On behalf of Oxford City Council, please find below our response to the request for stakeholder views on the future of the Health and Wellbeing Board.

Background

Oxford is a city with a population estimated to be just over 161,300 (ONS Mid-2016 Estimates). Due to the large student population, one-third of Oxford's population is aged 18 to 29, the highest proportion in England for that age group.

The health and wellbeing of the residents of Oxford varies between communities within the city. The geographic distribution of relative health deprivation has a clear divide, with many neighbourhoods north of the city centre amongst the least deprived in England; several neighbourhoods within, to the east of and to the south of the city centre rank amongst some of the most deprived areas on the Health Domain (English Index of Multiple Deprivation 2015). See Figure 1.

Whereas many of the city-level indicators of health and wellbeing are better than the national averages, there are key health issues for Oxford residents once the data is examined in more detail. The table further below summarises the main health and wellbeing issues facing the city of Oxford.

Oxford is a diverse and vibrant city; in areas of East Oxford and Churchill, around a third of the population is from black and minority ethnic populations (ONS UK Census 2011). As you will see in the supporting locality data at the link below, the protected characteristics of members of our population affect their experience of health conditions, as well as use of and access to health services. For example, in some of Oxford's deprived areas, such as Barton and the Leys, around 9 percent of households with dependent children also include at least one person with a disability or long-term health condition. Consequently, to ensure our response below reflects the needs of our City's population, we have drawn on the principles of good practice in the NICE Guideline (2016) and its recommendations on Community engagement: improving health and wellbeing and reducing health inequalities[1].

Supporting Data

(Link here)

[1] https://www.nice.org.uk/guidance/ng44/chapter/Recommendations#overarching-principles-of-good-practice

Our organisational responses to the questions that are guiding the review:

1. What should the functions of the HAWB be?

This current governance chart for the HAWB - Appendix 2

The HAWB is the board which can provide strategic leadership across the Oxfordshire health system; it provides a forum which brings partners together, forges important collaboration, and transforms care delivery through careful scrutiny of data and a 'task and finish' approach to problem solving. The Health and Wellbeing Board needs to provide whole-system strategic direction and oversight of Health and Wellbeing commissioning and delivery initiatives for Oxfordshire This whole-system strategic direction also needs to include and take account of children's services and education objectives.

Health and wellbeing initiatives cover all strategies, programmes, services, activities, projects or research that aim to improve health and wellbeing (both physical and mental) and reduce health inequalities for both the short and the long term.

This is supported by the recent Quality Care Commission report - "Oxfordshire local system review", Health and Wellbeing Board Dec17. To ensure this vision is applied and is effective, the board needs to:

- Challenge and hold to account performance; strive for continuous improvement
- Address health inequalities by ensuring additional efforts are made to involve local communities at risk of poor health. This includes people who are vulnerable, marginalised, isolated or living in deprived areas (Recommendation 1 Health Inequalities Report)
- Use the Joint Strategic Needs Assessment and other data to understand the demographics of local communities
- Use information to inform and influence the way services are targeted and designed
- Develop an agreed, deliverable action plan to inform decision making
- Commission or provide health and wellbeing initiatives in collaboration with local communities
- Ensure effective engagement
- Provide a clear line of work programme between HAWB and its sub-groups
- Have a clear diagram showing system flow and functionality
- Draw on learning from other effective boards, for example Manchester and Cambridgeshire

- Be a model of inter-agency collaboration
- Have a clear board process for review and evaluation.

2. What should its role be in any emerging proposals to form an Accountable Care System?

Discussions on an ACS for Oxfordshire are at an early stage; moving in this direction will involve a complex set of challenges and issues to address. This will be a significant shift and a long-term project which will need phased implementation. At the outset, it will be necessary to develop (a) a clear understanding of the benefits it will deliver and (b) support and agreement across the relevant organisations. The HAWB is well placed to be the forum to drive forward the thinking on this, involving stakeholders and the public. A working group could be established under the HAWB to develop the proposals.

