Delivering on Health and Wellbeing in Middlesbrough:
Review of current partnership working arrangements

FINAL REPORT
May 2015
Executive summary

i Middlesbrough Council commissioned Durham University to work with members of the Middlesbrough Health and Wellbeing Board (HWB) and its sub-structures (the four Delivery Partnerships, DPs) to examine how these fora function and add value to efforts to improve health and wellbeing for the people of Middlesbrough. A secondary aim was to support the development of each of the DPs by fostering connections between individuals and organisations, and strengthening internal relationships.

ii The context for this work involves the return of public health in England from the NHS to local government, which has generally been welcomed and generated high expectations. However, the shift took place at a time of unprecedented financial pressures on local authorities, alongside changing patterns of need that demand new ways of thinking and working in how health improvement is delivered.

iii The most up-to-date evidence suggests that widespread progress is being made across some common themes: building relationships between HWB members; using development sessions or informal meetings to clarify priorities; developing sub-structures and working groups to support the HWB; and using the Better Care Fund to provide a focus for their efforts. However, progress is slower than widely anticipated and many HWBs are still some way off driving the big issues. Frustration exists within and outside the boards nationally.

iv The present study set out to add to explore these issues locally and to find practical, sustainable ways forward from within the Middlesbrough health and wellbeing system. The study design comprised:

- A desk-based scoping exercise to review the existing evidence on partnership working to achieve health and wellbeing goals
- A series of workshops and conversations with local stakeholders, to better understand the challenges, experiences and opportunities for working in partnership to deliver the Middlesbrough Health and Wellbeing Strategy

v Recurring ideas and key insights were recorded by the research team and have been organised into four over-arching themes:

**Political and organisational context**

- The need to meet the challenge of continual contextual churn and uncertainty, including policy, organisational reforms, changing personnel, austerity and impending elections
- A recognition that the configuration of the HWB and DPs was a pragmatic response to the need to encompass key existing organisations and interests in the health and
wellbeing system, with little appetite for the upheaval involved in re-shaping the structure and governance arrangements

- A degree of ambiguity in relation to roles, responsibilities and expected contributions from the different agencies within the Middlesbrough health and wellbeing system, and the implications of the HWB operating as a council committee
- Challenges for organisations operating across local authority boundaries

Connectivity across the health and wellbeing system

- Uncertainty about the appropriate relationships between the HWB and the DPs, both in terms of setting priorities and reporting on performance
- The need to pay greater attention to how information flows around the system, i.e. between the DPs and the HWB, between the four DPs, and between each DP and other connected actors or partnerships
- Concerns about overlapping agendas and the potential for duplication between different parts of the system, coupled with a sense of ‘partnership fatigue’
- Resisting the urge to over-organise structures and instead to focus on the ‘softer’ issues around relationship building among the partners

Getting the process right

- The need to avoid being process-driven, rather than outcomes-focused
- A call for greater coherence and a shared vision in place of what currently feels diffuse and fragmented
- A more conscious attention to processes that help meetings function optimally

Making partnership working engaging and satisfying

- More effective central communication arrangements would help partners to know that they were making a difference and that their contribution was connected to the whole system
- Partners need to feel that they are connected to each other and that they understand each other’s’ roles, organisations and objectives, whilst ensuring that there is opportunity for the kinds of debate, challenge and contestation which can lead to innovation and change
- Early achievements needed to be celebrated and promoted so that partners feel that their efforts are recognised by others and encouraged by others’ success

The Middlesbrough health and wellbeing system is wrestling with the same issues as other similar systems across the country. These include complexity, competing policy and financial drivers, and the pull of different organisational priorities. In Middlesbrough’s favour are the commitment and pragmatism of the individuals involved. The challenge revolves around how to be successful in spite of factors that mitigate against success. These require an alert and conscious approach to partnership working.
Study participants identified a number of practical ways forward for the Middlesbrough health and wellbeing system, ranging from quick and easy-to-implement ideas to longer-term and more complicated changes. For the short-term, and chiming with findings from recent studies of HWBs elsewhere, were the following recommendations:

- Ensure that there is clarity of purpose in relation to each part of the partnership structure, and clear understanding about the expectations of different partners
- Regularly restate the purpose of the partnership and review membership accordingly
- Be conscious of effective partnership practice; invest time and effort in relationship building, and challenge and hold each other to account for actions
- Closely manage DP meetings to provide shorter, more focused agendas with opportunities to fully discuss important issues
- Provide sufficient central coordination and support to ensure that partners can see how their contribution relates to the overall successes of the HWB, to reduce the potential for duplication, and report between parts of the system as necessary
- Focus on areas of joint working, rather than on discussing work that proceeds in separate silos
- Devise and agree local data sharing arrangements to ensure that the HWB and DPs have access to the evidence needed to inform their work
- Spend time on action planning to achieve real clarity in terms of short-, medium- and longer-term outcomes
- Agree timeframes and key milestones, as well as the metrics and indicators used to monitor progress.

Future development work in Middlesbrough might focus on revisiting these areas or reinforcing the outcomes, building on previous learning and achievements.
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1 Introduction

1.1 Durham University was commissioned by Middlesbrough Council to conduct a research project involving key actors in Middlesbrough’s health and wellbeing system. The primary aim of the project was to work with members of the Middlesbrough Health and Wellbeing Board (HWB) and its accompanying sub-structures (the four Delivery Partnerships, DPs), to examine the place of these structures in the local system and explore their ability to function more effectively and add value to efforts to improve health and wellbeing for the people of Middlesbrough. A secondary aim was to support the development of each of the fora by fostering connections between individuals and organisations, and strengthening internal relationships. The four questions addressed through this research are shown in box 1.

1.2 A key element of this project involved locating developments in Middlesbrough in a wider national context and exploring the ways in which lessons learned from previous research can be adopted to inform and strengthen the new health and wellbeing partnership system. This resulted in the production of a background paper, shown at Appendix A, which was then used to inform the development of our subsequent data collection tools.

1.3 The report is presented in four sections:
- A description of the context in which the Middlesbrough Health and Wellbeing Strategy (HWS) is being delivered, as well as lessons learned from elsewhere
- Our study design
- Our findings in relation to how key actors in the Middlesbrough health and wellbeing system see the issues
- A brief conclusion and a series of pragmatic, sustainable ways forward, drawn from practical suggestions made by the study participants.

Box 1: Research questions

1. What can be learned about what works in complex multi-agency delivery of health and social care?
2. How can learning the lessons from existing research best be communicated and adopted in practice to inform and strengthen the new health and wellbeing partnership system?
3. What is the ‘lived experience’ of different partners in the Middlesbrough health and wellbeing partnership system?
4. How can informal governance and practice, communication and behaviours support the optimal functioning of the partnership and delivery of the HWS?
2 Context and lessons learned from elsewhere

National context

2.1 The return of public health in England from the NHS to local government in 2013 has been generally welcomed in recognition, among other things, that services such as housing and education have the most significant impact on health, wellbeing and quality of life (Hunter 2003, Hunter, Marks et al. 2010, Hunter and Perkins 2014). However, this shift has taken place at a time of unprecedented financial pressures on local authorities and of changing patterns of need that demand new ways of thinking and working in how we deliver health improvement (Ham, Dixon et al. 2012, Department of Health, LGA et al. 2013).

2.2 The Health and Social Care Act 2012 placed a statutory duty on local authorities to create a Health and Wellbeing Board (HWB) as a committee of the authority. HWBs bring together partners within the NHS, public health, adult social care and children’s services, as well as elected members and representatives from Healthwatch, in an effort to ensure strategic planning based on local health needs. HWBs became fully operational statutory bodies in April 2013, after almost two years in shadow form.

