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What we know about Health and Wellbeing Boards (HWBs): statutory definition, purpose, form, function, and future potential
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Executive Summary

Introduction to Health and Wellbeing Boards

Health and Wellbeing Boards (HWBs) are statutory committees of local authorities, introduced under the Health and Social Care Act 2012 and operational since April 2013. They represent an intention to increase integration of health and care commissioning, multi-agency partnership working to address wider determinants of health, and devolution of health and care governance.

Their core purpose is to provide strategic direction, instil joint working mechanisms, and improve population wellbeing. Their primary statutory duties are to lead production of JSNAs (Joint Strategic Needs Assessments), develop JHWSs (Joint Local Health and Wellbeing Strategies), and ensure these inform system planning and commissioning.

HWBs are primarily advisory bodies without commissioning powers or dedicated budgets but they can influence and oversee pooled funding allocation and sign off Better Care Fund arrangements. They therefore rely on 'soft power' to encourage collaborative working and ensure local concerns are heard at system level. Initially welcomed as 'system stewards' bolstering democratic legitimacy, HWBs have been criticised for relying on voluntary alignment and lacking the statutory 'teeth' to translate strategy into action.

Membership and organisation

Statutory core membership includes councillors, local authority directors (adult social services, children's services, public health), a Healthwatch representative, and at least one ICB (integrated care board) representative, plus locally chosen members. Membership can be augmented, temporarily or permanently, to reflect local priorities.

There is significant local variation in HWB structure, meeting frequency, and effectiveness. This can be viewed as both a strength (local responsiveness) and a challenge (assurance, consistency). ICBs and NHS England have a statutory duty to have regard to HWB outputs, though adherence to JHWS recommendations is uneven.

What research evidence tells us about HWBs in practice

HWBs uniquely combine democratic representation and place-level community connection, but research capacity within them is usually limited to what is available locally via local authority staff, embedded researchers, and Health Determinants Research Collaboratives (HDRCs). Facilitating meaningful public participation remains a persistent challenge, as does measuring HWB impact given the long-term nature of partnership-based governance and preventative public health work. Evaluations have consistently concluded that HWBs have not completely fulfilled their potential, with evidence of a lack of clear strategic goals and of impact limited by their lack of statutory powers and operational capability. The quality of relationships between partners is a key determining factor in their perceived success in influencing local strategy.

What changed for HWBs after the Health and Care Act 2022?

The Health and Care Act 2022 did not change HWBs' statutory duties but reconfigured integrated working through formal introduction of Integrated Care Systems, creating ICBs (with statutory commissioning duties and control over resources) and ICPs (integrated care partnerships; system-level collaborative partnerships). HWBs continued to feed place-

focused JSNAs and JHWSs into system-level strategic planning, though ICB/ICP 'due regard' for these reports has been inconsistent. Power imbalances remain despite the objective of equitable partnership working.

Future potential under the NHS 10 Year Health Plan and Neighbourhood Health Plans

The NHS 10 Year Health Plan (10YHP) introduces significant changes. A neighbourhood health plan will be drawn up by local government, the NHS and partners at single or upper tier authority level under HWB leadership, incorporating public health, social care, and the Better Care Fund. ICBs will integrate these local plans into population health improvement plans to inform commissioning.

ICPs will be abolished, creating a direct line between HWBs and their related ICBs but requiring ICBs to integrate local plans into system-wide strategy - work previously done by ICPs. The term 'neighbourhood' is used variably in recent policy and requires clarification as implementation guidance emerges.

The 10YHP does not significantly expand HWBs' statutory powers, funding, or resources. The proposed abolition of Healthwatch and ICPs risks weakening patient-public voice and oversight, and HWBs may be expected to fill these functions without commensurate resources.

Concurrent reforms (devolution, local government reorganisation, Mayoral Strategic Authorities) will require HWBs to be reconfigured across new geographies, disrupting longstanding relationships and creating short-term uncertainty. Misalignment between ICS footprints and mayoral strategic authorities will result in multiple HWBs feeding into single ICBs, complicating place-to-system influence. Larger geographies risk losing the 'sense of place' and local knowledge required to address community issues.

Key issues requiring urgent attention

- Clarify the footprint for 'neighbourhood health plans'
- Clarify the role, remit and alignment with NHS structures of Mayoral Strategic Authorities
- Provide HWBs with clarity over their role and responsibilities. If they are to undertake a more operational role in implementing neighbourhood health, their powers, make-up, staffing and resourcing must change accordingly
- Once HWB footprints are clear following local government reorganisations, determine how integration of local neighbourhood health plans will occur. One option: HWBs could form collective consortia at system-level to align priorities and co-develop strategies, though ICBs may resist relinquishing control over system-wide planning
- Increase investment in place-level research capacity to facilitate the production of more robust, evidence-based needs assessments
- Improve alignment of reporting and decision-making schedules across the system
- Invest in joint leadership development for HWB and ICB leaders to ensure coherent understanding of roles and equitable partnership working

HWBs have potential to play an important role in identifying local needs and supporting locally appropriate responses. As the NHS moves towards place-based care, HWBs are ideally positioned to contribute materially. However, achieving this potential will require good relationships, consistent attention to roles and responsibilities, and clear mechanisms to ensure their voices are heard and their influence is meaningful.

1. Introduction

The evidence base charting the development, implementation, and adaptation of Health and Wellbeing Boards (HWBs) spans well over 15 years. HWBs were borne of the enduring policy aspiration of more 'joined up' government, envisaged in terms of greater integration of health and care commissioning and services, multi-agency partnership working to address the wider determinants of health, and increased devolution and localisation of health and care governance to improve service delivery and population health.[1] This briefing tracks the development of HWBs over time, drawing on a collection of policy documents, implementation support documents, programme evaluations (of both shadow and established HWBs), and academic papers published since the early 2000s.

HWBs have been a core element of integrated health and care systems in England since their inception, despite the constant flux of the wider policy landscape. Launched amid 'great expectations' (Shared Intelligence 2014) that HWBs would become exemplary models of impactful localism and integration, they have been both lauded and criticised in subsequent years. They have been described as 'the beating heart in coordinating population health' (Hunter et al. 2018:7) and they have remained a constant amid the relentless churn of policies and mechanisms for managing health and care in England. Given the current climate of renewed change across Integrated Care Systems (ICSs), it will be useful to understand what HWBs are, how they work, and how their shape and purpose remained steady following the major restructuring of 2022 but may yet change from 2025 in the context of the NHS 10 Year Plan (10YHP).

