Centre for
Mental Health

A place for parity

Health and wellbeing boards and mental health

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Executive summary

Health and wellbeing boards bring together local authorities and health and care system leaders to improve the health and wellbeing of their local populations. Boards are tasked with identifying key health needs in their area through a joint strategic needs sssessment (JSNA) and with setting priorities for addressing these through a joint health and wellbeing strategy (JHWS).

We carried out a systematic review of 100 strategies and interviewed members of ten health and wellbeing boards to find out how far they have included mental health issues as a priority and what they have focused upon.

We found that:

91% of strategies aim to tackle at least one mental health issue.

The most commonly prioritised area of mental health was the needs of children and young people (in 55% of strategies)

Some vulnerable groups were under-represented or left out: for example only 5% of strategies addressed the mental health needs of homeless people

The majority of boards prioritised alcohol and smoking but few made the links with mental health.

In consequence, many strategies have not met the government's recent commitment to achieve parity of esteem between mental and physical health.

We identified some of the factors that can help or hinder the level of priority given to mental health in the strategies:

Boards run the risk of overlooking mental health in their strategies where they rely excessively on their needs assessments when setting their priorities.

Some boards have used their strategies to identify gaps in mental health support and aim to tackle them in new ways; others regard them solely as a 'framework' for mental health strategies already under way in their area.

Bringing on a few, select non-statutory members helps boards to better fulfill their strategic role, and can lead to a greater, better informed mental health focus.

Bringing on a mental health 'champion' can considerably benefit the mental health element of the strategy and help to ensure parity of esteem between physical and mental health.

Clinical commissioning groups (CCGs) are not always properly referring to their local strategies in their commissioning plans, and are instead setting their own priorities.

91% of strategies aim to tackle at least one mental health issue

46% of strategies include priorities focused on improving access to mental health services

19% of strategies include priorities dealing with alcohol or smoking and mental health

55% of strategies include children's mental health within their priorities.

41% of strategies include priorities dealing with employment and mental health

5% of strategies address the mental health needs of homeless people

Recommendations for boards

We make four recommendations to boards to help ensure that mental health receives the appropriate focus:

Boards should be aware of the limitations of their needs assessment, and actively consult with mental health service users, carers and professionals, to ensure their views are fully taken into account when setting local priorities.

Boards should use their strategy to highlight the mental health 'gaps' in their area and to try and tackle them differently, instead of using it purely as framework for strategies already underway.

Boards should consider how their membership reflects their local community and ensure parity of esteem between physical and mental health, by designating a mental health champion or by recruiting non-statutory members to the board, for example.

Boards should ensure that their CCGs are properly engaging with the strategy when devising their own commissioning plans, and hold them to account if this is not the case.

Recommendations for mental health organisations

This paper makes three recommendations for mental health organisations to help increase the boards' focus on mental health:

Mental health organisations should concentrate on influencing those strategy priorities intimately connected with mental health, but where the link with mental health has not been made such as alcohol, smoking and obesity.

Charities should both encourage and support boards to bring in or delegate a mental health 'champion'.

Mental health organisations should concentrate on influencing the JSNA steering groups in order to raise the profile of mental health.
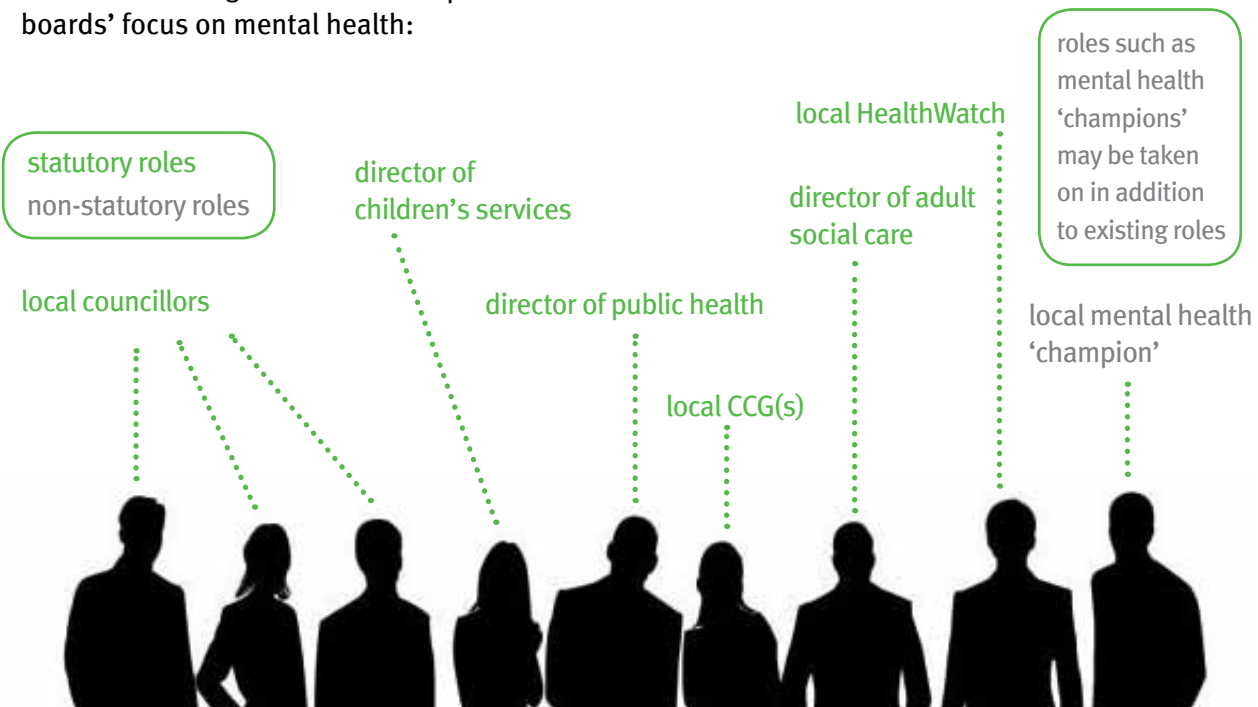
Recommendations for policy

This paper makes three policy recommendations to help increase the boards focus on mental health:

Further regulations should be developed to ensure that minimum standards are met by strategies.

The strategies and commissioning decisions of boards, CCGs and local authorities need to take into account the broad scope of mental health.

To achieve full integration across services, housing services and police and crime commissioners (PCCs) need to be involved in the decision-making processes of the boards.

statutory roles
non-statutory roles

local councillors

director of children's services

director of public health

local CCG(s)

local HealthWatch

director of adult social care

roles such as mental health 'champions' may be taken on in addition to existing roles

local mental health 'champion'

The make-up of health and wellbeing boards

Introduction

Centre for Mental Health has carried out an investigation into health and wellbeing boards to get a better idea of:

- How much focus the boards have given to mental health in their joint health and wellbeing strategies.