Once proposals are developed, the HAWB could provide either (a) the overall leadership of an ACS (or equivalent) or (b) a key role in governance, holding the ACS to account and providing check and balance. In order to do this, there would need to be changes to the way it currently works, its composition and its methods of involving the public and wider stakeholders. NICE Guidelines 2016 are helpful here, particularly principle 1.4 which provides a framework for directors of public health, other strategic leads and strategic groups[1] who plan, commission or provide health and wellbeing initiatives to make community engagement an integral part of health and wellbeing initiatives.

3. How should the board balance its role in coordinating a wide range of wellbeing issues with the specific needs to oversee 'system flow'?

The partnership should use performance data to identify hot spot areas across Oxfordshire; this information will be used to identify a number of joint strategic priorities, which should be health-focused and place-based. As such, the HAWB should be a strategic body whose purpose is to ensure that others are addressing issues such as system flow (for example, for discharge from hospital).

This should be done through specifically established 'task and finish' sub-groups, using (a) statutory organisations, (b) the knowledge and experience of local communities and community and voluntary organisations, and (c) expert witnesses to provide evidence, recommendations and timescales to tackle such issues. These specifically established taskforce sub-groups on priority issues would then need to report to and be accountable to the HAWB or its sub-boards. The board should support and influence

co-production to enable the delivery of initiatives that target these priorities. ‘Task and finish’ groups could be used as a mechanism to focus on key issues that need a short intensive piece of joint working to enable issues to progress (the right people involved at the right time). The interconnectivity between HAWB and HIB needs to be strengthened and a clear line of work programmes and reporting function should be clearly defined.

Coordinating wellbeing issues is important, but again perhaps too ‘operational’ for HAWB. It should be leading the way and setting priorities, and then holding organisations to account to do this within established timescales and using clear methods of monitoring, evaluating and reporting on engagement. It should take a population-based approach.

4. How should it carry out these functions?

The board would benefit from more strategic planning and prioritising. A clear plan of action should be developed by the board and used as the foundation for future work and performance management. The action plan would benefit from incorporating (a) a strategic view of the links into other boards and (b) strategic prioritisation, to prevent duplication of work at board and sub-group levels. The following would be necessary:

- Alignment of other board strategies and priorities
- An executive membership made up of, ideally, cross-organisational executives
- Access to data, analytics, management, expert advice and clinicians
- Peer interventions, possibly engaging expert evidence and advice from systems leaders
- Peer learning from other parts of the country where significant achievements have been made in the priority areas facing Oxfordshire.

5. The HAWB is currently advisory rather than decision-making; is this sufficient?

As an advisory body, the board lacks formal authority to attach weight to a joint vision and strategy or align priorities across different organisations in Oxfordshire; it also has insufficient levers to hold organisations to account.

This is not purely a structural challenge as severely constrained budget pressures force organisations within the partnership to focus on their own duties and responsibilities.

The board would benefit from having decision-making powers, but these need to reflect objectives and work programmes that are realistically within the board's ability to influence and achieve.

6. What governance arrangements are needed to make this effective?

Current arrangements and frequency of the HAWB meetings allow insufficient time and space to drive the board's agenda or ownership of outcomes. This could be addressed through:

- Increasing the frequency of HAWB meetings, or potentially introducing informal HAWB meetings or development sessions to give HAWB members time to talk in a less formal setting in more detail throughout the year. These sessions would cover specific topics in alignment with the Joint Health and Wellbeing Strategy, to develop a shared understanding about specific issues and ascertain what roles individual organisations can play in addressing these
- Establishing an executive to the HAWB with a core membership at senior level of the Local Authorities and health organisations
- Holding annual HAWB away-days or conferences to provide time and place to review the strategic challenges and set the board agenda
- Reviewing membership of the wider board to ensure representation from all relevant organisations, including geographic spread of partners, Local Authorities and NHS organisations
- Having representatives senior enough to make decisions and exercise influence within their organisations, with clear roles and responsibilities including accountability and consistent attendance
- Encouraging stronger and clearer public involvement (with corresponding accountability of any representatives).

7. What powers should organisations delegate to the board to make it effective?

This needs to be considered in the light of the future direction of the HAWB: it must be explored alongside developing the proposals for an Accountable Care System and the future HAWB role in governance of that.

8. What should its relationship be with bodies with a similar remit e.g. the Bucks Oxon Berks STP Executive and the Oxfordshire Transformation Board?

