month that incorporate;

- a set piece event with Ministers from across relevant Government Departments, alongside the Local Government Group, SOLACE, ADASS, ADCS and other key stakeholders
- an opportunity to thank early implementers, stimulate leadership and engagement in local authorities and underline our commitment to the role of local authorities in health and wellbeing
- an approach which secures national political engagement
- a focus on the links to GP consortia, Public Health and Patient Engagement

Proposed focus for the early implementer network

12. The Department, LGG and a core group of early implementers have developed a consensus on the key issues to be addressed through this work. These include, for example, joint commissioning, developing JSNAs and JHWS, making the right links to children's and wider public services, and strengthening patient and public engagement. A list of specific issues is attached at Annex B.

13. The early implementers are keen to take a cross-cutting approach to sharing learning around the issues, and have agreed that we should start addressing them through four overarching themes. These are

    a. **How do we set a new direction while ensuring current programmes through the transition?** This theme encompasses the desire to ensure the potential of these reforms is realised in

terms of improved outcomes and integrated working, while managing the risk of losing good relationships, talent and capacity during the transition.

b. **Relationships and knowledge:** this theme reflects the need to focus on building new and strong relationships particularly between emerging GP consortia and councils. It also includes issues around building basic understanding of how partner organisations function (eg GPs understanding how councils work and vice versa) and knowledge transfer between organisations (eg PCTs to GP consortia on JSNA).
c. **Accountability and transparency:** this theme focuses on how areas can make a success of the governance arrangements and complex accountabilities involved in working across organisations in this way. It will have a particular focus on how transparency and accountability to local people can be improved – making a reality of democratic legitimacy.
d. **Boundaries and levels:** this is a more practical theme around dealing with the complexities of operating in a world where GP consortia and councils are not co-terminus, with two tier authorities and cross boundary issues.

14. The group also identified a need for some focussed work on particular issues including

    a. Joint Strategic Needs Assessment
    b. Working with elected members

How the network will operate and how DH needs to support it

15. The network will develop in phases throughout 2011/12 and into 2012/13. We envisage structuring the learning and development across these phases in the following ways;

    a. A core group of early implementers (consisting of the 25 areas already identified); (1) co-designing with DH and LGG the initial process and (2) supporting collaboration between natural communities of local authorities who will develop learning by testing out the new roles and functions of health and wellbeing boards locally
    b. An extended network; joining the process in response to our invitation in January and a further invitation later in the year, building and adding to this learning during the first half of 2011/12 (see timeline at para 20).

c. Additional focus on a further phase of areas who start this element of the transition process later, either for legitimate local reasons or due local obstacles or barriers to engagement.

16. The size of the groups at (a) and (b) above will become apparent quickly in response to our invitation to engage in the network of early implementers. We are developing a strategy, alongside the early implementers and LGG, on how to build momentum and engage those places who might fall into (c). The emphasis of the work will not be on producing national guidance, but on working with local government and partners to accelerate the sharing of learning, ultimately supporting effective health and wellbeing boards that can bring together partners in local areas to better serve their communities.

17. As such it needs to be driven by local partnerships, but coordinated and supported nationally. We are asking the core group of local areas and others who join to collectively lead the network with us, through a range of existing mechanisms and new groups. This is likely to include work led through geographical networks based around SHAs and sub-regions that already operate (eg London, Greater Manchester, Tyneside, South Yorks, West Yorks) and new grouping based on PCT clusters, as well as issue based networks relating to two tier working, diversity and rurality.

18. The early implementers' view of the support and leadership they will need from us to do this is summarised as;

    a. **Purpose and challenge:** councils and partners felt DH needed to help them 'frame up' issues, to help keep the focus on the overall vision for the reforms and to facilitate peer challenge
    b. **Facilitation and building connections:** this is about supporting discussion and connections. It would include mapping who the early implementers are and their interests so others can see, encouraging them to host events and seminars bringing those with similar or connected interests together to work through issues with each other, facilitating and supporting such discussions, writing up and analysing learning in a way that is accessible.
    c. **Communication:** the group underlined the importance of having learning shared on a web forum, including interactive facilities such as blogs. They stressed that the approach to this should be consistent with that taken for GP pathfinders, and that it should be accessible in the same place. There will also be opportunities to use existing interactive web fora, such as the communities of practice set up by LGID.
    d. **Feeding learning into policy:** the group were keen to understand how to influence the development of policy and to know as early as possible what are already fixed points. DH colleagues can provide a way in to ensure that learning from the early implementers does feed the approach going forward – an example given was how the NHS Commissioning Board works.