- What areas of mental health have been focused on.

- What factors have helped and hindered the agenda of mental health - during the development of the strategies and when making the strategies a commissioning reality.

What are health and wellbeing boards?

The boards create a new forum that brings together local authorities, clinical commissioning groups (CCGs), local Healthwatch, public health, social care and children's services leaders to improve the health and wellbeing of their local populations. Boards took on their full statutory role in April 2013, in which they need to fulfil three key functions:

- To carry out a joint strategic needs assessment (JSNA) on the health needs of their local population.

- To produce a joint health and wellbeing strategy (JHWS) setting health priorities based upon these health needs.

- To promote greater integration and partnership, including joint commissioning, integrated provision and pooled budgets where appropriate.

Methodology

We carried out a systematic review of the health priorities of 100 of the 152 strategies:

- How much attention has been given to mental health.

- What specific areas of mental health have been focused on.

They were selected to give the best possible representation of the boards, with the board's location, size of locality, and urban/rural demographic being taken into consideration. The stage of development of each strategy was also a determining factor, with the majority of the strategies reviewed as a finished document or in a final draft. Of the strategies included, nine came from the south-west, 12 from the south-east, 20 from London, 10 from the Midlands, 11 from East Anglia, 20 from the north-east (including Yorkshire and Humber) and 18 from the north-west.

In order for a strategy's priority to be included in the statistics, it needed to clearly refer to mental health; either in its proposed actions, or the expected outcomes.

100 joint health and wellbeing strategies reviewed:
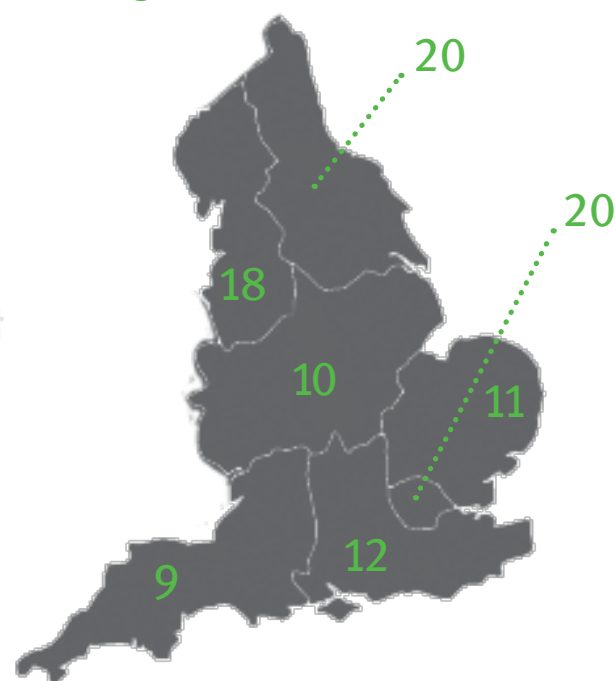
CCGs

There are 211 CCGs and 152 health and wellbeing boards with each covering slightly different areas. This means that some boards deal with more than one CCG and some CCGs deal with multiple boards.
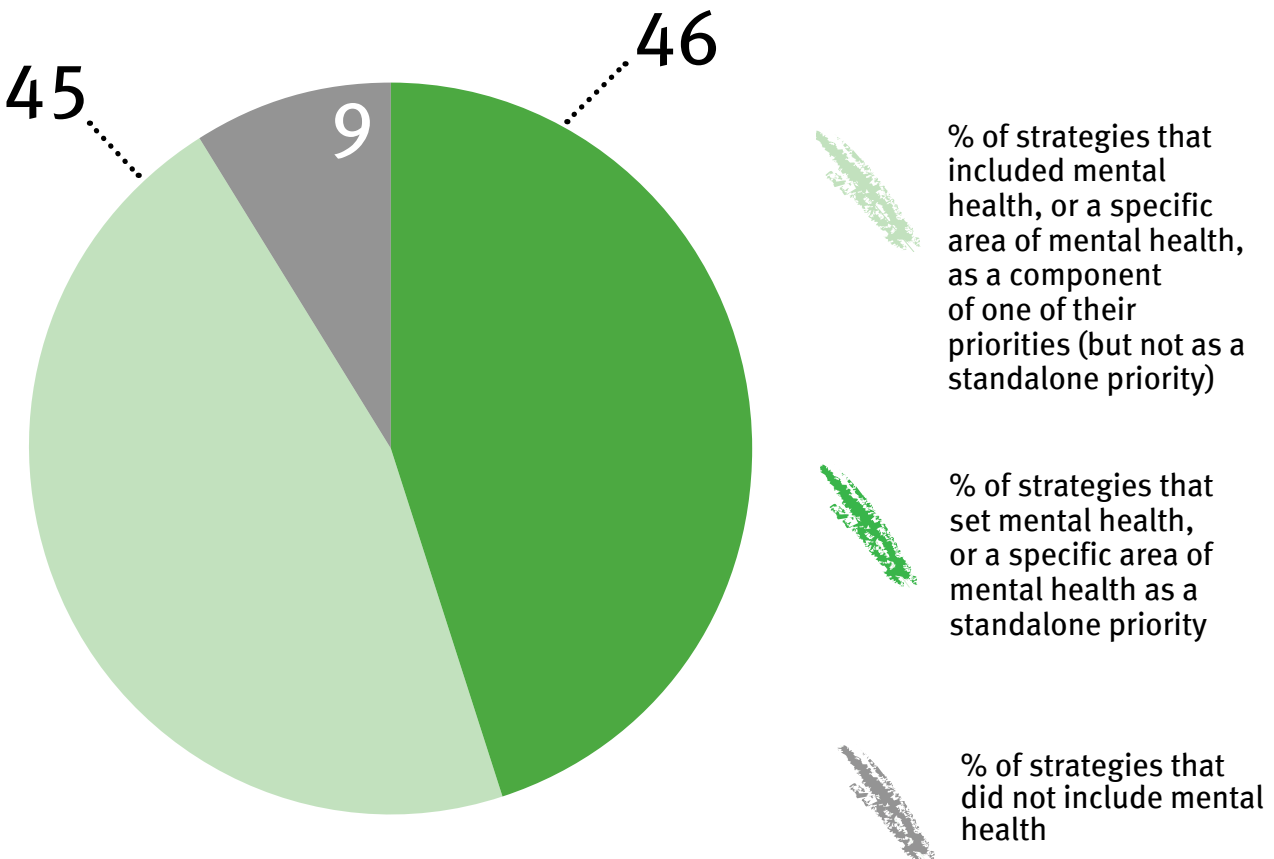
Health and wellbeing boards set priorities for a local authority area through joint health and wellbeing strategies but don't have their own budgets and cannot commission services directly. CCGs commission local health services and have to consider boards' joint health and wellbeing strategies in their commissioning plans.

What are strategies?