2.3 Councils have statutory duties to develop Joint Strategic Needs Assessments (JSNAs) and Health and Wellbeing Strategies (HWSs) to be discharged through the HWB. These are the mechanisms by which HWBs and partners are able to jointly plan and support delivery of improvements to the health and wellbeing of local populations, although they have no powers to ensure the implementation of the HWS (Rogers 2012). The hope was that the new HWBs would take account of the lessons from previous partnerships and become different kinds of bodies able to secure sustainable change across a local area. See box 2 for a summary.

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Box 2: Lessons from existing research on partnerships

- Policies and procedures need to be more streamlined – focus on outcomes not process and structure
- Those at higher strategic levels could learn from frontline practices which operate in a more organic and integrated way
- Partnerships in practice can be rather messy constructs
- Tendency to over-engineer partnerships, often to the exclusion of being clear about purpose and achievement
- Structures are less important than relational factors such as trust and goodwill
- Importance of leadership styles – collaborative, integrative and adaptive

(Hunter and Perkins, 2014)
Previous research on HWBs

2.4 The available evidence indicates considerable heterogeneity in the configuration and operation of HWBs. A 2013 survey found that, of the 70 boards that responded, two-thirds had 12 or more members and a similar proportion had a composition beyond the core prescribed membership (Humphries and Galea 2013). An earlier survey of 50 shadow boards highlighted potential tensions between the role of HWBs in overseeing commissioning and promoting integration across sectors, along with concerns that national policy imperatives would override locally agreed priorities (Humphries, Galea et al. 2012). The biggest anticipated challenge was whether HWBs would be able to deliver strong leadership across organisational boundaries and against a backdrop of existing structures and agendas.

2.5 While the 2013 survey suggested that local authorities have met this challenge, our recent and ongoing work suggests a more mixed view (Centre for Public Policy and Health 2014, Perkins and Hunter 2014). Although HWBs are seen as offering the potential for improved decision-making, questions have been raised as to whether they offer anything new over and above previous partnership arrangements. Reviews of the Local Government Association (LGA) Health and Wellbeing System Improvement Programme have also found that HWBs need to focus more, drive delivery more effectively and address a series of challenging issues in relation to future health and social care integration (Shared Intelligence 2013, Shared Intelligence 2014).

2.6 The most up-to-date evidence – drawn from a range of sources including six in-depth case studies and telephone interviews with 16 HWB chairs and vice-chairs across England – suggests that most boards are addressing these challenges with variable success (Shared Intelligence 2015). Widespread progress is being made across some common themes: building relationships between board members; using development sessions or informal meetings to clarify priorities; developing sub-structures and working groups to support the HWB; and using the Better Care Fund (BCF) to provide a focus for their efforts. However, progress is slower than widely anticipate and many HWBs are still some way off driving the big issues. Frustration exists within and outside the boards, locally and nationally.

2.7 Recent research looking specifically at the London Councils also found that the majority of members described their HWB as being on a journey, with very few claiming that the board was fulfilling its potential (London Councils 2015). HWB chairs were found to have the single biggest influence over a board’s focus and tone, and the status of HWBs as council committees was seen as one of the main challenges. This purportedly reinforces the perception of the HWB as a ‘council thing’ and focuses attention on board meetings, rather than the role of the board as a system leader. There was some evidence of added value on specific issues, such as instigating a review of access to primary care and establishing a Black Health and Wellbeing Commission, but little evidence of HWBs providing genuine systems leadership across the piece.
2.8 Many boards are yet to position themselves as the key strategic forum for driving the health and wellbeing agenda (Shared Intelligence 2015). A number of factors that tend to sit outside the immediate control of the HWB have been cited as having an impact on progress. See figure 1 for an illustration. The challenge is to stay focused on set priorities and not try to do everything, in the face of ‘mission creep’ and increasing demands arising from national expectations and pressures (Perkins and Hunter 2014, Shared Intelligence 2014).

Figure 1: Factors impacting on the progress of HWBs (Shared Intelligence 2015, p.19)

![Brakes and Accelerators](attachment:image.png)

- Political change/instability
- Change in board leadership
- Financial pressures
- Weak performance of partners in the system
- Mission creep of national expectations
- Coterminosity with CCG and providers
- Legacy of strong partnership working across council and health
- Standing, ambition and drive of HWB chair and key board personalities

2.9 Despite the apparent lack of progress, as well as the uncertain context of the national election and any further churn, HWB members and other stakeholders remain cautiously optimistic (Shared Intelligence 2015). It is generally acknowledged that HWBs have an important role to play in creating the conditions in which discussions can take place between councils, CCGs and service providers on the future shape of local health and social care systems (London Councils 2015). The challenge now is for HWBs to regroup, build capacity and ambition, and shift the focus from transition to transformation.

2.10 The minority of HWBs identified as being ‘ahead of the curve’ are characterised by their ability to look beyond tackling immediate problems in the system and keep a focus on the bigger picture (Shared Intelligence 2015). These ‘well-performing’ boards were found to have taken a number of key steps:

- Having the difficult conversations about shifting money around
- Keeping focused on the bigger picture, i.e. beyond the BCF
- Having real clarity on ‘quick wins’, short-medium term gains, and the longer term
- Maintaining a focus on both health and wellbeing and preventative and acute care
- Ensuring all members and their component organisations are brought into and acting upon board strategy.

2.11 In London, the more effective HWBs have created forums for open and honest debate, either by ensuring board meetings are planned and managed differently to other council committee meetings or, more often, by creating alternative opportunities for members to meet in informal settings; for example, sub-groups, chair’s briefing meetings or development days (London Councils 2015). It has been suggested that small changes, such as not using council headed paper for board papers, can make a difference. All boards must be encouraged to create spaces for reflection, constructive challenge and development (Shared Intelligence 2013).

2.12 The recent work undertaken by Shared Intelligence has resulted in the production of a list of questions that boards could ask themselves in reviewing their work priorities, practices and structures (see Appendix B), as well as the identification of key features of a successful HWB:

- Evidence passion and ambition
- Enthusiasm, drive and leadership
- Demonstrates positive behaviours
- Strong foundation of partnership working
- Trust, respect and genuine collaboration
- Open to learning and challenge
- Committed to engaging with local people and communities
- Shared understanding of how the HWB fits with other structures

This list of key features is not exhaustive but it provides a useful starting point for understanding where HWBs sit on the development spectrum and could usefully be adopted as part of a refreshed self-assessment diagnostic, alongside the questions at Appendix B (Shared Intelligence 2015). Key areas to develop include creating time and space to think, establishing greater clarity of purpose, and implementing a work programme to deliver and monitor progress (Shared Intelligence 2014, London Councils 2015).