Links to GP Consorita Pathfinders

19. Many of the responses to the consultation on *Liberating the NHS* underlined the importance developing Health and Wellbeing Boards - and local authority capacity more generally – alongside the development of GP Consortia. Building on the emphasis in the NHS Operating Framework for 2011-12 on the importance of SHA and PCT cluster support for development of GP capacity, we are working closely with the Commissioning Development team and SHA Directors of Commissioning to align the implementation approaches to early implementers and GP Consortia pathfinders.
20. DH initial focus is on aligning communications with shared websites, bulletins and learning materials for GP pathfinders and early implementers, as well as ensuring early implementers and local authorities form part of the regional transition events. DH are also working to develop a 'shared offer' on learning and support for GP pathfinders and early implementers.

Timing, alignment with the wider transition and Next steps

21. 2011-12 represents a critical 'transition year'. By April 2012 leadership for the new arrangements will be established in most places. The NHS Commissioning Board will be operational, GP Consortia will be taking on their full range of responsibilities, PCT clusters will have replaced existing PCT s and SHAs will be abolished. The new regulatory framework for health and social care will be defined. Local authorities will have in place leadership arrangements in readiness for their Health and Wellbeing and Public Health roles.

22. The broad timeline for development of early implementers is as follows. A further more detailed slide setting out milestones and progress is attached to this sub as annex C.

    - **January 2011:** invite all local authorities to engage in network of early implementers.
    - **February 2011 – April 2011:** pre-shadow running. Establish early implementers, formalise how DH, LG and NHS will collaborate to support them.
    - **April 2011 – October 2011:** local shadow working arrangements are established in early implementer areas, learning is collated and shared through network.
    - **October 2011 – April 2012:** disseminating learning and widening network so all local authorities have shadow health and well-being boards in place by April 2012, and are beginning to operate, eg refreshing JSNAs.

- **April 2012 – April 2013:** health and wellbeing boards operating in all areas on non-statutory basis, co-producing joint health and well-being strategies as basis for GP consortia and council commissioning.
- **April 2013 onwards:** health and wellbeing boards in place in every area as vehicle for councils new leadership role in integrating commissioning.

Conclusion

23. You are asked to

a. Note progress to date; and
b. Give agreement to and further comments on next steps

Annex A – List of areas we are currently working with

Blackburn with Darwen
Buckinghamshire
Calderdale
Cambridgeshire
East Sussex
Essex
Greater Manchester
Hammersmith & Fulham
Herefordshire
Hertfordshire
Lambeth
Leicestershire
Lewisham
Lincolnshire
NE Lincs
Norfolk
North Tyneside
Oxfordshire
Sheffield
Suffolk
Surrey
Sutton

Annex B – Specific issues raised by early implementers

- Building the relationship with GPs; including helping GPs understand the role of LAs and vice versa, clarifying the 'offer' from LAs to GP Consortia, bringing together clinical expertise and democratic representatives
- Ensuring this works in places with established integrated working as well as supporting those places with further to go
- HWBs' role in providing leadership on public health
- Pooling budgets and aligning funding locally, as well as joint and lead commissioning (Community Budgets)
- Managing the money through the transition
- Collaborating on a population basis across different geographies and making HWBs link to district, community or neighbourhood
- How to link HWBs to wider public services, and position as a city / county wide function for public service leadership
- Understanding the links for Children & Young People, including safeguarding (fit with Children's Trusts and Local Children's Safeguarding Boards)
- Understanding the role of Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies
- Getting patient and public engagement right through Healthwatch
- Developing HWBs as vehicles for improved working between DsPH, DASS', DCS' and GPs
- Links to QIPP (the NHS work to improve quality and productivity)
- Supporting front-line behaviour change
- Technical / legal issues around what functions and decisions can be delegated to the HWB and how this relates to council's constitutions