Joint health and wellbeing strategies (JHWS) set out the health priorities of a local authority. These priorities are aimed at tackling the key health needs of a board's local population, as identified by their joint strategic needs assessment (JSNA), public consultations and debate. The strategies create an overarching framework for commissioning plans to be developed for health services, social care, public health and other services as appropriate.

FIGURE 1

Prioritisation of mental health in the strategies

% of strategies that included mental health, or a specific area of mental health, as a component of one of their priorities (but not as a standalone priority)

% of strategies that set mental health, or a specific area of mental health as a standalone priority

% of strategies that did not include mental health

The overall level of engagement with mental health is encouraging, with 91% of the strategies prioritising at least one area of mental health. This included where mental health and specific areas of mental health were both set as standalone priorities (45%), and where mental health was included as a component of broader priorities (46%).

What areas of mental health have the strategies prioritised?

Three areas dominated the mental health priorities of the strategies; children's mental health, access to mental health services and employment. While the engagement with these themes is encouraging, many other key areas of mental health were severely under-represented, including issues surrounding mental health and housing, for example.

Children and schools

55% of strategies include children's mental health within their priorities.

This is the most widely prioritised mental health issue in the strategies. 13% of strategies prioritise children's mental health specifically within a school setting. Schools have the potential to improve the mental health of all of their students, to identify children who are at high risk of mental health problems and to act quickly to support those who are developing emotional or behavioural problems.

The importance of early intervention has been recognised by 13% of the strategies, the highest level of focus on any single area covering children's mental health. At present one child in 20 has a severe behavioural problem (Brown, Khan & Parsonage, 2012). These problems can have a devastating impact on their future, greatly increasing the risk of suicide, poor health, unemployment and crime. Early onset conduct problems have identifiable and, in many cases, preventable risk factors which can be tackled by well-designed, family and school-based early intervention programmes (Brown, Khan & Parsonage, 2012).

Improving support for vulnerable children was also well represented (10%). The predominant focus was on looked after children and children with learning disabilities. Other vulnerable groups such as young offenders were severely under-represented, or left out entirely.

8% focused on mothers' mental health needs (including postnatal depression and improving bonding between parents and babies).

Improved maternal mental health is vital both to support women's own mental health and to support healthy development in their children.

7% focused on improving the transition to adult mental health services. For too many young adults turning 18 means losing the support they received from child and adolescent mental health services without adequate replacements from adult services.

6% focused on improving access to children's mental health services (including reducing waiting times).

55% of strategies include children's mental health within their priorities.

13% of strategies prioritise children's mental health specifically within a school setting

13% of the strategies recognised the importance of early intervention

10% of the strategies looked at improving support for vulnerable children

8% of strategies focused on mothers' mental health needs

7% of strategies focused on improving the transition to adult mental health services

6% of strategies focused on improving access to children's mental health services (including reducing waiting times).

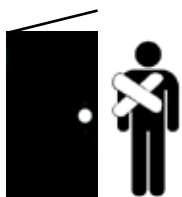## Improving access to mental health services

46% of the strategies include priorities focused on improving access to mental health services. 25% focused on Improving Access to Psychological Therapies (IAPT).

The NHS's IAPT programme supports the frontline NHS in implementing National Institute for Health and Care Excellence (NICE) guidelines for people suffering from depression and anxiety disorders. The high level of focus on IAPT corresponds with the recent growth in the programme - in the first three financial years to March 2012 over 1 million people had entered treatment (IAPT, 2012: 4).

Evidence shows that psychological therapies can help millions of people in the UK who experience a wide range of mental health problems (Mental Health Foundation *et al.*, 2010). Despite this evidence, in some areas many people are currently relying solely on anti-depressants due to talking therapies being unavailable. Waiting times vary hugely across England; in some areas many people wait well beyond IAPT's recommended 28-day period between referral and treatment, while in others the services appear to be meeting demand more effectively. A recent study carried out by Rethink found that most of the CCG commissioning plans surveyed had also focused on IAPT services, but this was part of a wider pattern of setting mental health priorities in line with the few incentivised national priorities (Rethink, 2013).

46% of strategies include priorities focused on improving access to mental health services

25% of strategies focused on Improving Access to Psychological Therapies (IAPT)

Employment

41% of strategies include priorities dealing with employment and mental health.

Employment can be an integral part of recovery from mental ill health, yet many people with a mental illness are unemployed. **The strategies tackling this area (27%) predominately focused on getting people with mental health problems into employment.**

At present only a small proportion of people who use mental health services have any paid work, yet many more would like the chance to gain employment. Through the Individual Placement and Support (IPS) approach, many more people who use mental health services could be supported into paid work. This method brings people into competitive employment first, then trains and supports them on the job through time-unlimited, individualised support (SCMH, 2009).

Only 7% of strategies focused on providing the appropriate support for people affected by mental ill health to stay in employment.

Another 7% focused on promoting general health and wellbeing in the workplace.

The cost of mental ill health at work is estimated to be £1,000 per employee for every workplace in the UK (Centre for Mental Health, 2010). Local authorities are major employers themselves as well as commissioning and contracting with local partners and suppliers. Encouraging better support for the mental health of staff in these organisations would boost the local economy by improving productivity, reducing sickness absence and preventing job loss.

41% of strategies include priorities for employment and mental health

27% of strategies predominately focused on getting people into employment

7% of strategies focused on providing the appropriate support for people to stay in employment

Mental and physical health

22% of strategies include priorities aimed at strengthening the integration of mental and physical health services.

Mental and physical ill health are strongly interlinked. People with long-term physical health conditions are more than twice as likely to experience mental health problems, including depression and anxiety (Fossey *et al.*, 2012). Having a mental health problem can also lead to a marked deterioration in the prognosis for a long-term condition, at very high cost to the individual, to their family and to health and social services.

22% strategies include priorities aimed at strengthening the integration of mental and physical health services

Housing

20% of strategies include priorities dealing with housing and mental health.

Having a stable and safe place to live has a profound effect on our mental wellbeing. Without it, mental health problems can begin, or be exacerbated, which in turn can lead to wider societal effects. Recent research has found that offenders with both mental health problems and unstable, unsafe places to live are more likely to become trapped in a cycle of offending and homelessness (Scott, 2011).

9% of strategies focused on increasing the percentage of people with mental illness in settled accommodation, while 7% focused specifically on improving access to appropriate accommodation for people with mental illness.

Only 5% of strategies specifically addressed the mental health needs of homeless people. And yet homelessness and mental health are intimately linked, with mental ill health being a major contributing factor to homelessness, and homelessness itself often worsening

existing conditions (Scott, 2011). At present, around 70% of people accessing homelessness services have a mental health problem (NHS Confederation, 2012).

2% focused on ensuring that planning processes (e.g. for housing density and quality) took into account possible mental health impacts.