The relationship needs to be simplified and clarified, with the responsibilities of each board clearly set out and communicated to avoid confused or competing agendas.

The OTB and HAWB both need to play a role in the development of the STP. The HAWB can provide a system-wide forum with a democratic mandate and ability to bring local political input which is otherwise lacking from STP process. A recent report for the LGA: 'The power of place Health and Wellbeing Boards in 2017' found that the most effective HAWBs have positioned themselves as a 'place anchor' for STPs, with an emphasis on their place-based leadership role as a strategic context for STPs. They are also working with neighbouring boards across the relevant STP footprint.

In Oxfordshire, this will require greater engagement with the HAWB and joint working with the OTB to develop a sub-regional approach to the STP that reflects Oxfordshire priorities. The HAWB should also consider bringing together CCG and HAWB leads from the BOB STP footprint to understand the impact on local systems and to share learning, for example from West Berkshire's approach to Accountable Care System which it sees as an 'evolved' version of the STP working as a locally integrated health system.

9. How should the public/ patient voice be engaged?

Representation from the population across Oxfordshire at board level should be improved. This could be done with a two-tier approach:

1. Representatives of local communities with seats at the board, but where those reps are accountable and consistent. These need to better represent the diversity of Oxfordshire's population and avoid the 'usual suspects'.
2. A broader advisory group which brings in a wide range of voices including health service users from marginalised groups and deprived communities, as well as the wider civic society (see the analogous example of Voxy below). In particular, we should take into account the NICE Guideline (2016) to 'ensure decision-making groups include members of the local community who reflect the diversity of that community'.

(Health inequalities ward level indicators - public health)

There are some good practice examples in effectively managing public/patient voice through existing countywide partnership, such as the Children's Trust and the membership of Voxy. NICE guidelines also identify some mechanisms to draw on the knowledge and experience of local communities and community and voluntary organisations to identify and recruit people to represent local needs and priorities. For example, they suggest asking those recruited to take on peer and lay roles as part of the health and wellbeing initiative. Effective peer and lay approaches are:

- Bridging roles to establish effective links between statutory, community and voluntary organisations and the local community and to determine which types of communication would most effectively help get people involved
- Carrying out 'peer interventions': that is, training and supporting people to offer information and support to others, either from the same community or from similar backgrounds (see learning and training)
- Promoting community health champions who aim to reach marginalised or vulnerable groups and help them get involved
- Promoting volunteer health roles whereby community members get involved in organising and delivering activities.
- Holding Inquiry Days or events to engage key stakeholders and the public in key agendas and inform HAWB plans with opportunity to listening to the experiences of local people and to mapping work to spot gaps.

There are plenty of analogies to this approach happening in other strategic boards across Oxfordshire. This could be achieved through a variety of ways:

- Learn from other effective structures, e.g. Children's Trust and their use of the Voice of Oxfordshire Youth (Voxy)
- Promote a 'task and finish' approach
- Proactively engage community groups (Community Engagement: improving health and wellbeing and reducing health inequalities - NICE guideline [NG44] Published date: March 2016)
- Target engagement to address inequality issues.

Areas of deprivation, for example where residents might experience fewer years of life expectancy, higher rates of childhood obesity, and more hospital stays for self-harm, are located in the wards of Blackbird Leys, Northfield Brook, Littlemore and Barton and Sandhills. These words are characterised by higher levels of unemployment and income deprivation, children living in poverty, and low levels of educational attainment. The taskforce sub-groups on priority areas would allow for further engagement with a wider number of community stakeholders to hear focussed evidence and recommendations under discussion. Here again the NICE Guideline (see 1.1.2) is helpful; it advises that, for effective community engagement, systems health leaders need to recognise that building relationships, trust, commitment, leadership and capacity across local communities and statutory organisations needs the following:

- time
- prior planning to provide sufficient resources (see identifying the resources needed)
- early community engagement, to shape the proposed initiative
- establishment of clear ways of working for all those involved
- early evaluation of community engagement activities, to capture all relevant outcomes (see evaluation and feedback).

The available data sets could be used to target groups within these areas, as shown below.

