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Health and wellbeing boards: public health decision making bodies or political pawns?

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ABSTRACT

Objectives: Health and Wellbeing boards in England are uniquely constituted; embedded in the local authorities with membership drawn from a range of stakeholders and partner organizations. This raises the question of how decision making functions of the boards reflects wider public health decision making, if criteria are applied to decision making, and what prioritization processes, if any, are used.

Methods: Qualitative research methods were employed and five local boards were approached, interview dyads were conducted with the boards Chair and Director of Public Health across four of these ($n = 4$). Three questions were addressed: how are decisions made? What are the criteria applied to decision making? And how are criteria then prioritized? A thematic approach was used to analyse data identifying codes and extracting key themes.

Results: Equity, effectiveness and consistency with strategies of board and partners were most consistently identified by participants as criteria influencing decisions. Prioritization was described as an engaged and collaborative process, but criteria were not explicitly referenced in the decision making of the boards which instead made unstructured prioritization of population sub-groups or interventions agreed by consensus.

Conclusions: Criteria identified are broadly consistent with those used in wider public health practice but additionally incorporated criteria which recognizes the political siting of the boards. The study explored the variety in different board's approaches to prioritization and identified a lack of clarity and rigour in the identification and use of criteria in prioritization processes. Decision making may benefit from the explicit inclusion of criteria in the prioritization process.

Introduction

Public health seeks the furtherance and improvement of the population's health. At a local level, in England, this responsibility falls to Local Authorities, through the work of Public Health departments working with the support of stakeholders through the Health and Wellbeing boards (HWB).[1]

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By seeking to understand if and how criteria are used in decision making of HWBs and the way in which prioritization occurs this study will be of interest to those working in and with local authority public health departments and the HWBs.

The enactment of the Health and Social Care Act in 2012, substantially changed the national health architecture from a system where oversight flowed from the Department of Health, to ten regional level strategic health authorities, to 152 primary care trusts (PCTs) who held commissioning budget and used this to fund primary and secondary care and public health. The new structures are more complex and a diagram is included at Annex 1, national public health spending is managed by 'Public health England' while control of local spending transitioned from PCTs to local authorities.[2] Alongside, HWBs were established as committees of local government; there are over 130 boards.[1,3,4]

Core membership of the Health and Wellbeing board as determined by the 2012 Act:

- At least one councillor from the relevant council
- The Director of Adult Social Services
- The Director of Children's Services
- The Director of Public Health
- A representative of the Healthwatch
- A representative of each relevant Clinical Commissioning Group (1)

In addition to core membership, the act allows for inclusion of any other members that the board may consider appropriate, meaning that membership can vary significantly between councils, and that each board is unique in its make-up.[1]

Committees of local government are ordinarily regulated under the Local Government Act 1972, yet those who sit as members of the HWBs are uniquely diverse, many of whom not being subject to, or bound by legislation that binds elected members and officers of local government.[5,6] To resolve this, the 2012 Act permits circumvention of much of the legislation that ordinarily applies to committees of the Local Authority.[1,6,7] The new HWBs are therefore constitutionally and organizationally unique.

Indeed, whilst others have noted that this is likely to influence how decisions are made, it has not yet been fully explored as to how participants understand the decision making to take place.[8]

Such a move occurring at a time of austerity when local authorities are facing unprecedented cuts presents key challenges to the core aims of public health, best articulated in the overarching vision outlined in Public Health Outcomes Framework:

Outcome 1: Increased healthy life expectancy.

Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities.[9]

Whilst the establishment of such diverse HWBs created an opportunity for public health to shape and influence in a manner potentially more far reaching than before, it also posed challenges. The creation of an integrated and shared agenda on these boards could allow for public health priorities to be shared and for wider support and investment in criteria valued by public health. However, it also opens up challenge from the priorities of others. Both the local priorities of councils and councillors must be accounted for, alongside the challenge of meeting the centrally determined goals of the health sector, as well as meeting the needs of other parties represented on the boards. Thus, it is interesting to explore if HWBs are subject to and hampered by the political priorities of their stakeholder members or if they can succeed as effective public health decision making bodies.

This research therefore seeks to answer three questions:

In the new Health and Wellbeing boards how are decisions made?

What are the criteria that underpin decision making?

How are identified criteria prioritized?

As relatively new bodies, formed with the enactment of the Health and Social Care Act in 2012, there is still limited research into the way in which decisions are reached and priorities set within these boards.[8] A focus on criteria was selected firstly on the perspective that every decision is made in the light of some standard of judgement, and this is most often expressed in the form of criteria, which reflect the values and preferences of the decision maker.[10] And secondly, experts in decision making have indicated that explicit awareness of criteria can improve the quality of decision making.[11] Criteria are defined here as attributes which are explicit, well defined, mutually exclusive and collectively exhaustive.[12,13]

Methods

Search of the literature identified three studies exploring public health decision making criteria, one of which additionally addresses prioritization (Table 1).[12,14,15] Details of the search strategy used are contained in Annex 2.

From the three papers identified a number of key themes emerged. First, the use of criteria in public health decision making lends merit to the process, increasing transparency and accountability, and facilitating the prioritization process; it is a means of ensuring that the decisions made by the new HWBs will bring the greatest benefit to the populations that they serve.[12,14] By explicitly identifying criteria such as cost, effectiveness or evidence in the decision making arena, their incorporation into the final decision is guaranteed.

In order for criteria to be used effectively they must be clearly defined, with input from all stakeholders in their determination and whilst there is no ideal number, the list must be limited so as to maintain clarity and prevent overlap.[12,14] Having done this, an agreed set of standards or criteria to guide decision making allows consensus to be more readily