20% of strategies include priorities dealing with housing and mental health

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2% of strategies focused on ensuring that planning processes took into account possible mental health impacts

Alcohol/Smoking

19% of strategies include priorities dealing with alcohol or smoking and mental health. The areas tackled included addressing the mental health impacts of alcohol abuse on families, increasing the level of support available for people with mental health issues to quit smoking and improving early intervention services for people at risk of alcohol abuse.

Only 5% of the strategies focused on joining-up mental health and alcohol services through better referral and care pathways. Yet a large percentage of people with mental health problems have co-occurring problems with alcohol misuse and few received the integrated support they require to achieve recovery.

Some 66% of strategies prioritised alcohol and smoking but did not directly broach the associated mental health issues. The lack of focus on the mental health aspects of alcohol consumption mirrors the government's recent strategy on alcohol, which concentrates on the outward causes and effects of excessive alcohol consumption, including giving more powers to local areas to restrict opening and closing times, controlling the density of licensed premises and charging a late night levy to support policing (Home Office, 2012: 2). This is a major missed opportunity to focus on the social and psychological causes of alcohol misuse.

5% focused on ensuring that people with mental health problems had the support they needed to give up smoking. In England, 42% of cigarettes are smoked by people with a mental health condition or drug or alcohol dependency. Recent research suggests that people with a mental illness are as keen to quit as other smokers and that smoking cessation techniques are highly effective for this group.

3% focused on increasing the number of people receiving effective and timely treatment for alcohol dependency.

19% of strategies include priorities dealing with alcohol or smoking and mental health

5% of strategies focused on joining-up mental health and alcohol services through better referral and care pathways

66% of strategies prioritised alcohol and smoking but did not directly broach associated mental health issues.

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3% of strategies focused on increasing the number of people receiving effective and timely treatment for alcohol dependency

Weaknesses in the strategies

Health and wellbeing boards have taken a range of approaches when creating their strategies. They vary significantly – from very short, high-level vision documents to much longer evidence based publications with detailed delivery plans. The range of approaches taken produces several issues that need to be taken into consideration when viewing the statistics:

Broad statements

Very broad statements, such as "improve mental health", are included as standalone priorities in some strategies, with no further detail as to the specific focus or how to achieve this outcome. Our figure of 91% is the best possible estimate of the number of boards that have prioritised mental health in their strategies, as it's not clear to what degree this will lead to concerted action.

Long lists of priorities

A number of boards' strategies contain very long, often undetailed, lists of mental health issues. While these documents look commendable, they sometimes suggest a lack of thought from the boards when setting their priorities. Rather than trying to tackle the key health issues in their area, these strategies appear to be more focused on fulfilling every national and local health guidance without a clear focus on any specific areas or actions.

In listing so many priorities, these strategies also go against the guidance of the Department of Health which states that the purpose of the JHWS is "not about taking action on everything at once, but about setting a small number of key strategic priorities for action, that will make a real impact on people's lives" (Department of Health, 2012).

A recent report by the National Learning Network (NLN) also highlighted that the most effective strategies were those that were "concentrating on key themes where they can add value, not attempting to deliver solutions for all local health and wellbeing issues" and involved boards agreeing a "robust and transparent prioritisation process, taking into account such

factors as type and complexity of need, how priorities can be delivered, what is directly achievable by board members and what requires the wider influence of stakeholders and partners" (NLN, 2013:).

This was then seen as setting a stronger foundation for joined-up commissioning and integrated services.

A lack of overt references to mental health

The majority of strategies which prioritised mental health in one area neglected to address it in other priorities they set which were intimately related to mental health. For example, while the majority of strategies prioritised alcohol and smoking, only 19% addressed the mental health issues involved.

The lack of overt references to mental health in some strategies raises the question of whether mental health is better treated as a standalone priority or as a component of other priorities. If mental health is not clearly identifiable as a priority, it can be more easily overlooked, something which has historically happened in the NHS. But if it is separated it can be neglected by other services.

Prioritising mental health is not about putting it above other conditions, but instead making sure that parity of esteem is created between physical and mental health and the 'mental health treatment gap' that currently exists in the NHS is closed. This gap is exemplified by lower treatment rates for mental health conditions, premature mortality of people with mental health problems and the underfunding of mental health care relative to the scale and impact of mental health problems (Bailey, 2013). Durham's board was aware of this issue, and decided mental health was too important to risk overlooking:

"We took a view that, at the end of the day, it [mental health and wellbeing] needs to be understandable to what we do, we need to be able to communicate specifically our actions, and

we should be able to say what we intend to do - which is improve mental health and wellbeing... not everybody accepts that it [mental health and wellbeing] should be separated and identifiable, but we took a view that it ought to be".

Mental health and dementia

Dementia was often set as a mental health priority, or was included as a sub-point within a mental health priority. The grouping of the two areas suggests either lack of awareness of the difference or, more likely, that dementia and mental health were viewed as a convenient 'grouping'. In putting the two areas together, boards both run the risk of overlooking other mental health issues by concentrating on dementia services. A recent report carried out by Rethink Mental Illness found that this lack of clarity continued into the CCGs' commissioning plans, with 50% of CCGs surveyed including dementia as a mental health priority (Rethink, 2013).

Key themes from interviews

We carried out interviews with members from 10 different health and wellbeing boards from across the country. The aim of this research was to get a better idea of what factors had helped and hindered the agenda of mental health during the development of the strategy and as boards look to make them a commissioning reality.

The board members interviewed came from a variety of backgrounds, and included councillors, GPs and Healthwatch members.

We have not identified any organisations or individuals by name, except for best practice case studies.

The importance of the joint strategic needs assessment

Eight of the board members interviewed said that their need assessment was document key to informing their priorities, with all 10 saying it had had a significant impact. Most boards had prioritised health areas that their needs assessment had highlighted as affecting the largest proportion of their local population. All 10 needs assessments highlighted significant mental health problems in the boards' localities and so this helped lead to mental health being prioritised in all of their strategies.

Several boards had relied heavily on their needs assessment when setting their priorities because of a belief that it contained all the information necessary to set the priorities. One board member declared: "The JSNA covers all aspects of health", but when asked about how it was conducted replied: "I don't know the answer to that". This belief in the all-encompassing nature of the needs assessment had clearly helped to shape the focus of some boards' priorities. There is no guarantee, however, that all JSNAs provide comprehensive data on local health needs. Many key areas of mental health, for example rates of behavioural problems among children, are poorly recorded and these can create important gaps in the available data for a JSNA. There is no template or format that must be used to produce a needs assessment, and no mandatory data set to be included (Department of Health,

2012). By primarily drawing upon data in the needs assessment when setting their priorities, boards run the risk of overlooking mental health generally, as well in specific areas.

This issue appears to have been compounded by the lack of debate among the board members while priorities were being set, which may, in part, be due to the over reliance on the needs assessment. One board member, when asked why there had been such little debate, answered: "Our JSNA already had a clear idea of where we should focus".