2. Statutory definition and purpose

Health and Wellbeing boards (HWBs) are formal statutory bodies introduced by the Health and Social Care Act 2012 (HSCA2012); they are formal committees of all English local authorities with health and social care responsibilities. Following a preparatory run of 'shadow HWBs' starting in 2011, HWBs became operational on 1 April 2013. They were introduced as a mechanism to formalise local partnership working following large-scale NHS reform and, crucially, the transfer of public health functions to local authorities under ss.29-32 the HSCA2012, guided by the newly formed Public Health England.

Their development came during a wave of policy focus on localism, collaborative partnership working, and cross-government, cross-sector 'joined up thinking' to address the wider determinants of health. All upper tier authorities with health and social care responsibilities are required to have a HWB, and they have been seen as a key policy mechanism for driving joined up working at a local level, and for informing population health management at system level, since they were established. HWBs are widely viewed as a rare point of continuity in the constantly shifting health and care policy landscape (LGA 2021b).

Their formal purpose is to:

- provide a strong focus on establishing a sense of place

[1] Partnership working, and the drive towards 'joined up solutions for joined up problems', has been adopted as the most effective means of tackling 'wicked' problems and implementing policy reform since the 1990s, see DH 1997; Ling 2002; Marmot et al 2010; Glasby, Dickinson & Miller 2011. Integrated care has remained the core model and aspiration, despite political changes and economic pressures.

- provide a mechanism for joint working and improving the wellbeing of their local population
- set strategic direction to improve health and wellbeing (DHSC 2022c).

HWBs have primarily advisory and oversight roles; they are not currently an operational or executive arm of place. They have therefore been viewed as performing 'soft' roles, as brokers, enablers, and catalysts for change (Miller et al. 2010; Hunter et al. 2018; Visram et al. 2024). The 2012 Act uses the terminology of 'encouragement' of integrated partnership working, with the work of the HWB 'informing' decision-making at both system and place levels. Despite the political status of core board members, and the overlap in membership with ICBs and other parts of the ICS (see below), HWBs lack executive power to commission services, or to ensure that the guidance they produce is taken up or applied to system level decision-making.

The core statutory duties of HWBs are to:

- Produce a JSNA [Joint Strategic Needs Assessment], providing data about local health, need, and capacity
- Produce a JHWS [Joint Health and Wellbeing Strategy] as a decision-support tool, based on the JSNA findings, that outlines how community needs will be met
- Ensure that these are considered by ICS teams when planning, prioritising, and redesigning services for local communities

JSNAs preceded the launch of HWBs in the 2012 Act; they were first posited as a means of partnership working in the 'Independence, Wellbeing and Choice' Green Paper on social care (DH 2005:45) and were introduced under the Local Government and Public Involvement in Health Act 2007. By 2013, HWBs were made responsible for their production and dissemination. JSNAs are produced using research (whether conducted by local authority officers or externally, by academics), local insight and intelligence, published evidence and data, and more detailed local needs assessments focused at 1) the needs of specific groups most likely to experience poor health outcomes, and 2) district or ward level needs (DHSC 2022c). They must also take into consideration the wider issues that affect health, such as housing or risk of homelessness, employment, education, crime, community safety, transport or planning. JSNAs reflect the 'life course' approach adopted by local authority public health teams, along with the NHS Core20PLUS5 framework (Care Quality Commission 2024, NHSE 2025). There is no nationally mandated schedule for the 'rolling' production of JSNAs, but most local authorities produce one annually; subject-specific reports and summaries are produced more frequently and should feed into these more comprehensive documents. The collection of data is treated as a continuous process, and the production of JSNAs, JHWSs and high-level summaries should ideally align with system-level planning and commissioning cycles to feed into the production of Joint Forward Plans.

HWBs do not hold their own budget, nor do they have powers to directly allocate funds to specific projects. Instead, they gather place-level intelligence and provide strategic guidance on priority issues to inform funding decisions at local level through the local authority and at system level through ICBs. They can facilitate the creation of pooled budgets between different bodies to address specific local issues, and they can encourage joint commissioning. HWBs are also responsible for signing off, and providing ongoing oversight for, Better Care Fund (BCF) expenditure at place level and providing governance for pooled funds, which are hosted by local authorities and can be used under section 75 arrangements to support health and care delivery at place level (DHSC 2022c).

3. Membership and organisation

HWBs 'provide a forum where political, clinical, professional and community leaders from across the health and care system come together to improve the health and wellbeing of their local population and reduce health inequalities' (DHSC 2022c). The core statutory membership was established under the HSCA2012 at s. 194 (2)(a-g), and includes:

> *(a)subject to subsection (4), at least one councillor of the local authority, nominated in accordance with subsection (3),*
>
> *(b)the director of adult social services for the local authority,*
>
> *(c)the director of children's services for the local authority,*
>
> *(d)the director of public health for the local authority,*
>
> *(e)a representative of the Local Healthwatch organisation for the area of the local authority,*
>
> *(f)a representative of each relevant [integrated care board], and*
>
> *(g)such other persons, or representatives of such other persons, as the local authority thinks appropriate.*

This core membership can be, and often is, augmented on a permanent or temporary basis to include e.g. representatives of district councils (where applicable), police and crime commissioners, or service providers, to reflect the local priorities of the HWB. Nominations to join the HWB must be made to the leader of the local authority and then approved by the existing members of the HWB. Members are required to work collaboratively and adhere to the Nolan Principles (Committee of Standards in Public Life 1995). Nonetheless, collaboration between members of the HWB can be challenging and is particularly at risk when budgets are tight and unevenly distributed: *'Successful boards are likely to comprise of partners who do not withdraw from joint working to protect their own budgets or attempt to shift costs from one part of the system, which might significantly affect another part' (NHS Confederation et al. 2011: 3*). The goals are to embody quality relationships, distributed leadership, and collective responsibility.

Flexibility and discretion are built into the legislation and statutory guidance to allow for responsiveness to local conditions. Training, capacity building, and implementation support have been provided regularly to HWB members both via DHSC guidance and interventions prepared by LGA and partners.