Local context

2.13 Middlesbrough is a large town with a population of around 139,000 inhabitants that is part of the Teesside conurbation in North East England. One-third of local children live in poverty and life expectancy is lower than the national average (PHE 2014). There are also significant inequalities within the town; life expectancy is 15.9 years lower for men and 10.8 years lower for women living in the most deprived areas in comparison with the most affluent areas. Local public health priorities centre on improving health outcomes for children, tackling lifestyle-related risk factors, addressing the social determinants of poor health, and improving emotional wellbeing and mental health across the life course (PHE 2014).
2.14 The Middlesbrough HWB is well established and has developed a Joint HWS for 2013-23. Delivery of the HWS is overseen through four Delivery Partnerships (DPs):

- Children and Young People’s Delivery Partnership
- Health and Social Care Delivery Partnership
- Public Health Delivery Partnership
- Wellbeing in Middlesbrough Partnership

2.15 Each DP engages with multiple organisations, projects and related strategies. This presents particular challenges, such as the need to ensure that activity is consistent with the aims of the HWS, guarding against overlapping agendas, preventing silo-working and fragmentation, and communicating within a complex, multi-agency system. The research project described in this report was commissioned in an effort to find practical, sustainable ways to overcome these challenges from within the Middlesbrough health and wellbeing system.
3 Study design

3.1 The study was informed by an action research approach and complex systems thinking, allowing us to take into account the fact that complex adaptive systems (in this case HWBs) are dynamic entities that evolve in ways that may be unforeseen and unpredictable (Pisek and Greenhalgh 2001, Savigny and Adam 2009). The design consisted of two phases:

- A desk-based scoping exercise to review the existing evidence on partnership working to achieve health and wellbeing goals
- A series of workshops and conversations with local stakeholders, to better understand the challenges, experiences and opportunities for working in partnership to deliver the Middlesbrough HWS

3.2 An interview schedule was developed for use with members of the Middlesbrough HWB, who were invited to take part in the research via an email from the Director of Public Health. Four semi-structured interviews were conducted in person (n=2) or by telephone (n=2). The job titles and host organisations of those interviewed are not detailed in this report in an effort to preserve their anonymity.

3.3 We also conducted three interactive workshops with members of three of the DPs, and observed a meeting of the fourth DP. The workshops were delivered as half-day sessions either at Durham University Queen’s Campus or another suitable venue offered by Middlesbrough Council. They were introduced with a presentation by Professor David Hunter, setting the overall context for partnership working and drawing on previous work in relation to the impact of public health partnerships in England (Hunter and Perkins 2014), which included a systematic review of the partnership literature (Smith, Bambra et al. 2009). The slides used in the presentation can be found at Appendix C.

3.4 Facilitated workshop discussions followed the principles of participatory appraisal, which is a family of approaches and methods that values people’s knowledge and experience and their ability to come up with solutions to problems that affect them (Chilvers 2008). Various activities were used to generate discussion around the opportunities and challenges presented by the new partnership structure in Middlesbrough and lessons to be taken on board from existing research. The emphasis was on creating a relaxed atmosphere and ‘safe’ environment to encourage honest dialogue and promote ownership of the discussion.

3.5 The workshops were observed and recorded in the form of detailed notes taken by the research team and collation of materials produced during the participatory appraisal activities. The conversations with HWB members were audio-recorded, with the participants’ informed consent, and transcribed verbatim. All the information gathered was examined by the team for recurring themes and key insights.
4 Workshop and interview findings

4.1 This section of our report summarises feedback from the one-to-one interviews with HWB members and interactive workshops with DP members. Our findings are illustrated using anonymised data extracts and organised within four over-arching themes:

- Political and organisational context
- Connectivity across the health and wellbeing system
- Getting the process right
- Making partnership working engaging and satisfying

4.2 Workshop participants generally valued the opportunity to come together and reflect on the ways in which their own DP operated within the wider context and in terms of how the meetings were held and managed. Some participants reportedly took their own notes of the workshops into subsequent development discussions, while others informed us that they intended to refresh their approach in the light of the discussions.

Political and organisational context

4.3 Participants spoke about the need to operate in a context of constant change, both within their own organisations and across the health and wellbeing system as a whole in Middlesbrough. One DP member noted that the ‘speed and scale of change makes it difficult to maintain consistency’ and also to plan for the future. There was a recognised need to find ways to buffer against, and withstand, the ongoing reforms and reorganisations in order to achieve impact through partnership working. This included possible future changes and disruption that were anticipated to result from the forthcoming general and local elections.

4.4 The current configuration of the HWB and DPs was seen as a pragmatic response to the need to encompass key existing organisations and interests in the health and wellbeing system. There was little appetite for the upheaval involved in re-shaping the structure and governance arrangements. However, many partners referred to the HWB as essentially ‘a sub-committee of the council’ and this perception may have implications for the way in which leadership within the structure is perceived and for how non-local authority partners engage. As one interviewee who was involved in establishing the board stated, ‘There were people on the board who couldn’t vote on a council committee issue, potentially even officers having a vote on a council committee... We’d never seen anything of the like.’

4.5 There was felt to be a lack of clarity in terms of roles, responsibilities and expected contributions from the different agencies within the Middlesbrough health and wellbeing system. The role of the local authority in particular was queried in the context of trying to do more with less resource, and the challenge of trying to reconcile a traditional ‘paternalistic’ approach with a need to reduce reliance on the system. There was also a query in relation to whether the rhetoric that ‘public health is everyone’s business’ was realistic in the current
climate. It was suggested that a selective approach (i.e. targeting particular public health issues or populations) might be more achievable, while recognising that this was not necessarily the ‘easy option’. It would also contradict policy underpinning the return of public health to local government.

4.6 An additional challenge reportedly arises from the fact that the boundaries of the various NHS organisations that serve the population of Middlesbrough are not coterminous with local authority boundaries. As a result, these organisations are represented on more than one HWB, creating perceived inefficiencies. This is illustrated by the quote shown in box 3.

4.7 These challenges are located within a wider context of austerity, which was described on the one hand as offering an opportunity to do things differently and work together in different ways. However, it was also felt to create a risk of increased insularity and people retreating into silos rather than working collaboratively.

Connectivity across the health and wellbeing system

4.8 Some uncertainty was expressed about the nature of the relationship between the HWB and the DPs, both in terms of setting priorities and reporting on performance. For example, there appeared to be a degree of tension between the DP members expecting a steer from the HWB and wanting the autonomy to choose their own priorities. There was a suggestion during one of the workshops that ‘the DPs should be driving the agenda and going to the HWB for sign-off’.

4.9 It was felt that greater attention needed to be paid to how information flows around the system, i.e. between the DPs and the HWB, between the four DPs, and between each DP and other connected actors or partnerships, such as Middlesbrough Environment City and the Integrated Social Care Partnership. The main mode of communication between the DPs and HWB is a report by exception, which ‘tends to be quite a short part of the [HWB] meeting’. The primary role of the HWB was described by one participant as ‘rubber-stamping’ the reports and proposals submitted by its members, rather than encouraging open discussion and facilitating information sharing between the various partners.

4.10 Many participants expressed concern about what they believed were overlapping agendas and the potential for duplication between different parts of the system, although they had
little opportunity to check the extent to which this was actually happening due to the lack of a central coordination function. During the workshops, participants worked in small groups to clarify the purpose of their particular DP in everyday language. The results are shown in figures 2 to 4, highlighting that there are few areas of overlap between the DPs. The two main areas of overlap are: i) bringing together diverse groups of people to coordinate actions, and ii) sharing knowledge, best practice and ‘influencing across the system’.

Figure 2: Purpose of the Health and Social Care DP

Figure 3: Purpose of the Public Health DP (group 1 and 2)
4.11 This concern about potential overlap was coupled with a sense of ‘partnership fatigue’, in terms of reportedly having to attend several meetings which involved the same people trying to address the same issues. It was suggested that partners ‘should question structures that are absorbing everyone’s time’ in order to enhance their efficiency and add value.