Public and service user engagement

Each board did carry out a variety of consultations and engagement activities on their draft strategies with a variety of stakeholders, including mental health professionals and service users. While all of the boards agreed this had been informative, it generally led to priorities being tweaked or added to rather than being fundamentally changed from the priorities set by the needs assessment.

Boards should ensure that they do not set their priorities in stone too early in the process. Consultations should be carried out with a wide range of service users and professionals, and the feedback from these properly incorporated into the strategies. Boards should be open to a u-turn on priorities, or overhauling elements of the priorities as a result of this feedback. Boards should also co-produce, not just consult, with service users when setting their priorities in the strategy - something which should happen above and beyond the needs assessment process.

Swindon's board have recognised that mental health requires a more focused approach in their needs assessment, and are addressing this by carrying out a further needs assessment specifically focused on mental health. The aim of this new research is to:

- Create a more nuanced picture of mental health need in Swindon.

- Gather more information to inform their health and wellbeing priorities for the future.

The purpose of a strategy

After the boards had set their priorities, there was a split in opinion on what they had created in their strategies.

Four of the boards saw their strategy as 'filling-in' the mental health gaps that exist in their area. They had an awareness of previous strategies as well as those that are ongoing and still delivering on mental health issues, but they aimed to create something new that addressed the mental health gaps, and tackled them differently. This approach was summed up by one board member as: "...trying something new with an eye to what had gone before".

County Durham's board have used their strategy to tackle the mental health 'gaps' in their area. It was felt that mental health had been dealt with fairly sporadically, with a focus on acute and secondary care services and so Durham's board used their strategy to deal with some of the more primary care-related aspects of mental health and wellbeing. They highlighted this in one of their key strategic actions, to: "Develop and implement programmes to increase resilience and wellbeing through practical support and healthy lifestyles", with a specific focus on supporting ex-military personnel who have poor mental and physical health.

Six of the board members in Durham saw the primary purpose of their strategy as a 'framework' for health strategies already in place in their area, rather than as a vehicle to try and highlight 'gaps' and tackle them in new ways. Often they had taken on the priorities of strategies already in place in their area wholesale, for example those of the local strategic partnerships (LSPs) and the pieces of work associated with them.

The difficulty faced by boards when trying to create something new with their strategies was summed up by one member:

"If you think about the whole process, we're all going around the wrong way. In an ideal world you would do your JSNA to identify your needs, and then do your strategy that informs commissioning. What you have to remember is that when we brought in all this new legislation, we already had a whole suite of strategies and proof of the health and wellbeing of our populations. So a lot of those strategies didn't come about because of the health and wellbeing board or because of the joint health and wellbeing strategy."

The wholesale transfer of 'what was going on before' is to be somewhat expected because of the newness of the health and wellbeing boards, and board members are still finding their feet in their roles. In some cases, the length of time between the needs assessment being carried out and the board coming up with its priorities had also led to an over-reliance on past strategies. What will be important as time goes on is the boards utilising their position to try and add "value to what would have happened anyway, and in ways that will achieve significantly better local health outcomes." (NLN, 2013). One interviewee felt that: "Initially there will be a very marked similarity [between the strategy and the previous health strategies] because it's just evolved. What it will be like next year when we're thinking about how we are going to do our JSNA ...that might be different".

Size of the board's membership

Each Board contains a core statutory membership of at least one nominated councillor of the local authority, the director of adult social services, the director of children's services, the director of public health, a representative of the local HealthWatch, a representative of each relevant commissioning group and 'such other persons as the local authority deems appropriate'. The choice of additional members outside of this core membership is not covered by statutory guidance; instead the Department of Health states that: "these decisions need to be made locally" (Department of Health, 2012).

Keeping the board membership 'as small as possible' had been an important factor for most of the members we interviewed. Keeping the board small was felt to increase efficiency and

the ability to deal with problems, while stopping it from becoming a 'talking shop'. Evidence from private sector organisations supports this view, where better-performing companies have fewer board members, with a membership of between 8 and 12 being seen as most effective (Galea *et al.*, 2012).

The boards' interpretation of 'as small as possible' has generally led to a membership of around 13 (although one had over 20 members). Keeping boards around this size has helped them to decide on their priorities quicker, helped strong relationships to form, and has facilitated constructive debate about mental health. When matched up with a small number of focused priorities, this appears to have created a stronger foundation for joined-up commissioning and integrated services.

Make-up of the board membership

While the majority of members agreed that having a smaller board had made it more efficient, many also felt that bringing on a few, select, non-statutory members had helped the board to better deliver its strategic role. One member highlighted that the key difference between their strategy and the health strategies that had come before was the sign-up and ownership it attracted. They felt that having non-statutory members (including the police commissioner and a representative of the voluntary sector) had resulted in greater deliberation around the strategy, and an "awareness of the need to have things in it that incorporate the whole range of the board's responsibilities".

Non-statutory members had been brought into the boards we interviewed from a variety of sectors including service providers, housing trusts and the voluntary sector. The mental health community was represented on two boards - by the voluntary sector on one and an NHS mental health provider on the other. The reasons for bringing on new members came down to perceived local need, although previous organisational relationships were also a factor.

One board had brought on four new members to represent each of their four main foundation trusts stating that:

"We were of the view if we were going to get things done and our main objective was around integration, how on earth could we do that without the major foundation trusts? Not every foundation trust that provides services to people in this area, but certainly those with the major patient flows. There was no disagreement on that actually".

A mental health trust was one of these four new members, and its membership on the board in question clearly helped to raise the profile of mental health. As the board set its priorities the trust helped to ensure that mental health pervaded, rather than being limited to its own priority. One of the board's key objectives is 'Ensuring that children and young people make healthy life choices and have the best possible start in life'. The mental health trust added a mental health priority to this objective: ensuring that mental health physicians worked with midwives in antenatal clinics and with pregnant women who have either mental illness or risk of developing mental illness.

One board member believed that having the mental health trust on the health and wellbeing board would not only help with setting priorities but would also mean better leadership on the elements of the strategy with mental health aspects. This is particularly relevant in particular areas as some of the actions in the strategy are owned by the foundation and so the board could look at embedding the recovery approach in secondary mental health services, for example.

Boards have also developed other methods of maintaining smaller, efficient memberships while ensuring that they have input from a variety of different sectors. One board had effectively created a two-tier membership, with the core group made up of the statutory, voting members, and then a larger group made up of wider stakeholders including representatives from provider organisations, the police service, the service fire service and housing services. This larger group met every alternate board meeting, and was a very open forum. Another board had LSP in their area which had a much wider membership, including the chief executive of the mental health trust. This a local strategic partnership was already carrying out many

of the functions of the health and wellbeing board - creating a strategic vision for the area, delivering on these outcomes, and promoting effective multi-agency working - and so its discussions have fed into the decisions of the health and wellbeing board.