In practice, HWBs vary substantially in structure, membership, meeting frequency, decision-making authority, and influence over commissioning and service delivery. This diversity is partly a consequence of their place-based remit and resultant specificity of form and focus; it also influenced by local politics and governance cultures, resource availability, community needs, and even individual actors – all of which can shape how a board operates. While such variation can be appropriate and responsive to local circumstances, it also means that there are uneven outputs and differing views of their success; their impact and effectiveness have proven difficult to measure.

Scrutiny of HWBs and their outputs takes place within local authorities, primarily by Health and Wellbeing Scrutiny Committees, or by local Healthwatch organisations. There is a degree of upstream scrutiny and accountability wherein ICBs are required to produce annual reports to review any steps they have taken to implement such JHWSs to which they are required to have regard. In preparing this review, the ICB must consult each relevant HWB, of which

there may be several within a given ICS area.[2] Further, NHS England has had a duty to undertake an annual performance assessment of each ICB, and this must include an assessment of how well the ICB has met the duty 'to have regard to' the relevant JSNAs and JHWSs within its area. NHS England must consult each relevant HWB for their views on the ICB's contribution to the delivery of any JHWS to which it was required to have regard. (DHSC 2022c). Despite the language of 'due regard', JHWSs are not always adhered to, and plans and strategies are not always co-ordinated or followed up to ensure they are implemented. Without such binding powers, the potential of HWBs 'to reduce duplication at different levels in the system and to ensure that scare resources are wisely used to maximise local impact' is 'a waste' (Hunter et al. 2018: 7-8).

4. *Published commentary on the development and operation of HWBs*

HWBs were initially posited in the 2010 'Equity and Excellence: Liberating the NHS' White Paper as a mechanism to 'strengthen the local democratic legitimacy of the NHS' through the establishment of local authority level oversight and to support and enable commissioners and providers in their decision-making (DH 2010a). The return of public health to local government in 2013 and the establishment of HWBs was 'almost universally welcomed' (Humphries et al. 2012:2; Communities and Local Government Committee 2013:12). The trial run of shadow HWBs was broadly considered a success, despite concerns about the scope and prospects of the project, and with familiar problems such as:

> *heavy dependence on voluntary agreements to align the strategic plans of the many different new statutory bodies; a significant role for mundane organisational processes in determining the extent of effective co-operation; and problems arising from factors such as size and the arrangements of local boundaries (Coleman et al 2014: 560).*

Another early evaluation noted that newly established HWBs had 'made a good start' but warned that the priority was now to convert enthusiasm into tangible effect, observing that HWBs operated 'in the context of very high expectations nationally and locally about what HWBs can and should deliver' (Shared Intelligence 2013: 6).

HWBs were viewed as place-based civic conveners - the new 'system stewards' - charged with ensuring that different bodies, boards, and teams should work collaboratively towards improving the health of local populations (Coleman et al. 2016). They were intended to act 'as a "boundary spanner" and "systems translator" helping health and local government colleagues work more effectively together' (Shared Intelligence 2016:2).

They were heralded as 'a key coordinating mechanism' for health and care integration (Coleman et al. 2016). As 'the only forum bringing together political, community and health leaders,' HWBs have been charged with 'building strong relationships among equals, with trust, shared values and a common vision underpinning their shared endeavours' (LGA 2019:6). However, this focus on the relational, while crucial to successful partnership working, belies how difficult it is to leverage commissioning decisions to serve place-level needs. Given the lack of statutory power built into their role, HWBs have had to 'acquire soft power as influencers and negotiators of change' (Hunter et al. 2018:3).

[2] The number of relevant HWBs vary according to system size, and the number of local authorities located within a given ICS area. It is subject to further change following the recent clustering and merging of many ICBs.

Further, the objective of collective responsibility among equal partners is laudable, but not always practicable. There are no nationally shared rules on accountability, collective responsibility, or voting rights, and HWBs therefore display wide variation in structure, maturity and impact across the country. The LGA argues that this heterogeneity is a strength when addressing local issues, and that HWBs exemplify the merits of localised responses to local issues: 'HWBs provide robust vehicles to help partners navigate local challenges or tensions, as well as the imposition of national requirements, enabling leaders to act more quickly and be more flexible' (LGA 2019b: 6). But this heterogeneity does not lend itself so well to assurance and accountability.

In short, HWBs were launched with high hopes that they would be 'the beating heart' (Hunter et al. 2018: 7) for coordinating population health. Yet, over time, and because they do not have the power to act as decision-making bodies nor to hold partners to account, '*the shine has gone off HWBs despite the fact that the issues they were set up to tackle remain as visible and deep-seated as ever*' (Hunter 2020).

5. What research evidence tells us about HWBs in practice

5.1 Democratic role, political involvement and use of 'evidence'

Members of HWBs include elected officials, senior strategic health and care managers (at ICB level), Chairs of local Healthwatch, and selected representatives of other local agencies, providers, and VCSEs. This means that HWBs are the only part of the system with both democratic accountability and the place-level capability to directly connect with, and respond to, local communities.

However, the involvement of elected members also means that evidence-based decision making about health and wellbeing is subject to political agendas and potential bias (LaPlaca & Knight 2014; Phillips & Green 2015). In a study conducted in established HWBs, Beenstock et al. (2015: 461) found that their efforts were focused largely on the production of the JSNA, but that critical research capacity was limited: '[T]he term 'evidence' was used most commonly referring to local need, rather than evidence of effectiveness', more descriptive and less analytical or evaluative. They argued that if HWBs are to be fit for purpose that efforts must be made to inculcate a research culture, including access to data and capability to conduct research where necessary, and that the HWB guidance should clarify the distinction between need and effectiveness (ibid.; see also Kneale et al. 2017). Moreover, since preventative public health interventions require time to bed in and show results, they do not lend themselves to a project-based system of short-term funding (Dhesi 2014), nor standard performance metrics.