4.12 There was general agreement within the workshops that ‘form has to follow function’ and that partnerships should avoid becoming hung up on structures at the expense of achieving their goals. This highlighted a need to resist the urge to endlessly over-organise structures and instead focus on the ‘softer’ issues around relationship building among the partners. The structure of the Middlesbrough HWB was believed to get in the way of tapping into the people who can get things done. One participant described it as a ‘big, unwieldy structure’ and both the HWB and DPs were seen as being at risk of becoming ‘talking shops’.

4.13 There was some disagreement as to whether or not the creation of the HWB had improved relationships between key stakeholders. See the quotes in box 4 for an illustration. However, there was acceptance of the need to work together to achieve health and wellbeing goals and to continue working to join up different elements of the system.
It was suggested by one participant that partnerships should be thought of as organic entities that go through phases of growth, maturity and renewal. Others agreed that there needs to be an acceptance that many of the pitfalls of partnership working cannot be avoided and that the process of ‘continually refreshing and renewing’ should be seen as an opportunity for learning.

Getting the process right

Within each of the workshops, the discussions highlighted a need to avoid being process-driven, rather than outcomes-focused. In other words, participants recognised the HWB and DPs as being a means to an end, rather than an end in themselves. At the same time, some process objectives were felt to be necessary to ensure that they are ‘moving in the right direction’, for example, by setting realistic goals and establishing clear rules of engagement. At present there is perceived to be a danger of the DPs ‘doing very little about lots of things’, rather than having a greater impact in one or two areas.

Participants identified a need for greater coherence and a shared vision in place of what currently feels diffuse and fragmented. This was felt to involve identifying and building on common elements within the current system, such as the adoption of a life course perspective to address ‘wicked’ issues and the emphasis on tackling local health inequalities. However, one HWB member reported that, ‘we just default to health inequalities and early deaths’ in Middlesbrough and that this had resulted in people ‘confusing the role of the board with public health’, rather than focusing on the integration of health and social care.

There also exists an identified need for more conscious attention to process, as illustrated by figures 5 and 6. These H-diagrams\(^1\) were completed by the workshop participants, who did not rate themselves highly in terms of holding each other to account for progress. Participants reported that DP meetings are currently structured around lots of presentations and discussion of specific issues or projects, with limited time for open discussion. They felt that the meetings could function better by:

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Box 4: Quotes from HWB members

“I would say that the value [of the HWB] would be in we’ve got much tighter relationships now with our colleagues in health because the Board’s there. So it certainly helped, simply because we’d spent the time on relationship building and we were able to have the conversation.” (ID 4)

“I never see these people, these other people, apart from at the Health and Wellbeing Board. So you don’t get the chance to actually form any sort of relationship with them. I’m sure they do on the groups, I mean the task groups [DPs], and I’m sure the officers do, but as a member, you know, I don’t really come across the other people at all.” (ID 3)

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\(^1\)H-diagrams are a participatory appraisal tool that encourages participants to record their views in a non-threatening, open but structured way. They combine attributes of SWOT analysis with ranking exercises.
• Having shorter, more focused agendas
• Breaking into sub-groups to fully discuss meeting papers
• Being clear about the expectations of different partners
• Regularly restating the purpose of the partnership
• Agreeing milestones and accepting the need for ‘quick wins’
• Challenging and holding each other to account for actions
• Reviewing and refreshing the membership
• Investing more time and effort in relationship building

Figure 5: H-diagram – As DP members, we hold each other to account for progress

![H-diagram image]

Clarity of partnerships and governance arrangements
Pressures
Decision avoidance
Re-running decision-making based on attendance at meetings
Replicating decision-making in other forms
Organisational need
Rules of engagement – expectations, gives and gets
Clarity about what we will achieve and avoid – reflect as agenda
Shared ownership of aim 3 [of the HWS]

Making partnership working engaging and satisfying

4.18 Through the workshops and one-to-one interviews, participants demonstrated a high level of enthusiasm and commitment to health and wellbeing in Middlesbrough. It was felt that this commitment needed to be rewarded by partners believing that they are making a difference and that their contribution is connected to the whole system through effective reporting and communication structures.
4.19 The DP and HWB members expressed a need to feel that they are connected to each other and that they understand each other’s roles, organisations and objectives. At the same time, for change and innovation to occur, it was felt that there needs to be room for debate, challenge and contestation, rather than maintenance of the status quo. These issues are related in that partners who do not have good relationships are unlikely to feel comfortable enough to challenge one another.

4.20 It was felt that the various partnerships within the Middlesbrough health and wellbeing system were still evolving and that more time was needed for them to become embedded and develop trust. While there was a sense of a lack of achievement, some early successes were reported, as illustrated by the quote:

“...the Health and Wellbeing Board; it’s the bits under the Health and Wellbeing Board that have an impact. Like the work that’s been done on alcohol, the work that’s been done on smoking, I think those are definitely having an impact. [...] If you can do something about those, then you can do something about overall health. Obesity is something that we’re doing lots of work on, but that’s happening below the Health and Wellbeing Board. It’s not directly from the Health and Wellbeing Board; it’s the task-and-finish groups [DPs] doing that.” (ID 2)
shown in box 5. The workshop participants felt that these achievements need to be celebrated and promoted so that partners feel that their efforts are recognised by others.

4.21 Key drivers for ongoing partnership working in Middlesbrough were reported to include the need to make best use of limited resources and ensure that any existing improvements are sustained over the longer term. Within the current system there is a great deal of experience of working with limited resources to address complex health and social issues. One HWB member described this by saying, ‘As a town we’re doing a great job against the odds’.

4.22 Participants were keen to learn from the experiences of other HWBs and the lessons from previous research on partnerships, while appreciating that what works in other areas may not work in Middlesbrough. There was a recognised need to develop a better understanding of what can be achieved locally. The time was felt to be right to ‘draw breath, look at what we’ve learnt over the last two years’ and refresh the approach taken in Middlesbrough.
5 Conclusion and practical ways forward

5.1 The main findings arising from this research are: the importance of acknowledging the role of the political, organisational and economic context, in terms of acting as an impediment to progress; the existence of various threats and enablers to ensuring connectivity across the health and wellbeing system; the importance of getting the process right, while remaining outcomes-focused rather than process-driven; and the need to make partnership working engaging and satisfying to ensure that partners remain motivated.

5.2 The Middlesbrough health and wellbeing system is wrestling with the same issues as other similar systems across the country. The findings of this research are supported by those of previous studies, which have highlighted the difficult task faced by HWBs in bringing together many siloed agendas and organisations impacting on health and wellbeing (Humphries, Galea et al. 2012, Humphries and Galea 2013, Shared Intelligence 2015). They face complexity, competing policy and financial drivers, and the pull of different organisational priorities.

5.3 In Middlesbrough’s favour are the commitment and pragmatism of the individuals involved. The challenge revolves around how to be successful in spite of factors that mitigate against success. These require an alert and conscious approach to partnership working that includes:

- Having a strong narrative or vision from the HWB
- Being comfortable with complexity and ambiguity about responsibilities
- Focusing on a small number of things at a time
- Keeping parts of the system connected to each other through central coordination and effective communication, such as good, concise, readable briefings
- Managing DPs so that individual meetings are purposeful, engage everyone, leave room for healthy debate and hold each other to account for progress
- Recognising that people will make this work and that work therefore needs to be done to keep their energy and interest stimulated and successes acknowledged.