Two boards had chosen not to bring on any non-statutory members. Although keeping the boards efficient and functional was a primary concern, there was also an uncertainty over who to actually involve. As one member explained:

"It's very difficult if you've got somebody who doesn't have to be there under statutory guidelines. Who else do you then invite? Providers? We have a number of big providers in the area. We've got a local district hospital, we've got ---- special hospital, we've got ---- hospital just over the border where a lot of our population go. So there's half a dozen hospitals, so it would be very difficult to decide which one should be brought on to the board."

While this uncertainty is understandable, the benefits that boards have gained from bringing on a few, select, non-statutory members appear to outweigh the small increase in numbers. For example, having a mental health foundation trust as a non-statutory member resulted in a strategy that was more nuanced and comprehensive concerning mental health, and had provided the board with a member who could directly lead on some of their mental health priorities.

Two of the boards have had problems maintaining a small, efficient membership because of the number of CCGs in their area. The government's guidelines state that a representative from each CCG is required to be on each board, but in one case this resulted in five CCG members. This factor is a particular issue for some county councils, which have to engage with several CCGs as well as a second tier of district councils (Galea *et al.*, 2012:). While some boards, after realising they had too large a membership to enable focused delivery of the strategies, have reduced their number of members accordingly, when the increased membership is due to CCGs this is not possible. One interviewee commented: "It's very hard to run any board with 22 or 23 people on it", and was very worried that their board had just become a forum for discussion rather than leading change in the area.

Cambridgeshire have tried to circumnavigate the size of board issue by creating three 'spare' membership slots. These slots can be used to bring people onto the board who are experts in a particular area when an issue arises. These experts then become a member for as long as that item lasts, which can be as short as a single meeting or for a period of months. The Cambridgeshire Health and Wellbeing Board member we interviewed said: *"We wanted to be a small and dynamic board that could make quick and useful decisions without endless hours of debate. We also wanted the flexibility to bring in all sorts of different people"*.

The role of mental health 'champions'

The idea of having a mental health champion on a board is to help ensure that parity of esteem is achieved between physical and mental health. Currently, parity does not exist. Three quarters of people with mental health problems receive no treatment whatsoever (Department of Health, 2013), despite mental health representing the largest burden of disease in England and affecting a quarter of the population at any one time.

Two of the boards we spoke to had brought on or designated a mental health 'champion' who promoted good practice and scrutinised how mental health was being addressed on the board. The boards felt that including a champion had considerably beneficial effect on the mental health element of their strategy by helping to shape and develop the details of their mental health priority. The benefit was felt to be especially strong when a champion had a personal or professional background in mental health. One interviewee, whose board had a member of Mind as their champion, remarked:

"[The champion's] presence and influence has affected our priorities as he was there during some of the consultations that we had around the priorities and was able to feed in some of the specific issues around mental health which was really helpful. And it just helps, certainly from my perspective, that it wasn't just me telling everyone, it was coming from a position of expertise around mental health as well".

Suffolk have a champion for each of their four priorities, with one designated as the mental health champion. His role includes responsibility for: coordinating the work programme; facilitating the delivery of the action plan; regularly reporting to the board; liaising with the board; proactively leading communication for the theme; working with other strategic leads, stakeholders and partners; and identifying synergies between the theme and other pieces of work.

The majority of board members we interviewed were reluctant to bring on a mental health champion and expressed worries about champions being brought onto boards for every agenda, which would lead to a large and unwieldy group with mental health being prioritised above other areas.

The fact that parity does not exist and that mental health need has, and continues to be, ignored is why it is so important that boards bring on a mental health champion to help raise its profile. Mental health also cuts across all aspects of health and does not just refer to one condition, and in consequence should run through everything that boards do. Having a mental health champion helps to strengthen this cut through as well as and increasing the chances of parity of esteem between physical and mental health being achieved.

Despite the reluctance to bring on a mental health champion several boards had brought on other non-statutory members who, though not formally designated as such, could be viewed as champions for other areas. Housing providers, for example, had been brought on by one board as they were viewed to be "so fundamental to providing a range of health and social care services".

It is also important to note that having a mental health champion does not need to increase a board's membership as existing members can take on this role, as is the case in Suffolk. Having a specialist champion from the mental health community did increase one board's membership, but they felt the benefits outweighed the increase in numbers. In fact, having a champion was felt to be even more important where mental health had been set as they were able to ensure that mental health stayed on the agenda and could provide added detail on specific areas of mental health. One interviewee stated: *"Obviously mental health is a priority for a number of partners, but he [the mental health champion] is the representative, which is really good...as it is a really major area for us"*.

Making the strategies' priorities a reality

We asked the ten board members interviewed about the efforts that had taken place since their strategies had been created to implement their priorities. Issues were raised in regard to the role of NHS clinical commissioning groups (CCGs) and of councils themselves.

CCGs

CCGs are the new organisations responsible for commissioning the majority of health and social care services in their local areas, including for most mental health care. Each of the 8,000 GP practices in England are now part of a CCG, with 211 CCGs in total, commissioning care for an average of 226,000 people (Addicott *et al.*, 2013). In 2013/14, CCGs will be responsible for a budget of £65 billion, around 60% of the total NHS budget (Addicott *et al.*, 2013).

CCGs and health and wellbeing boards can each covering slightly different areas. This means that some boards deal with more than one CCG and some CCGs deal with multiple boards. In some areas of England, the two are entirely coterminous, while in others there are as many as five CCGs for each upper tier local authority and in a few places CCGs cover larger areas than their partner councils.

 Health and wellbeing boards set priorities for a local authority area through joint health and wellbeing strategies but don't have their own budgets and cannot commission services directly. CCGs commission the majority of local health services and have to consider boards' joint health and wellbeing strategies in their commissioning plans. Some very specialised health services, such as prison healthcare and secure hospitals, are commissioned by the national body NHS England. NHS England also commissions primary health care. Local authorities, meanwhile, commission children's services and adult social care, which works very closely with the NHS in mental health services.

Boards and CCGs are intimately linked. Firstly, a member from each CCG has a statutory position on their local health and wellbeing board, and should be actively involved in its decisions. Secondly, each CCG must refer to the local strategy in their commissioning plan, and justify any part of their plan that is not consistent with it (Department of Health, 2012). If a board believes a CCG has not taken proper account of the strategy, it can make this clearly known to the CCG when consulted, contact NHS England, and in extreme circumstances, it could escalate the issue to the Secretary of State for Health (Department of Health, 2012).

Most of the boards felt that they had very strong working relationships with their CCG(s), particularly when the local authority area was coterminous with the CCG's boundaries. A 'circular' working relationship had helped create strong bonds between the two organisations for several boards. One interviewee, who sat on both the board and the CCG, commented: *"We [the CCG] have been thinking about doing such-and-such a thing and we have put it in our strategy. We have discussed it at the health and wellbeing board who have either taken it on board, or modified it, and then we have taken that back into our organisation...it's an evolving, ongoing process".*

For two boards, a strong relationship with the CCG(s) had clearly resulted in more joined-up working between the local authorities and the CCG(s). This had then led to a practical application of the strategy resulting in demonstrable mental health outcomes. Board members were generally very positive about their CCG's efforts to embrace their strategy, but several issues were raised.