These tensions, between democratisation of public health and drivers to increase use of 'evidence' to enhance efficiency and accountability, have only increased over time. As Kneale et al. (2019: 61) found:

> *Increased political involvement in local public health decision-making, while welcomed by some participants as a form of democratising public health, has influenced evidence preferences in a number of ways. Political and individual ideologies of locally elected officials meant that certain forms of evidence could be overlooked in favour of evidence that corresponded to decision-makers' preferences.*

The past decade has seen some sustained work to help improve the research, data analysis, and knowledge transfer capacity informing population health decisions. For example, the Health Foundation's Local Authority Champions of Research (LACoR) model was an early

embedded researcher initiative to strengthen research capacity and evidence use in local government decision-making (Cheetham et al., 2019). Building on this foundation, the NIHR-funded Health Determinants Research Collaboration (HDRC) programme was established in 2022 to improve research capacity within councils and to embed academic expertise directly into local policy-making processes (NIHR, 2023; Booth, Hock & Scope 2023; Hock, Scope & Booth 2024). HDRCs support local authorities in generating and applying locally relevant evidence on the wider determinants of health (such as housing, education, employment, and environment). This means that HWBs, as committees of the local authority, can access HDRC projects and data collection to better assess the likely health impacts of local policies, target interventions to reduce inequalities, and commission evaluations where evidence is lacking (Bell et al. 2025). Given the complexity of the issues HWBs and ICBs aim to address, there is a strong appetite for increased and ongoing collaborative research and capacity building work between local authority officers and academics (Cheetham et al. 2023)

5.2 Evidence from evaluation

The largest scale evaluation of HWBs carried out by Hunter et al (2018) found that HWBs had generally failed to fulfil their potential as local system leaders. Explanations for this included:

- The absence of statutory powers
- The failure to learn from previous models of partnership working
- Lack of strategic direction and a failure to focus upon clear objectives, leading to a failure of other system actors to view HWBs as system leaders
- A tendency for HWB members to be seen as primarily accountable to their 'home' organisation, rather than being collectively accountable
- Tensions between policy focus on localism and the NHS tendency for centralisation and top-down targets, with competing hierarchies
- A tendency for the role of overseeing Better Care Fund expenditure to trump other HWB roles
- Issues associated with lack of resources in both health and social care systems
- Failure to institute performance monitoring or oversight

The evaluation found that the prime enablers of positive action by HWBs were good relationships and trust, and that these took time to develop. Those HWBS, and ICS areas, which had worked together over considerable time were at an advantage.

5.3 Evidence of impact

It can be difficult to measure the success of 'governance of place' or the kind of stewardship role performed by the HWB and indeed, more broadly, the kinds of preventative work that is the mainstay of public health programming. The simplest measure might be to ascertain the extent to which a JSNA had had demonstrable influence on commissioning choices, but this can be influenced by financial and political concerns. It has been particularly challenging to evaluate the impact or effectiveness of health and care systems that rely on partnership working where 'performance management regimes favoured single organizational success' (Marks et al. 2011), rather than an understanding and acknowledgement of the preventative results of system-wide collective effort. Worryingly, the evaluation by Hunter et al (2018) found that there was evidence that JHWS were sometimes 'retrofitted' to existing programmes of work rather than representing authentic responses to local needs.

More broadly, HWBs are intended to capture and represent the views and needs of the local population. From the outset, it was clear that the broad remit of HWBs meant that they

would need to engage with stakeholders and local public and communities, and that this could not be achieved through board structures alone; HWBs would need to find 'more imaginative ways of engaging' (Humphries et al. 2012:5). The most extensive evaluation of HWBs found that they had not, as intended, extended democracy. '*There was widespread acknowledgement that little had been achieved by HWBs in terms of public and user involvement*' (Hunter et al. 2018:5). Fostering and maintaining public participation in public health decision-making remains a persistent challenge, hindered by entrenched structural, financial, and cultural obstacles (Baxter et al. 2022).

In general, HWB meetings are accessible to members of the public, and written questions can be submitted as per the standing agenda, but there is little publicity of meetings or outreach activity, resulting in scant public attendance (Visram et al. 2020:939). Representation of 'citizen voice' at HWB meetings is nonetheless a statutory requirement. Part of this engagement work may be done by local authority officers and others through local surveys and outreach teams or embedded university researchers but, since 2012, the onus has been on local branches of Healthwatch to fulfil this important role, despite their lack of capacity to do so (Ibid.: 944; Zoccatelli et al. 2020). 'Healthwatch had made effective contributions to boards and challenged them on occasion,' but despite the legal requirement and the efforts of local branches, 'it was contested that it was not Healthwatch's role to conduct engagement on behalf of the HWB' or the wider local authority (Hunter et al. 2018:124).

Healthwatch is an arm's length organisation created under the Health and Social Care Act 2012 (HSCA12). It was launched in 2013 as 'a new consumer champion' (HSCA12; Carter & Martin 2016), though it now describes itself as 'your health and social care champion' (Healthwatch nd.). Healthwatch England is a statutory committee of the Care Quality Commission, while local Healthwatch branches are funded by and accountable to local authorities. Each local Healthwatch has an ICS Engagement Lead who should be part of a professional network to support this work (Healthwatch 2025).

Under the HSCA12, a Healthwatch representative (usually the Chair) of the local branch has a mandatory seat at the table of their local HWB, ostensibly as an equal partner but with variable or low levels of participation reported (Sanderson et al. 2025: 71). While its role and presence have been broadly welcomed and valued – Healthwatch is officially viewed as playing a key role in scrutiny and challenge on HWBs, and for reporting to Health and Wellbeing Scrutiny Committees (LGA 2014: 14-15) – in practice its efficacy, impact, and status as a HWB or wider system partner is more contested (Martin et al 2024; Zoccatelli et al. 2020), as is its status as a truly independent representative of citizen voice. A recent survey found that 67% of local Healthwatch are represented on their respective ICBs and 84% on their ICPs (Healthwatch 2024:4), on an upwards trajectory. Recent research found that relatively few local HWs had voting rights when they sat at ICB or ICP meetings, despite being expected at ICB meetings and a statutory member of ICPs (Sanderson et al. 69-71). Local Healthwatch branches are run on tight budgets, with a real terms cut in core funding (Healthwatch 2024:2), and often struggle to attend and contribute to the meetings of multiple and multi-level boards and committees, in addition to their research, oversight, and community engagement roles (Sanderson et al. 2025) .

The Government announced in 2025 that Healthwatch is to be abolished and closed by 2027 as part of the major restructuring under the 10YHP. Early indications are that Healthwatch England functions will be brought into the DHSC, while the functions of local branches will be undertaken by ICBs. It is unclear how or whether these local Healthwatch functions – as members of HWBs, ICPs, and ICBs, or in its wider remits of providing oversight, amplifying

patient and public voice, and conducting focused place-level research for system-wide circulation – will be replaced.