5.4 Limitations of this study centre on the difficulties experienced in attempting to engage some participants, particularly in the HWB member interviews. Due primarily to time constraints, we were not able to interview anyone from the NHS, social care or voluntary and community sector, and therefore the views of these sectors are not fully represented here. However, we were able to engage diverse groups of partners in the workshops, where the organisations represented included: Cleveland Police, Cleveland Fire Brigade, Healthwatch Tees, Jobcentre Plus, Middlesbrough College, Middlesbrough Environment City, Middlesbrough Voluntary Development Agency, NHS South Tees Clinical Commissioning Group (CCG) and Thirteen Group. Key strengths of the study were the levels of participation in the workshops and the
acceptance amongst partners that all was not working well and that there was room for improvement.

5.5 Participants identified a number of practical ways forward for the Middlesbrough health and wellbeing system. These suggestions can be located on a spectrum from practical, quick and easy-to-implement ideas (e.g. meet more often, break into sub-groups, good chairing, clear/structured agendas, building in learning from other local areas) to longer-term and more complicated changes (e.g. giving the HWB more powers, putting health and social care into one integrated organisation, creating a Tees Valley-wide HWB or combined authority). It is the responsibility of partners to consider these ideas and discuss their feasibility and suitability in the Middlesbrough context.

5.6 In the short term, it will be important to review the existing partnership structures and ensure that there is clarity with regards to the purpose of each structure and the expectations of different partners. Participants in the DP workshops suggested that membership should be reviewed and refreshed on a regular basis, to ensure that the right people are around the table in terms of being able to implement any actions agreed.

5.7 There should be sufficient central coordination and support to ensure that partners in the system can see how their contribution relates to the overall successes of the HWB, to reduce the potential for overlap and duplication, and to facilitate reporting between parts of the system as necessary.

5.8 A key issue to arise from this research is that much of the ‘real work’ is seen as going on elsewhere, in terms of a range of other partnerships, agencies and services doing the ‘hands on’ work to improve health and wellbeing in Middlesbrough. The focus for the DPs should be on areas of joint working, rather than on discussing work that proceeds in separate silos. Another issue involves the sharing of good quality data, which underpins successful joint working. There is a need to devise and agree local data sharing arrangements to ensure that the HWB and DPs have access to the evidence needed to inform their work.

5.9 The HWB and DPs need to spend time on action planning to achieve real clarity in terms of their short-, medium- and longer-term outcomes. There needs to be agreement on timeframes and key milestones, as well as the metrics and indicators used to monitor progress. Establishing a set of focused action plans and performance measures is one of the key activities identified in previous work, in the context of areas still requiring attention by many HWBs (Shared Intelligence 2015). See Appendix D for details. Future development work in Middlesbrough might focus on revisiting these areas or reinforcing the outcomes, building on previous learning and achievements rather than starting afresh.
6 Post-script

6.1 The research findings and practical ways forward were used to structure a development session on 22nd April 2015 involving members of the Middlesbrough HWB. In his introduction, the Director of Public Health (DPH) for Middlesbrough, Edward Kunonga, set out ‘the story so far’ and emphasised that this was a chance to take stock after two years in operation. There have been a number of achievements, such as the successful transition of public health from the NHS, development of the JHWS and DPH annual report, delivery of a local employability conference, and refresh of the pharmaceutical needs assessment. It was recognised that it is now time to shift from a focus on processes to outcomes, and ask the question of whether the HWB is making a difference in Middlesbrough.

6.2 Professor Hunter presented a summary of our research findings, along with the findings from the national work by Shared Intelligence and lessons from previous research on public health partnerships. Feedback from the audience suggested that there were no surprises in either the presentation or our report. At one level this provided welcome reassurance that Middlesbrough was not an outlier and that its experience was typical of the majority of places featured in the other studies. It also confirmed what the key issues were in need of attention. The main challenge remains a question of how to achieve a balance between localism and effective change, in terms of improving health and wellbeing both in Middlesbrough and across the bigger footprint of many HWB partners. The HWB must acknowledge and work within the structures, systems and wider remits of these organisations, without being distracted by the different drivers and challenges.

6.3 There was a suggestion that the biggest impact could be achieved from focusing on a specific task or issue, starting with grassroots work and building up. It was felt that HWB structures sometimes ‘get in the way’ and that members should instead focus on work at the local level, acknowledging the need to be clear about precisely what ‘local’ means in this context. The focus on smaller-scale projects would help to address the lack of capacity in terms of central coordination of the HWB. However, ensuring that this work is ‘bottom up’ as opposed to communities feeling that things are being ‘done to them’ remains a challenge.

6.4 There was a sense of frustration that current governance structures prevent the HWB from being action-oriented and undertaking genuine joint planning, leading one participant to describe the current design as ‘counter-productive’. There exists the potential for non-council partners to feel disenfranchised, but it was felt that this has not happened in Middlesbrough because of the strong relationships between board members. One radical solution proposed by participants involved setting up the HWB as a separate entity, with partners contributing the financial and human resources necessary to fund its operation.

6.5 Following on from the plenary session, participants divided into three groups to discuss key issues arising from the research: data sharing, coordination of the HWB, and the status of
the board as a council committee. Each group separately raised the issue of the need to focus on specific issues and projects. The data sharing group suggested building on the work with schools and the Troubled Families programme, although it was recognised that working with adult service users can be more complicated. Partners often ‘have the bits of the jigsaw but no mechanism to bring these together’ and, as a result, the HWB is ‘data rich but intelligence poor’. The challenge is to seek agreement from people to share their data before they become service users, which may require reconfiguration of services, increased use of honorary contracts, and adoption of an ‘opt out’ rather than ‘opt in’ approach. The ability to share data across the Middlesbrough health and wellbeing system was seen as central to the delivery of a more integrated, efficient and cost-effective offer.

6.6 Coordination of the HWB and DPs requires a dedicated team that is properly resourced by the various partner organisations, yet much of the burden currently falls on Middlesbrough Council. It was suggested that partners need ‘to invest to save’ and that this investment includes time; quarterly HWB meetings were felt to be insufficient for an organisation of this size. The coordination group discussed the need to make better use of electronic systems, rather than relying on particular individuals, and also redesigning the website to highlight work from each DP as well as links to partner organisations. This could help to bring the DPs together to avoid overlap and address the perceived lack of public recognition for the HWB.

6.7 The third group highlighted the need to review and refresh membership of the board, and promote wider involvement in agenda setting. Partners are not being asked to commit anything at present. There was a perception that the HWB is ‘too polite’ and that members should have the confidence and trust to hold each other to account through constructive and honest conversations. The board exists to provide leadership and challenge, setting the tone and empowering others. It represents an opportunity to bring leaders together to ‘oil the wheels’ and help to overcome bureaucracy, ‘unblocking blockages’ for the DPs wherever possible. However, the group questioned whether DPs are the right mechanism, particularly where initiatives are geographical or thematic, and suggested that there might also be a need for short-term task-and-finish groups. The board has a key role to play in identifying ‘game changers’, i.e. initiatives that will improve the health of local residents, to be taken forward by these other groups.