> The Cheshire West and Chester Health and Wellbeing Board emphasised excess winter deaths in its strategy. Their CCG took up this element of the strategy and worked with the local authority to create ten evidence based outcomes that would reduce excess winter deaths. In doing this, the two organisations found that it was an issue that mainly affected vulnerable groups such as the elderly and people with mental health problems. Working together, the CCG and local council came up with new and dynamic ways of tackling the problem. To identify vulnerable people they used the local authority's bins list, a record of people who need help with getting their wheelie bins out. This list identified a vulnerable group who were either housebound or frail in some way, and they used it to target individuals to visit if the weather was bad or to provide extra information to. The board member interviewed, who was also on the CCG, commented that these "were all joint things that we [the CCG] did with the local authority which I think we wouldn't have done before we had a health and wellbeing board".

A number of CCGs had finished developing, and had approved, their own commissioning plans before their area's strategy had been completed. This action had occurred because the CCGs were keen to get to grips with their new role, but it did create a problem. In preceding the strategy, the CCGs negated a key element of the board's statutory role - to inform the commissioning plans of the CCG and ensure that they were commissioning in line with the priorities set by the board.

One interviewee voiced concerns that when their local JHWS and their CCGs' commissioning plans were being developed they "went along in parallel really, without necessarily touching". This resulted in the CCGs' commissioning plans focusing on quite different areas to the final priorities of the JHWS. While the strategy in question had put significant emphasis on mental health, one CCG plan had a more 'traditional' list of priorities that focused on physical health. CCGs ware expected to update their commissioning plans in line with the board's priorities, but some board members stated that they had seen little evidence of this. On another board, the development of the CCGs' commissioning plans prior the development of the strategy had led to an inverted decision-making process, where the CCG's plans had heavily influenced the choice of the board's priorities.

Two interviewees voiced concerns that their CCGs were referring to the strategy to get their commissioning plans approved, but thought that this may be "mere lip service". Rather than fully engaging with the strategy, the board members were worried that the CCGs were referencing it just enough to get their commissioning plans approved, but essentially had their own priorities. This lack of engagement was also highlighted by the NLN, which noted that: "As yet there is limited evidence of alignment between the strategic objectives of the boards and the local pattern of expenditure" (NLN, 2013).

Boards are required to highlight if and when a CCG has a lack of involvement with the strategy, but ambiguous references to the strategy combined with the CCG members sitting on boards may create a situation where it is not easy to reject them.

Many boards were already concerned, when they were in 'shadow' form prior to the Health and Social Care Act being enacted, before they took on their full statutory role, that national policy imperatives may override their locally-agreed priorities despite the rhetoric of localism (Galea *et al.*, 2012). This appears to have happened in many cases, with CCGs setting their mental health priorities in line with the few incentivised national priorities such as IAPT services (Rethink, 2013).

On boards aligned with multiple CCGs, there was sometimes a concern that once they had got their commissioning plans approved there was a lack of communication and coordination between the different CCGs. A paucity of dialogue was seen to have resulted in significant duplication and overlap between their commissioning plans, rather than a coordinated effort to address the priorities set out in the strategy. One board member, taking patient engagement as an example, said:

"Each of the CCGs are approaching patient engagement in entirely different ways, with different priorities, none of it coordinated, and none aligned with the strategy they have written, which is just a huge wish list of things they might do because they are so new and are not really sure what they are doing, and how strategically they are going to do it".

Councils

The board members interviewed were generally very positive about their council's engagement with both the board and the strategy, and had seen this engagement in two main ways concerning mental health.

First, board members have seen their mental health priorities incorporated into new strategies undertaken by the councils. Two of the councils we looked at had produced strategies aimed at increasing physical activity in response to their board prioritising the improvement of people's mental and physical wellbeing through exercise. One council was then in the process of developing a delivery plan for the strategy, with the expectation that it would be incorporated into constituent members' own work plans. The member of this board saw this as an "increasing feature of how [the strategy] gets down to ground level".

Second, boards have advised councils on specific mental health issues which had resulted in councils changing their decisions. In one area, a homeless project heavily used by people with mental health problems was going to be closed by the council. The issue was brought to the attention of the board who flagged up a variety of wider health impacts, which had not been taken into consideration. The board's input resulted in the project remaining open.

The Cambridgeshire Health and Wellbeing Board have built a statutory area into their council's papers, where members have to show how the paper affects health and wellbeing. This action was taken in order to remind every department that they have a new obligation to meet the board's strategic goals. A Cambridgeshire board member said:

"We are already seeing an effect…because people think when they're writing a paper 'well what are the obligations here for health and wellbeing, and have I forgotten something?', and that, even at this early stage, is jogging minds and making people think how they could join with us and get where we want to be."

While several board members highlighted their council's positive uptake of their strategy and its mental health element, they were unsure of how this promise was making its way into the council's decisions and processes. One member stated: **"There's a lot of willingness to ensure that we improve health and wellbeing for residents, how that then works its way through I'm not sure"**. Councils need to ensure that they both fully sign up to the strategy, and make their engagement with it as transparent as possible.

Concerns of board members

The board members we interviewed expressed a variety of concerns about health and wellbeing boards.

Two interviewees were worried that the boards were being seen as "everything to everybody" and a "repository for everything". They were concerned that this was happening to such an extent that the boards would not be able to focus on their primary functions and fully deliver on their priorities. One member commented:

"We are inundated... we've just had a request for example, to sign up to the disabled children's charter, and we have had requests from all sorts of associations, all sorts of lobbying groups, to sign up to everything...and there has to be an understanding that the boards are strategic bodies with a limited number of objectives... yet there is a perception amongst everybody, including the government, that everything can actually be directed towards them."

Concerns were also expressed that structures had been put in place that may be used to protect the boards from members of the public. One member highlighted a paper dealing with the protocol for public questions. This paper stated that members of the public wanting to ask a question had to submit it 24 hours before the public board meeting. The reasoning was to allow the board time to think about the answer, and answer it in the best way possible. The interviewee expressed a concern that this policy could be used to escape unplanned for, awkward questions.

An interviewee also raised concerns that they had "no real idea about the added value of a health and wellbeing board". They felt the board was hampered by the fact that responsibility for delivering the strategy rested with the local authority while control of most of the relevant spending sat with the CCG(s). This meant that when "anything difficult comes up" members split down organisational lines.