6. *The role of HWBs post 2022 Health and Care Act*

The Health and Care Act 2022 (HCA22) did not change the statutory duties of HWBs as set out by the 2012 Act, but it did change the architecture of integrated working through the formal introduction of Integrated Care Systems (ICSs) (DHSC 2021a; DHSC 2022a; Charles 2022; Dunn et al. 2022; Sanderson et al. 2023) and the establishment of new system-level Integrated Care Boards (ICBs), and Integrated Care Partnerships (ICPs) (Perrin et al. 2023). This section will outline the adjustments to systemic roles and responsibilities as under the 2022 Act, prior to the changes announced in 2025.

The establishment of 42 ICSs (each covering populations ranging between 500,000 and 3 million people) signalled a major NHS overhaul and a stride towards integration. At their inception, ICSs varied in terms of: footprint; diversity of population served, demographics, and levels of deprivation; complexity of health needs; and workforce capacity. As a result, the task facing the newly formed ICSs in 2022 was 'not equal' (Dunn et al. 2022). Each was made up of an ICB and an ICP. The ICB was responsible for planning health service delivery and controlling most NHS resources, having taken on the role formerly held by CCGs. An ICP was a broader collaborative body charged with driving the local 'integrated care strategy' based on the 'health in all policies' model (PHE, LGA 2016). The ICB must produce a five-year strategic plan, drawing on a synthesis of strategic planning work produced by NHS England, ICPs, and HWBs.

Like HWBs, ICPs brought together an alliance of partners concerned with improving the health, care, and wellbeing of its population, with membership determined locally. ICPs have arguably had a similar remit to HWBs, and a degree of overlap and/or duplication of board membership and task, albeit at system - rather than place-level. Moreover, like HWBs, ICPs do not hold a budget or directly commission services. Their sole statutory duty is the production of an integrated care strategy, informed by the JHWSs prepared by local HWBs. This integrated care strategy should 'set out how the assessed needs' identified by the JSNAs are to be met by the functions of the ICB, or by NHS England, or responsible local authorities (DHSC 2024).

Fundamentally, post-HCA22, HWBs continued the type of relationship they had had with CCGs with one of the 42 newly formed ICBs – feeding in local priorities and strategic guidance via the JSNAs and JHWSs. HWBs were required to have regard for the assessments and strategies of their associated ICB and should consider adjusting their JHWS if indicated by priorities in the system-level integrated care strategy.

In turn, ICBs, while primarily accountable to NHS England, were required to 'support the 'primacy of place' and the principle of subsidiarity in health, care and wellbeing planning, commissioning, and delivery' (LGA 2019: 9) and to have 'due regard' for the formal information provided by HWBs. However, this has been tasked to ICBs with no formal mechanisms or guidance on how to do this; in the context of growing financial challenge, this level of subsidiarity and regard has not happened in many places (Warwick-Giles et al. 2025). Ideally, all HWBs in each ICB area worked together with their associated ICB and ICP teams to produce a system-wide and system-level (eg. issues like workforce planning; information sharing) integrated care strategy. As part of this work, they would jointly consider whether certain needs might be better met via pooled funding arrangements at place level under section 75 of the NHS Act 2006.

The membership and strategic focus of HWBs, ICBs, and ICPs are intertwined – and arguably duplicated, with a member of the relevant ICB sitting on the HWB and a senior representative (or more) of the HWB sitting on the relevant ICB and/or ICP. There is wide variation on which members have voting rights. In some places, local government is further represented on the ICB through local authority partner members, and on the ICP through the involvement of Mayoral Strategic Authorities (MSAs). These arrangements were intended to ensure strategic alignment at both system-level and place-level, as both NHS and local authority have a role in the development of JSNAs and JHWSs, which should reflect an evidence-based knowledge of place-level health, need, and capacity. These are then used to inform and influence priorities and funding decisions at system level. ICB and ICP leaders, LAs, and HWBs '*should work together to ensure effective system and place-based working – following the principle of subsidiarity,' working 'bottom-up' while ensuring that leadership is collaborative, and 'avoiding the duplication of existing governance mechanisms'* (DHSC 2022c).

Guidance from DHSC (2022c) emphasises that ICB and ICP leaders within local systems, informed by the people in their local communities, need to have regard for the work of HWBs to maximise the value of place-based collaboration and integration, and reduce the risk of duplication. They should ensure that action at system-wide level adds value to the action at place level, and that they are all aligned in understanding what is best for their population. ICB and ICP strategies and priorities should not detract from or undermine the local collaboration at place level. In an effective health and care system the ICP should build upon the existing work of HWBs and any other place-based partnerships to further integrate services (DHSC 2022c).

According to an LGA survey of HWB members in Autumn 2021, this mutual understanding was felt to be working reasonably well despite a lack of full systemic alignment, though it was viewed as more effective at place- than system-level. It found that 90% of respondents thought that their HWB 'showed collaborative local leadership' to a great or moderate extent while 69 % thought so for their ICS. Further, 72% of HWB members surveyed reported having effective working relationships and high levels of trust with ICSs to a great or moderate extent. 73% were actively having discussions to ensure greater alignment with the Integrated Care Partnership (ICP) (LGA 2021a).

DHSC guidance states that '*Where the HWB and ICP are coterminous (cover the same geographical boundaries), it may be appropriate to bring the HWB and ICP together, although each will need to fulfil its own statutory functions. The relationship between an ICP and HWBs will vary depending on the number of HWBs in the system, their maturity, and the existing partnership arrangements*' (DHSC 2022c). Closeness can be achieved through shared memberships, joint/aligned/streamlined meetings, and the deeper integration of common strategic frameworks to avoid duplication. However, this 'bringing together' has its limits, given that HWBs and ICPs sit within different governance tiers and have their own distinct statutory duties.

History suggests that it is challenging to avoid duplication of task or output in the health and care system and, despite intentions underpinning policy, establishing equality in partnership arrangements has proved difficult. Crucially, maintaining relationships of trust requires consistency and care. In her recent review of the state of the wider ICS project, Dame Patricia Hewitt re-emphasised the core principles of successful integration, urging colleagues to focus on their relational interdependence: '*Rather than thinking about national organisations, regions, systems, places and neighbourhoods as a hierarchy, we should view each other as real partners with*

complementary and interdependent roles and work accordingly' (2023:16). In practice, this aspiration is notoriously difficult to achieve.