6.8 Immediate priorities for the Middlesbrough HWB include reviewing the existing partnership structure, as well as the frequency and format of board meetings, to address issues raised during the research. The board and DPs should also consider developing and implementing a number of bespoke projects focusing on genuine areas of joint working to achieve health and wellbeing outcomes. Longer-term priorities include ensuring the appropriate infrastructure is in place to support the board and delivery of its actions, and making best use of electronic systems to enhance communication between HWB members and also with the public.
Appendices

Appendix A: Background paper

Introduction

Researchers at Durham University have been commissioned to work with individuals and agencies engaged in the delivery of Middlesbrough’s HWS in order to maximise the impact of partnership working within a highly complex multi-agency health and social care system. A key element of the project involves exploring the ways in which lessons learned from previous research on public health partnerships can be adopted to inform and strengthen the new health and wellbeing partnership system in Middlesbrough. A desk-based exercise has been conducted to review existing evidence — including grey literature and expert opinion — on examples of partnership working to achieve health and wellbeing goals. This exercise followed Government Social Research guidelines on conducting rapid evidence assessments (REAs), which provide an assessment of what is already known about a policy or practice issue, using systematic methods to locate and critically appraise relevant evidence (Civil Service year unknown). Searches were conducted via Web of Science, Google Scholar and Google, using terms such as ‘Health and Wellbeing Board, ‘partnership working’, ‘public health’ and ‘health improvement’. Evidence was also gathered via the researchers’ existing networks. This exercise has culminated in the production of this background paper and related materials for use in subsequent phases of the action research project (i.e. participatory workshops and interviews).

Core functions of HWBs

Much of the literature published to date on the subject of HWBs is descriptive rather than evaluative, which is unsurprising given that they are new bodies that have only formally been in existence since April 2013. HWBs will act as the main strategic vehicle to achieve integrated working between commissioners and providers, with the expectation that fulfilling this remit will lead to better outcomes for service users and local communities (Staite and Miller 2011, Humphries and Galea 2013). See figure 1 for an overview of their core functions. The fact that HWBs have some statutory duties but no statutory powers suggests that their role is a ‘soft’ one, as brokers, enablers and catalysts for change (Miller, Glasby et al. 2010). HWBs have a duty to produce a JSNA (previously conducted by NHS Primary Care Trusts), which in some areas — such as the Wirral — includes a Joint Strategic Assets Assessment, reflecting a growing interest in capturing community assets as well as deficits (Foot and Hopkins 2010, Boardman and Friedli 2013). The process of completing the JSNA and developing their HWS, if done well, necessitates wide engagement with users and other stakeholder groups, both via their local HealthWatch and directly. It also requires HWBs to have a good grasp of how the whole health and social care system and the connected economy currently operate (Staite and Miller 2011). The choice of priorities should be based on evidence both of need and what works, and therefore HWBs require the knowledge and skills to balance conflicting demand and understand conflicting evidence. A recent study conducted by a team of researchers from the North East examined a random sample of one-third of HWSs produced by upper tier local
authorities in England (n=47) and found that, most often, ‘evidence’ was used to mean ‘evidence of need’ (Beenstock, Sowden et al. 2014). This was usually identified through the JSNA and appeared to be locally gathered intelligence, rather than from a national source of research evidence or intelligence. Most HWSs referred to JSNAs, with some making explicit links between their JSNA and HWS. However, two strategies did not make any reference to their JSNAs.

**Figure 1: Health and Wellbeing Boards at a glance (taken from Humphries and Galea 2013)**

Similar studies have been undertaken by researchers linked to the Terrence Higgins Trust and the Campaign to End Loneliness. The former involved analysis of JSNAs and draft or final HWSs produced by 35 local authorities identified as having relatively high levels of HIV diagnosis and high levels of late diagnosis (Evans, Moss et al. 2013). Only 34% prioritised HIV in both documents and just over half of HWSs did not included HIV as a priority, despite 83% of JSNAs recommending HIV priority actions. There were some exceptions; for example, the JSNA for Merton included extensive analysis of epidemiological and demographic data, and showed a comprehensive understanding that prevention efforts can be targeted to those most at risk. Research conducted as part of the Campaign to End Loneliness involved analysing and ranking HWSs, as well as conducting telephone interviews with strategy authors or lead officers (Cupitt 2013). Around half of the HWSs located (n=61 of 128) mentioned loneliness, but only eight were deemed to be ‘gold-rated’, i.e. containing measurable actions and/or targets on reducing loneliness either in older age or for the whole population. This is in spite of the Campaign to End Loneliness working to influence HWBs through their ‘Loneliness Harms Health’ campaign, which set out to get HWBs to measure loneliness in JSNAs and commit to taking action to reduce loneliness in older people in their HWSs. These studies and others (e.g. Diabetes UK and Novo Nordisk 2013, Scrutton 2013) demonstrate that HWSs’ content is variable in terms of the links made to evidence from JSNAs and other sources.
A number of HWBs are using policy objectives from the Marmot Review to drive their HWSs and to ensure a focus on health inequalities and the wider determinants of health (Boardman and Friedli 2013, Humphries and Galea 2013). The study by Beenstock et al (2014) found that the Marmot Report was the most referred to national source of evidence, being cited as justification for proposals in 19 of the 47 strategies. This finding is reinforced by ongoing work being undertaken locally by Alyson Learmonth, a former director of public health for Gateshead. Learmonth conducted a review of the 12 North East HWSs in order to establish current practice, build on strengths and identify areas where development may be useful, with a particular focus on issues of inequalities, place-shaping and wellbeing. Marmot’s strategic priorities are referenced by six local authorities (Darlington, Newcastle, Middlesbrough, North Tyneside, South Tyneside and Sunderland). In addition, Hartlepool, Middlesbrough and Stockton have used them to frame their entire HWSs, with Stockton providing “a particularly clear summary of evidence-based practice related to each of the six priorities”. Additional strengths of the local HWSs are as follows:

- Focusing on the whole system rather than a narrow view of health
- Shifting the centre of gravity of spend
- Increased coverage of wellbeing and place-shaping
- Setting out practical steps to achieve local health improvement

There is considerable consensus across the North East in terms of the top priority issues identified by the 12 HWBs in their HWSs. The main priorities locally are ‘children to have the best start in life’ (12/12) and ‘early death/life expectancy/inequalities’ (11/12).

Composition and configuration

Findings from previous and ongoing studies indicate considerable heterogeneity in the configuration and operation of HWBs. A survey conducted by the King’s Fund found that, of the 70 boards that responded, two-thirds had 12 or more members and a similar proportion had a composition beyond the core membership prescribed in the Health and Social Care Act (Humphries and Galea 2013). See figure 2 below for an illustration, with the size of the text corresponding to the frequency with which these stakeholders were mentioned. The survey found that local authorities have shown strong leadership in establishing the boards, with most being chaired by a senior elected member, and nearly all have produced JSNAs and HWSs. An earlier survey of 50 shadow boards highlighted potential tensions between the role of HWBs in overseeing commissioning and promoting integration across sectors, along with concerns that national policy imperatives would override locally agreed priorities (Humphries, Galae et al. 2012). The biggest anticipated challenge was whether HWBs would be able to deliver strong leadership across organisational boundaries and against a backdrop of existing structures and agendas. Although the more recent survey indicated that local authorities have met this challenge – with most HWBs (83%) being chaired by a senior elected member – our ongoing work suggests a more mixed view. Preliminary analyses from a national study on prioritising investment in public health suggest that, although HWBs are seen as offering the potential for a more holistic and joined-up approach to decision-making, questions have

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2 This information is taken from a draft report discussed at the Fuse (UK Centre for Translational Research in Public Health) members meeting, September 2014. A detailed report is being prepared for publication.

3 Ibid.
been raised as to whether they offer anything new (Centre for Public Policy and Health 2014). This study has also identified perceived tensions around provider membership of the boards.