Conclusion

The Health and Social Care Act 2012 aimed to set out a new vision for the leadership and delivery of public services which focused on localism - where decisions about health services are made locally in order to achieve the best health and care outcomes (Department of Health, 2012). Boards were expected to approach their strategy according to their own local circumstances, with the government declaring that it would not "be appropriate for central government to be prescriptive about the process or to monitor the outputs (Department of Health, 2012)".

The same Act established the principle of parity between mental and physical health throughout the health and care system. Joint health and wellbeing strategies are an ideal focus for action to put this principle into practice.

This report has shown that while many boards are addressing mental health issues in their area, the lack of prescription about the process or monitoring of outputs has helped contribute to a very wide range of outcomes concerning mental health. Mental health need has been completely ignored in some strategies and dealt with excellently in others. In some areas, local mental health care has stayed essentially unchanged while in others it has been approached in new and dynamic ways. Some local CCG commissioning plans have ignored their strategies, while others have fully engaged with them.

The success of health and wellbeing boards in dealing with mental health comes down to each individual board, the information and expertise that is made available to its members, the willingness of its members to fully engage with the new format in order to address the health challenges in their area and the strength of personal and organisational relationships.

Recommendations for health and wellbeing boards

Boards should be aware of the limitations of their joint strategic needs assessment (JSNA) and actively consult with mental health service users, carers and professionals, to ensure their views are fully taken into account when setting local priorities.

The needs assessments, while detailed, cannot contain all the information needed to set the health priorities for its entire community. Boards should ensure that they do not set their priorities in stone too early in the process. A wide range of service users and professionals should be invited to co-produce strategies. Boards should be open to changing their priorities or overhauling elements of them as a result of this involvement.

Boards should use their strategy to highlight the mental health 'gaps' in their area and to try and tackle them differently, instead of using it purely as 'framework' for health strategies already under way.

Strategies create an opportunity to address the health issues on which the previous system was falling short. They can drive concerted action to increase parity between mental and physical health in a local area.

Boards should consider how their membership reflects their local community and ensures parity of esteem between physical and mental health, for example by designating a mental health 'champion' or by recruiting non-statutory members to the board.

Achieving parity of esteem between physical and mental health is vital if boards truly want to improve the overall health of their local

populations. Mental health need has been, and continues to be, a lower priority than physical health in most parts of England. Bringing on a mental health champion can help raise its profile, and should result in the boards better reflecting the health needs of their local communities. Appointing a champion should not be seen as way of prioritising mental health above other health areas but instead should be seen as a mechanism to help to close the gap.

Bringing on a few select, non-statutory members who represent the mental health community, such as mental health foundation trusts, can also help boards to create a more comprehensive strategy, and provide them with members who can directly lead on some of their mental health priorities.

Boards should ensure that their CCGs are properly engaging with the strategy when devising their commissioning plans, and hold them to account if this is not the case.

Boards must ensure that the CCGs are commissioning in line with their priorities and focusing on the biggest gaps identified in strategies. Boards should not assume that CCGs are engaging with the strategy; they need to thoroughly review the CCGs' commissioning plans, and question any vague references. Boards should not be afraid to hold CCGs to account if they believe that there has not been proper engagement.

Recommendations for mental health organisations

Mental health organisations should concentrate on influencing strategy priorities intimately connected with mental health where the link with mental health has not been made.

A majority of health and wellbeing boards have given priority to public health issues (such as alcohol, smoking and obesity) that have significant mental health elements, which, in most cases, have not been recognised.

Councils have taken control of alcohol services for the first time and will want to actively address the subject. One board member told us: *"The local authority were mindful that they were taking over drugs and alcohol services, so they did have a definite emphasis on that because that was new for them and that was a massive area they obviously needed to start thinking about…. We probably talked more on that than any other aspect of mental health"*.

Charities should both encourage and help boards to bring on or delegate a mental health 'champion'.

Having a mental health champion can help to raise the profile of mental health, and so mental health organisations should both encourage and help boards in bringing or delegating one on the board. While some members had concerns about having a mental health champion, most had not ruled it out completely. One member commented that they "would be really interested to see the evidence and to see how that has worked in other areas". This report has highlighted some

of the benefits of a mental health champion for boards but it would be useful to carry out further research into this particular area in order to present them with a larger range of evidence. Crucially, having a member champion is a very practical way to ensure the boards are meeting the commitment to parity of esteem between physical and mental health, as set out in the Health and Social Care Act, ensuring continued focus on mental health across all of the areas for which they have responsibility (Whitelock, 2013).

The most common reason, aside from board size, for not bringing a mental health champion onto a board was that they were seen as changing their generic role on the board, which could lead to unnecessary conflicts. It is therefore important that we also clearly define the purpose and role of a champion and how they can benefit the board without detrimentally affecting physical health outcomes.

Mental health organisations should concentrate on influencing the JSNA steering groups in order to raise the profile of mental health.

JSNA steering groups could prove to be another productive avenue for raising the profile of mental health. These groups lead the development of the JSNA on behalf of the board. As the boards primarily use this document to set their priorities, getting the needs assessment to have a more thorough mental health focus could lead to strategies with a greater mental health element.

Recommendations for national and local policymakers

Further regulations should be developed to ensure that minimum standards are met by strategies.

There are limited regulations concerning the production of JHWSs, partly as a result of the 2012 Health and Social Care Act's focus on localism, where decisions about health services are made locally in order to achieve the best health and care outcomes. The lack of regulation has resulted in boards taking a range of approaches when creating their strategies, and in turn a very wide range of outcomes for mental health.

The strategies and commissioning decisions of boards, CCGs and local authorities need to take into account the broad scope of mental health.

Mental health does not just refer to one condition or area: it encompasses a wide range of conditions, experiences and issues. It also affects not just a person's health but their wider life chances, and in consequence can be influenced by almost all health and community services such as housing, transport and leisure. Boards, CCGs and local authorities therefore need to address mental health in all of their commissioning decisions. In doing this, these bodies will help to ensure the better joined-up commissioning of services- saving public money and reducing the risk of duplicating work or leaving gaps between services.

To achieve full integration across services both housing services and police and crime commissioners (PCCs) need to be involved in the decision-making processes of the boards.

A key role of the boards is to create better integration between services in order to more effectively deal with people's health needs. Effective integration cannot occur without the inclusion of housing services and PCCs. Boards should consider how best to involve these key functions in the development, implementation and review of their strategies, either by making them permanent members or by creating open membership slots that bring them into discussions on pertinent issues.

Priorities for future research

The relative infancy of health and wellbeing boards means that, however great a board's mental health focus is in principle, we have very few examples of how this has translated into real mental health benefits for communities. Therefore, it would be advantageous to conduct further research in 12-18 months' time to find out:

- The level and detail of prioritisation of mental health and whether it is achieving parity of esteem.

- The extent to which CCGs commissioned in line with the strategies of their local boards.

- If health and care commissioning produced demonstrable, positive mental health outcomes.

- If such outcomes are different to what would have happened before the new system was in place.

Acknowledgements

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