Yet, as Perrin et al. found in their interviews with ICS colleagues, the reality is more complex than the rhetoric*: 'building partnerships of equals' often sounds straightforward, but accounting for a natural feeling of power imbalance between, for example, an acute provider chief executive and a local charity leader, is by no means straightforward. Interviewees felt it requires constant, intentional effort to ensure everyone is truly on an equal footing'* (Perrin et al. 2024: 17). Moore et al. have argued that disproportionate focus has been placed at system level in the development of ICSs, with '*little consideration of the leadership that will be required to implement collaborative action across health and social care […] for the common good*' (2023:358), particularly at the delivery end.

A recent study found that HWBs were not generally viewed by research participants as having achieved their laudable goals; rather, they found that '*meetings represented carefully staged and scripted performances that tended to inhibit rather than enhance democratic accountability'* (Visram et al. 2024: 931). Nonetheless, grounded in their place-based expertise, HWBs are said to be a rare point of stability in an otherwise tumultuous system:

> *a point of continuity in the continual changes to the health and care landscape. In part, this is because they have carved out a unique joint leadership role at place, as well as the recognition of the further opportunities they provide to shape and influence the wider system to drive long-lasting improvements to population health and wellbeing. (LGA 2021a).*

We now consider how the latest round of policy changes may affect the role and position of HWBs, post-2025.

7. Future potential: HWBs in the 10 Year Health Plan

This snapshot of what has been written about HWBs to date, with waves of policy papers and statutory and implementation guidance, closely followed by evaluations and academic publications, has shown that these place-level statutory bodies were launched with great ambitions. They aimed to: improve place-based integration and collaboration; ensure that local concerns are heard by system-level strategists and commissioners; and democratise population health decision-making and delivery. They embedded quite smoothly, with enthusiastic uptake to the Shadow Health and Wellbeing programme prior to April 2013 (Heath 2014a). Over time, with neither budget nor commissioning powers, the 'new system stewards' arguably became 'talking shops', thwarted by a compound range of barriers, including entrenched resource and capacity gaps (Alderwick et al. 2024), routinised and performative actions (Coleman & Glendinning 2015; Visram et al. 2020), and structural and power imbalances between ostensibly equal partners (Zoccatelli et al. 2020).

The NHS 10YHP brings further changes to the roles and responsibilities of HWBs, primarily in response to the new neighbourhood health service plans:

> *Although the NHS and local government have a shared purpose to improve the lives of local citizens, the multitude of plans, committees and measures have resulted in confusion, siloed working and inaction. In the future, a neighbourhood health plan will be drawn up by local government, the NHS and its partners at single or upper tier authority*

> *level* ***under the leadership of the Health and Wellbeing Board****, incorporating public health, social care, and the Better Care Fund. The ICB will bring together these local neighbourhood health plans into a population health improvement plan for their footprint and use it to inform commissioning decisions (UK Government, NHS 2025:83, our emphasis).*

To bring about this simplification, ICPs will be abolished, arguably removing one source of duplication by creating a direct line between all of the HWBs in an ICB area and the ICB planning process. However, ICBs will now have to do the work of integrating local plans into a system-wide strategy, a role which previously was carried out by ICPs.

The situation of such plans as being at 'neighbourhood' level is interesting, as the term neighbourhood is not explicitly defined within the 10YHP. Latterly featuring in the 2024 Labour manifesto, 'neighbourhood health' is a term used in 'different ways by different people and in different contexts' (Naylor 2025). This is further complicated by the government's other neighbourhood agendas, with the English Devolution Bill requiring local government to introduce 'effective neighbourhood governance', and the Pride in Place Programme seeking implementation through 'neighbourhood trailblazers' (MHCLG 2025). At the same time, the Neighbourhood Policing Guarantee will require a named officer in every neighbourhood and a neighbourhood policing team in every local area (Home Office 2025). Given the variety of neighbourhood approaches, it will be important that working definitions and terms of reference of 'neighbourhood health' are clarified before implementation commences. If HWBs are to create 'neighbourhood health plans' it is important that they understand the footprints over which such plans are to be made. It is possible, for example, that each HWB may be construed as having a number of 'neighbourhoods'; if so, it is conceivable that a HWB will need to produce multiple plans – or produce a single plan spanning a number of neighbourhoods with quite different needs. Alignment with other government initiatives will also be important to effective delivery.

A King's Fund team has identified three broad ways of conceptualising neighbourhood health:

> *1) the ways health care is delivered to patients – aimed at promoting prevention over hospital treatment,*
>
> *2) the way wider services come together at local levels to improve health and wellbeing – building on existing ways of integrated partnership working, but re-focusing on the wider determinants of health, and*
>
> *3) the way communities play central roles in the design and delivery of services – encouraging coproduction with local communities and encouraging a strengths-based approach to building local capacity (Morris, Baird & Charles 2025).*

NHS England has provided some 2025-2026 planning guidelines (NHSE 2025a) to be trialled in the National Neighbourhood Health Implementation Programme (NNHIP), ahead of the publication of a Model Neighbourhood Framework. The guidance doesn't contain anything completely new but rather collates existing models and systems. Importantly these 'neighbourhoods' are generally focused at what the NHS calls 'place' level, which is loosely aligned with current lower tier authorities or local boroughs of metropolitan councils, although some occupy a smaller footprint.

The 10YHP also highlights the need to reconsider democratic oversight and accountability in light of the new NHS operating model, the development of MSA, and reforms to local government. Local government reforms will see the end of the county-district model, which

will result in many HWBs being reconstituted within new local authorities across new geographies. The emergence of mayoral authorities and their new 'health duty' creates opportunities for better join up of local government's public health activities, but it also creates the risk of further fragmentation and institutional complexity, especially in the wake of ICPs being abolished. It has also introduced a national peer review system for public health teams on a five-year cycle from 2026 (UK Government, NHS 2025:83). This 'peer challenge' is 'intended to promote transparency, accountability, and continuous improvement across local authorities' (LGA 2025b). In response, the LGA has called for increased investment for sector-led improvement work, and the development of a national-local coalition to guide the implementation of neighbourhood health models – with a leadership role for LAs (LGA 2025b).