Figure 2: Non-prescribed HWB members (taken from Humphries and Galea 2013)

Although the King’s Fund surveys indicate some improvement over time, there remain national differences in the level of engagement between HWBs and the providers who serve their communities (Humphries, Galea et al. 2012, Humphries and Galea 2013). This is associated with the ‘hard’ elements of the board’s role, in terms of commissioners having to make difficult decisions about their priorities and potentially cutting or withdrawing funding from some providers (Staite and Miller 2011). These decisions will also be implemented through contracting processes, which will include performance management of providers, thereby creating serious consequences for partnership relationships between commissioners and providers on the HWB. Regardless, there is a push for these relationships to expand, as illustrated by the following extract taken from a letter to local authority Chief Executives (and copied to CCG Chairs) from the Secretary of State for Health:

‘Boards and providers must be positively engaged in the local decision making process, and it is the responsibility of all parties to ensure that engagement is effective, timely and meaningful. I would therefore urge Boards that do not include providers to reconsider this position, or at least to consider their current engagements, and assure themselves that the right structures and relationships are in place.’ (Letter from Jeremy Hunt, October 2014)

Formal board meetings are not the only way in which key stakeholders may be involved in the decision-making process. Responses to the 2013 King’s Fund survey demonstrate that the main ways in which engagement tends to occurs is though partnership groups, provider forums and specific workshops where priorities are discussed (Humphries and Galea 2013). A number of localities have implemented wider partnerships for wellbeing that include a range of local providers, community and voluntary agencies, and representatives of local communities (Boardman and Friedli 2013). For example, North Yorkshire County Council describes their new arrangements as follows:
“The [health and wellbeing] board will give communities a greater say in the services needed to provide care for local people and to tackle the wider influences on health, such as education, transport, housing, employment and leisure services. The board will have two “doing arms” to drive forward its day to day work. These will be North Yorkshire’s Children’s Trust and North Yorkshire’s Adult Partnership Trust (involving representation from acute hospital trusts, mental health trusts, the voluntary sector and care sector etc).”

(North Yorkshire Partnerships: http://www.nypartnerships.org.uk/)

Opportunities and challenges

There remains a great deal of optimism around the potential for HWBs to achieve health improvement through the integration of public health with health and social care, and through the development of place-based approaches to health improvement (Boardman and Friedli 2013, Colin-Thome and Fisher 2013). This integration also poses a tension and a challenge, due to the risk of public health being eclipsed by the focus on social care where the political interest is nationally and where there are resources through the Better Care Fund (Perkins and Hunter 2014). However, HWBs have the potential to influence commissioning in a way that promotes and protects wellbeing for people in local communities, by synchronising the efforts of local authorities, NHS providers, voluntary groups, schools and other organisations. Individually-focused approaches to lifestyle change (e.g. smoking cessation and weight management) could be combined with social approaches that build on the strengths within communities (i.e. asset-based community development) (Colin-Thome and Fisher 2013). There is a danger that HWBs become expensive ‘talking shops’ rather than system leaders and that failure will result from a narrow focus on a small number of clinically-driven priorities. At the same time, they have the potential to take on a wider role and create the conditions required for producing better health at lower cost, as set out in Wanless’s vision of a ‘fully engaged scenario’ (Wanless 2004). A study consisting of a systematic review and case studies conducted across England revealed a range of issues concerning partnerships and their operation in the public health sphere (Smith, Bambra et al. 2009, Hunter, Perkins et al. 2011). See figure 3 below.

Although a succession of policy initiatives has promoted partnership working, the literature highlights a lack of evidence to support the effectiveness of partnerships for health improvement (Hunter, Perkins et al. 2011, Hunter and Perkins 2012). Existing power relationships tend to be left intact, with partnerships usually dominated by the more powerful partners and failing to ‘deliver’ for others (Balloch and Taylor 2001, Secker and Hill 2001, Hunter and Perkins 2014). This risk exists for HWBs, along with the risk of failure to achieve a shared vision, reluctance or inability to share information, and a lack of effective leadership across boundaries. Professional structures and diverse, inconsistent policy imperatives at the institutional level pose challenges for the realisation of objectives for integrated working across boundaries (Currie, Finn et al. 2008, Finn, Currie et al. 2010). In recent years there has been a ‘backlash’ against the ill-defined concept of partnership that has been seen as a solution to all problems, with little evidence of concrete outcomes (Kingsnorth 2013). On the other hand, partnerships remain a potentially powerful way of increasing accountability and inclusivity, and addressing the kinds of ‘wicked issues’ that single organisations cannot resolve by themselves, such as health inequalities (Wildridge, Childs et al. 2004, Hunter, Marks et al. 2010, South, Hunter et al. 2014). Distributed leadership and effective knowledge...
exchange for informed decision-making are crucial for integration, and are shaped by the institutional environment and local organisational conditions (Currie and Lockett 2011, Currie and White 2012). The challenge for HWBs is to find ways to work with the multiple institutional, policy and cultural factors that both threaten their success but which may also secure it if effective working practices can be established and sustained.

**Figure 3: Factors influencing partnerships in public health**

<table>
<thead>
<tr>
<th>Determinants of successful partnerships</th>
<th>Barriers to effective partnership working</th>
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<tbody>
<tr>
<td>Clarity regarding the goals and objectives of the partnership</td>
<td>Conflicting agency priorities negate or limit the potential of the partnership</td>
</tr>
<tr>
<td>Clarity regarding roles and responsibilities within the partnership</td>
<td>Good information-sharing protocols not in place</td>
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<tr>
<td>A clear strategic overview of performance through robust monitoring and evaluation</td>
<td>Lacking vertical as well as horizontal linkages, i.e. absence of ownership</td>
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<tr>
<td>The existence of goodwill and trust between partners, particularly at the frontline level</td>
<td>Bureaucracy, making it easy to get ‘bogged down’ with process issues</td>
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<tr>
<td></td>
<td>Too many initiatives, targets, policies and reorganisations from central government</td>
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</table>

A qualitative study conducted in one London borough set out to explore the transfer of public health responsibilities to local authorities and the implications for health and wellbeing through partnership working (Kingsnorth 2013). The HWB was seen by interviewees as central to ensuring commitment to and delivery of a partnership approach to health and wellbeing, but there was some uncertainty as to whether it was developing with an appropriately broad understanding of health and wellbeing. There remains a general risk that HWBs could become preoccupied by the integrated care agenda and therefore their impact on public health could be lost. There were also felt to be challenges posed by the fact that elements of the public health skill set are defined through clinical competencies, whereas the local government skill set is defined through management competencies. In the past, clinical expertise has tended to be more highly prized, making equality in partnerships difficult, yet the potential dilution of medical skill could affect relationships between the public health team and clinical commissioners. There was a general consensus that a gap existed in the political awareness of the public health team. These findings highlight the importance of trust and relational factors being more important than structures and processes, as demonstrated in previous research on partnerships in public health (Hunter and Perkins 2012, Perkins and Hunter 2014). The HWB needs to be at the centre of wider engagement with a range of stakeholders about the local vision for health and wellbeing. Guidance produced by the Local Government Association emphasises the importance of HWBs being agents of change and having clear strategies for communication and engagement with a range of stakeholders, including the public (LGA 2013).

**Conclusion**

Six lessons can be drawn from the existing research on partnerships (Hunter and Perkins 2012):
i. Policies and procedures need to be more streamlined, with an emphasis on outcomes rather than simply expending energy and effort on process and structure;

ii. Those operating at higher strategic levels could learn from frontline practices which operate in a more organic and integrated way;

iii. Partnerships in practice tend to be rather messy constructs with no clear causal relationship between what they do and what partnership organisations achieve by way of outcomes;

iv. There is a powerful tendency to over-engineer partnerships, often to the exclusion of being clear about purpose and achievement;

v. Structures are less important than relational factors such as trust and goodwill;

vi. The importance of leadership, particularly collaborative, integrative and adaptive leadership as a means of nurturing joined-up working, should be emphasised.