The narrative around the new NHS operating model is thus reminiscent of the ongoing integration agenda, and the aspirations around devolution, alignment, equitable partnership, and accountability surrounding the early development of HWBs. However, the parallel reform agendas in the NHS and local government are not currently moving towards alignment and integration. Geographically and institutionally, there are discontinuities between: neighbourhood governance and neighbourhood health; local government reform and NHS 'places'; and English devolution and ICS reforms. The new model should thus include a reassessment of NHS-centric assumptions, and:

> *devolve decision-making to local leaders to drive change, while holding them accountable for outcomes. To deliver neighbourhood health and shift towards prevention, the NHS must become a more effective partner within the system and with local communities. This requires alignment between two of the largest reforms and reorganisations ever seen in both the NHS and local government (Bliss 2025:4).*

Further, under the 10YHP Healthwatch is set to be closed down by 2027, with the national hub being integrated into the DHSC under a 'new national director of patient experience' and the activities of its local branches 'brought together with ICB and provider engagement functions.' (NHS Confederation 2025:19). The loss of local Healthwatch, along with the abolition of ICPs in the context of ICB budget cuts, makes it conceivable that HWBs may be required to step up and fill the gap as the core mechanism for ensuring a joined up, place-level perspective, with VCSE and patient/public representation, for local population health management. This suggests that HWBs will have an important role, not only drawing up local health plans but also providing the core infrastructure for engagement with local communities.

In understanding how far it is likely that HWBs will be able to fulfil this enhanced role it is worth considering their early experiences. The literature surrounding the launch of HWBs reflect integration aspirations ripe with optimism: *'[they] must become the crucible of health and social care integration' (NHS Future Forum 2012:12)*, *'acting as one of the engines of integration in the reformed system' (DH 2012b).* However, this vision was marred, even early on, by scepticism about how they would fare given they hadn't been furnished with funds or commissioning power (Humphries 2013:8). *'HWBs are the only place where the system can come together. Unfortunately, HWBs in their current form are for the most part unable to occupy this pivotal role or to function accordingly* (Hunter et al. 2018:7). Before a decade had passed, one research team found that '*while they were generally perceived to be well-intentioned, they were also considered to be largely ineffective in facilitating action to improve health and wellbeing and reduce health inequalities'* (Visram et al. 2020: 945). Thus, whilst HWBs are strategically situated to be able to perform the role assigned to them, the practical achievement of this role may be very challenging.

HWBs are expressly, if very briefly, referenced in the 10YHP as part of the local governance infrastructure, supporting the delivery of place-based health strategies. They will do this by continuing to provide JSNAs and JHWSs to guide the work of ICBs and nudge systems towards alignment with local authority priorities. It makes sense to consider them for this role, given that they have previously been presented as '*anchors of place, providing leadership and stability, and helping to bring coherence to the new ways of working that connect neighbourhood, place and system*' (LGA 2019:2). However, the 10YHP does not propose any significant reform or expansion of HWBs' powers, funding, or capacity, leaving their role largely advisory and giving them few levers with which to influence ICBs. This has sparked concerns that the plan 'misses an opportunity to strengthen HWBs as vehicles for local accountability and integration' (LGA 2025a) and raises concerns that the thwarted aspirations associated with the early days of HWBs will be repeated.

The current situation risks repeating a longstanding pattern of policy aspirations being undermined by chronic funding restrictions, structural upheaval, political jostling at both place- and system-level, and the usual hard realities of service delivery across the system:

> *'Tensions aligning national health with local government have been in existence since the NHS was created' and while attempts at alignment between local priorities and system-level decision-making, of integration and delivery strategies, and of geographical boundaries, may be helpful, it's unlikely they'll be sufficient to resolve longstanding problems and acute financial pressure (Lorne et al. 2019: 4).*

In short, although HWBs have not featured prominently in early proposals for a new NHS Operating Model or the proposed Neighbourhood Health Service, they retain statutory legitimacy, democratic accountability, and existing infrastructure and local networks for multi-agency population health leadership. Given their relative stability in the wider system, HWBs may well provide a ready-made locus, or at least a practical foundation, for delivering the place-based expertise and collaboration that the current reforms demand. However, the key question is the extent to which HWBs will have the political power and levers necessary to influence the work of ICBs. To cite one critical expert on HWBs and integrated systems, '*the need for powerful HWBs that can bring about real change to improve the lot of ravaged communities has never been greater*' (Hunter 2020).

8. Discussion: learning from history: what can the evidence about the role of HWBs tell us about their future role?

As we have seen, HWBs represent notable endurance in the context of a shifting health and social care landscape. It is therefore useful to consider how the existing capacity of HWBs, with their collective networks and expertise, could be better harnessed or enhanced to meet the vision and needs of the 10YHP. Building upon the evidence from the first decade of their existence, we here consider which features of HWBs might be improved or extended to more effectively inform and influence decision-making and commissioning at system-level and facilitate resource allocation at place- and neighbourhood-level.

8.1 Shifting context – changing boundaries and footprints

To consider this in context, we need also to look to the concurrent English devolution agenda and local government reorganisation (LGR). In many parts of the country, two-tier county

councils are being replaced with one or more unitary authorities. This will require HWBs to be reworked across new geographies, with new board compositions, and covering different populations. While this is likely to create further short-term uncertainty, it should create more uniformity in local government arrangements across the country. At the same time, MSAs are emerging at system level. Tasked with a new health duty, MSAs will pool some local authority powers and draw down powers from the centre. MSAs were expected to play a significant role in ICPs, but the abolition of ICPs and the clustering of ICBs at a larger geography leaves the role of MSAs uncertain. If both the NHS and local government are to be rationalised to enable integrated working for population health, the new local and strategic authorities should ideally be aligned with NHS places and ICBs, in terms of boundaries and responsibilities (NHSE 2025c). The extent to which the post-2025 configuration of health and care bodies can respond and adapt to the priorities of the 10YHP will, in part, be shaped by the decisions taken within these dual reform spaces.