Partnership working to achieve health and wellbeing goals is destined to become more complex and challenging in future, in light of a greater emphasis on competition and diversity of provision (Hunter, Perkins et al. 2011). Experiments with different forms of partnership – including HWBs – which rely less on formal structures and more on what appears necessary to tackle complex public health challenges should be encouraged and evaluated appropriately. A number of relevant studies and national evaluations are underway. These include: an NIHR School for Public Health Research project on prioritising investment in public health (lead: Hunter, Durham); a project funded by the Department of Health (DoH) Policy Research Unit in Commissioning and the Healthcare System (PRUComm) on commissioning for health and wellbeing (lead: Peckham, Kent, with Hunter as an advisor); a DoH Policy Research Programme (PRP) project evaluating the role of HWBs (lead: Hunter, Durham, with Visram as a co-applicant); and a second DoH PRP study on commissioning public health services (lead: Marks, Durham, with Hunter and Visram as co-applicants). We anticipate that the various projects will act as mutually informative pieces in the evidence jigsaw on the impact of the health reforms in England.
Appendix B: Questions for HWBs to consider

Reproduced from the Shared Intelligence ‘Great Expectations’ report (2014), Appendix I:

- Have you reviewed the fundamental purpose of your board and are its membership, sub-structures and ways of working fit for that purpose?

- Is the board playing a leadership and oversight role in relation to the big issues, notably health and social care integration and the reconfiguration of health care services?

- Do you need to improve engagement with key stakeholder who are not directly represented on the board, including: major providers, district councils and locality/neighborhood structures?

- Is there a need to streamline the partnership structures in your area?

- Are you considering what action may be appropriate at a sub-regional level?

- Are you using the evidence available to you in the most effective way to set priorities, drive change and monitor progress?

- Are you giving due weight to qualitative evidence such as the personal stories of board members and the user, patient, carer and community voice?

- Do all councillors and GPs in your area have a shared understanding of the communities they serve and their roles in meeting local needs?

- Do you have a good understanding of the constraints and opportunities facing the major organisations in the health and social care system?

- Is the board in control of its agenda and work programme?

- Does the board have appropriate business and policy support?

- Do you have an appropriate mix of formal and informal meetings?

- Do you have the opportunity to think and reflect as a board and to explore questions such of those set out above?

- Are you applying lessons from other major change processes in your area?
Appendix C: Presentation by Professor Hunter

Strictly Come Partnering: What does the research tell us?

Presented by David Hunter
Professor of Health Policy and Management
12th January 2015

The Appeal of Partnerships

‘Like ‘community’, partnership is a word of obvious virtue (what sensible person would choose conflict over collaboration).’


Limits to Partnerships

‘The indefinable in pursuit of the unachievable.’


Why Partnerships?

- ‘Wicked problems’ evident in public health
- Complex systems: cross-cutting, multi-sectoral, multiple stakeholders
- Reduce fragmentation
- Access new resources, sharing expertise

Are Partnerships Always ‘a Good Thing’?

- May lead to fragmentation of structures and processes
- May blur responsibilities and accountabilities
- Fear of loss of control over policy-making

Benefits of Partnerships

- Sharing information and best practice
- Sharing roles and responsibilities
- Pooling different agency perspectives and resources
- Realising economies of scale; shared services
Challenges facing Partnerships
- Getting partners to agree on priorities for action
- Keeping partners actively involved
- Avoiding the partnership from becoming a ‘talking shop’
- Avoiding ‘partnership overload’

Why Partnerships Fail
- Conflict about goals and objectives
- Philosophical differences among partners
- High transaction costs – building trust and consensus take time
- Weak accountability among partners for success or failure
- Pull of policy and structural silos
- Tribalism and territorialism – partnerships seen as detracting from mainstream initiatives

Why Partnerships Succeed (1)
- Shared vision
- Realistic goals and objectives
- Resist over-engineering structures
- Invest in relationship development
- Ability to have honest dialogue

Why Partnerships Succeed (2)
- Optimum number and mix of members
- Importance of ‘boundary spanners’
- Collaborative leadership style
- Joint ownership of decisions and collective responsibility
- Focus on outcomes

Six Lessons from Existing Research on Partnerships
- Policies and procedures need to be more streamlined – focus on outcomes not process and structure
- Those at higher strategic levels could learn from frontline practices which operate in a more organic and integrated way
- Partnerships in practice can be rather messy constructs
- Tendency to over-engineer partnerships, often to the exclusion of being clear about purpose and achievement
- Structures are less important than relational factors such as trust and goodwill
- Importance of leadership styles – collaborative, integrative and adaptive

Leadership in Partnership
- Leaders provide space, encouragement and support - not solutions
- Leaders in partnerships are not necessarily the ‘bosses’
- The influence of leadership is crucial, and is complex:
  - Positional
  - Knowledge and understanding
  - Personal
  - Networked
Leading with different sources of authority

New World of Health and Wellbeing: People and Place-shaping

- Health in All Policies (HiAP)
- Influencing the wider determinants of health
- Whole-of-government and whole-of-society approaches
- Importance of whole system leadership and ‘soft power’

Questions to Consider in Moving Forward

- How do you avoid an over-reliance on partnership structures?
- How is a shared vision for health and wellbeing to be defined and agreed?
- How can time and space be created to discuss shared learning regarding behaviours that support partnerships?
- How do we avoid the pitfalls of partnership working?

Thank You!
Appendix D: Four areas requiring attention by HWBs

Reproduced from the Shared Intelligence ‘Stick with it!’ report (2015), p.20:

<table>
<thead>
<tr>
<th>Areas requiring attention</th>
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<tbody>
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<td><strong>Ensuring clarity of purpose</strong></td>
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<tr>
<td>• Establishing the board as the primary strategic forum for driving change</td>
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<tr>
<td>• Reviewing positioning in relation to wider partnership structures</td>
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<td>• Sharpening priorities and agreeing big ticket items</td>
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<td>• Ensuring alignment with other relevant strategies and plans</td>
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<tr>
<td><strong>Building model of shared leadership within board</strong></td>
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<tr>
<td>• Developing skills and confidence of all board members</td>
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<tr>
<td>• Ensuring parity between board members – not about ‘posturing’ between health and local government, not a council ‘piece of kit’</td>
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<tr>
<td>• Understanding each other’s needs and constraints</td>
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<tr>
<td><strong>Working with key partners to develop systems leadership role</strong></td>
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<tr>
<td>• Understanding what only the board as a collective can do, not its individual component parts</td>
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<tr>
<td>• Considering how to proactively engage providers and to be relevant to them</td>
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<tr>
<td>• Being ambitious and visible</td>
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<tr>
<td>• Recognising the board is not providing a scrutiny function</td>
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<tr>
<td><strong>Ensuring delivery and impact</strong></td>
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<tr>
<td>• Ensuring board agenda focuses on the delivery of key priorities</td>
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<tr>
<td>• Establishing a set a focused action plans and performance measures</td>
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<tr>
<td>• Ensuring discipline to stick with priorities</td>
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<tr>
<td>• Making smarter use of data and evidence to monitor impact</td>
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<tr>
<td>• Maximising formal board meetings and making better use of time between board meetings</td>
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<tr>
<td>• <strong>Ensuring officer support structure is robust to support the board and drive performance</strong></td>
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References