If the current situation in which there are several HWBs in each ICB area attempting to influence system-level decision-making and resource allocation reflects a disjuncture between system- and place-level thinking, the present restructuring and scaling up of ICS footprints '*will leave a wide gap between leadership at local and at system level*' (Arnold-Forster 2025). This is likely to be worsened by the abolition of ICPs and the emerging role of misaligned MSAs. The dissolution or reconfiguration/reframing of ICP arrangements has created a gap in system-wide strategic coordination to ensure that commissioning decisions and service delivery models reflect the diversity of needs across places. At the time of writing, the HSJ reported that 26% of ICB members surveyed on the reforms said they 'intended to keep the ICP as a non-statutory structure, despite its legal abolition'; 46% said they intended to 'incorporate ICP functions into health and wellbeing boards,' and 40% that they would 'work in partnership with regional strategic authorities' (Launder 2025).

There is therefore a question as to how ICSs should be aligned with MSAs, and how NHS places should be aligned with local authorities, but there is also a question of scale. As the system upscales (with ICBs merging to cover larger footprints and the abolition of lower tier authorities) and drops some roles for community-level actors as ICPs are abolished, there is a risk that sight and presence will be lost precisely where the 10YHP wants to refocus attention: at place- and neighbourhood-levels. As both the NHS and local authorities settle on larger footprints the need for stronger alignment between local priorities and system-level strategic planning only increases. This raises important questions as to how larger geographies can maintain a comprehensible 'local' identity, and how they can maintain active community engagement and buy-in to shape effective place-based and/or neighbourhood governance arrangements.

At the neighbourhood scale, there are further integration and alignment questions, with the 10YHP promising the roll-out of neighbourhood health and the English Devolution White Paper promising the roll-out of neighbourhood governance, without any apparent attempt to join up the two agendas. This could create major difficulties if HWBs are tasked with implementing neighbourhood health, detached from the wider responsibility of local authorities to roll-out neighbourhood governance.

8.2 Learning from the evidence

Research exploring the role of HWBs consistently contrasts their potential strengths as locally-focused, democratically engaged forums for integration, public and community involvement and proactive planning with their apparently limited influence. Explanations for this mismatch include: lack of statutory powers; lack of clear strategic direction; competing

hierarchies, with tension between localism and the need for NHS partners to respond to national objectives; lack of resources in both the health and care system; and lack of performance monitoring. Those HWBs seen to be most effective were those with strongly developed relationships and trust between partners.

Taken together, this evidence highlights a number of risks which may limit the potential of HWBs to undertake an enhanced role in the system. The most obvious of these is that the **reorganisation of local authorities and of ICBs at the same time may disrupt the trusting relationships required to support true partnership working**. Moreover, **current proposals do not include any enhanced statutory levers for HWBs**, with the ICB required to take account of the individual HWB neighbourhood health plans, but without statutory levers to enforce this and with no new performance monitoring for HWBs. **There remains a danger that competing hierarchies will act to limit the extent to which HWBs can generate a coherent agenda**, and the **abolition of Healthwatch and ICPs suggests that HWBs may have enhanced responsibility for public engagement without enhanced resources** with which to achieve this.

The evidence also suggests a number of issues which require urgent attention:

- It would be valuable if **the footprint across which 'neighbourhood health plans' are to be made could be clarified**. At present NHS services think of neighbourhoods as 'sub-place' level entities, covering small populations of around 30-50,000 people. However, given the local authority approach to neighbourhood governance it seems possible that the 10YHP intends 'neighbourhood plans' to be place-focused
- More widely, the **intended role of Mayoral Strategic Authorities, their as yet un-clarified health duties and their alignment with NHS structures, could also be usefully clarified**

If HWBs are to play a strong role in the developing neighbourhood health agenda, then they urgently need clarity over their role and responsibilities. The imminent publication of the 'model neighbourhood blueprint' may help with this. **If HWBs are intended to undertake a more operational role in the implementation of neighbourhood health,** as statutory bodies with relevant local knowledge and relationships, **then their powers, make-up, staffing and resourcing will need to change**. HWBs role has always been strategic and advisory, focusing upon planning and oversight of BCF expenditure. They have never had an operational role, and they do not currently have operational staff.

In terms of effectively influencing ICB strategy and planning, much depends upon the footprint over which HWBs are established following the current local government reorganisations. Once this is clear, then **consideration needs to be given to how the necessary integration of local neighbourhood health plans is to take place.** One of the new demands on ICBs is to produce a range of strategic planning and performance monitoring reports (on a five-year cycle), alongside an integrated needs assessment setting out a 'detailed understanding of the population served'. This is to be delivered by March 2026 and then updated annually. This system-level assessment must be 'broken down' by 'the agreed local places (typically at health and wellbeing board level) and neighbourhoods that make up the ICB geography' (NHSE 2025d:10); it *'must build on and complement the joint strategic needs assessments led by local government public health teams and overseen by HWBs in each ICS'* (ibid.:31, note 3). In delivering this, the relationship between ICBs and their constituent HWBs will be crucial, and without the ICP much will depend upon the role of individual leaders in both HWB and ICBs. In order to facilitate the integration of local plans at ICB level one option would be for HWBs to form a collective consortium of HWBs (comprising multiple

cross-sector HWB representatives?) sitting at system-level, occupying the space previously occupied by ICPs. Such consortia would provide a structured forum through which HWBs across an ICS footprint can align priorities, share intelligence, and co-develop strategies that reflect local needs while supporting system coherence e.g. through the production of an integrated care strategy, formulated with equitable representation for each place. However, ICBs may not wish to relinquish their role in aligning plans across their footprint in this way, as it would limit their ability to prioritise and meet NHS operational targets.

Looking more generally at the operation and role of HWBs, the literature suggests that consideration should be given to:

- Increased investment in building place-level research capacity to facilitate the development of more robust, evidence-based needs assessments by HWBs
- Investment in leadership development, potentially targeting HWB and ICB leaders together to ensure the development of coherent understandings of respective roles and more equitable approaches to partnership working

Commentators and evaluators alike agree that HWBs have the potential to play an important role in identifying and understanding local needs and health challenges and supporting the development of locally appropriate mechanisms for addressing these. The mission of a functioning HWB remains the same: to '*ensure that the voices of people who use services and carers, local communities, and the voluntary and community sector, are included in the integrated care partnership and its strategy*' (LGA 2021a). However, this potential has not yet been realised, despite more than a decade of trying. As the NHS moves towards a more community-focused, place-based model of care, HWBs would seem to be ideally placed to contribute in a material way. However, achieving their potential will require good local and system-wide relationships and consistent attention to roles and responsibilities, and footprints and sources of leverage, to ensure that their voices are heard.

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