Oxford IMD Decile Rankings

Overall Index, Domains, two additional indicators, and selected Sub-domain decile rankings for Oxford LSOAs that are amongst the 30% most deprived areas in England. Ranked in ascending order by Overall IMD score. Key: 1 = most deprived, 10 = least deprived

									Supplementary Indices		Edu Sub-domains	
Oxford LSOA Name	IMD	Income	Empl	Edu & Skills	Health	Crime	Housing & Svcs	Living Env	Child Poverty	Pensioner Poverty	Children & Yng people	Adult Skills
Rose Hill and Iffley 76	1	1	2	1	2	1	2	4	1	2	1	1
Northfield Brook 68	1	1	2	1	2	4	2	7	1	2	1	1
Northfield Brook 69	2	2	2	1	1	6	1	8	2	2	1	2
Blackbird Leys 18	2	2	2	1	2	4	2	6	2	3	1	1
Blackbird Leys 20	2	1	2	1	2	3	3	7	1	3	2	1
Barton and Sandhills 13	2	2	3	1	2	3	2	5	2	2	1	4
Blackbird Leys 17	2	3	3	1	2	2	1	8	2	4	1	2
Barton and Sandhills 14	2	2	3	1	2	6	2	6	2	2	1	1
Rose Hill and Iffley 77	2	2	3	1	3	5	3	7	1	2	1	2
Northfield Brook 67	2	2	3	2	3	2	3	6	2	3	2	2
Carfax/Holywell 22	3	5	5	5	1	1	4	1	3	2	2	9
Churchill 24	3	3	3	2	2	8	5	6	2	4	1	4
Blackbird Leys 19	3	3	4	1	4	2	5	4	2	4	1	2
Iffley Fields 46	3	3	3	4	2	3	5	4	3	3	4	5
Littlemore 52	3	2	4	3	3	4	5	6	1	4	3	2
Littlemore 53	3	4	3	2	3	5	5	4	3	6	1	6
Barton and Sandhills 16	3	3	4	2	4	2	3	6	3	7	1	6
Hinksey Park 43	3	4	3	6	3	2	2	5	4	5	4	9

Summary Despite having 60% of its neighbourhood areas ('Lower-layer Super Output Areas' or LSOAs) in the least deprived half of the Index of Multiple Deprivation (IMD) ranking, Oxford has a significant proportion (18 out of 83) of its areas in the most deprived 30% in England. Key aspects of relative deprivation in Oxford are low income (especially child poverty) and poor educational attainment. 9 out of 10 LSOAs in the 20% most deprived areas in England are also amongst the 10% most deprived areas for education, skills, and training. Between 20% and 30% of the population in these areas live on incomes below the poverty line. In addition to education deprivation, the LSOAs in the first and second most deprived deciles also see higher levels of health deprivation.

10. Should the current HAWB sub-groups be changed?

The sub-group approach has worked well and is key to enabling the HAWB to balance its strategic leadership role whilst driving forward specific interventions involving the right partnership organisations. For example, having all districts involved in the HIB meant it has been effective in developing a pooled budget and a joint commissioning process for homeless services.

There is really an opportunity to build capacity within these formal sub-group structures (different in function to the taskforce group discussed above). The following points should be considered:

- Current sub-groups could be reviewed, as well as their mechanism for reporting into the HAWB
- A task-based 'task and finish' approach should be encouraged
- The scope of the HIB is very useful but could be broadened
- There needs to be an Adult Social Care Board held in public; this would provide consistency with the effective Children's Trust, but for adult services
- Given the recurring issues around mental health and complex users, a board focussed on this could also be helpful. At the very minimum, this should be a priority taskforce group for a core of HAWB members to oversee with co-opted clinicians, experts and expert service users.

11. How should statutory organisations be represented and with what authority?

There should be formal membership of statutory organisations. All statutory organisations need to participate, including primary care providers.

Representation should be at the level of CEO or chair/leader. If the board's purpose is mainly governance, chairs /leaders should be there with possible executive attendance. These senior representatives should delegate as appropriate within their organisations to ensure the right expertise on the 'task and finish' groups

12. How should a potentially wide range of other organisations and stakeholders (e.g. the voluntary sector) be engaged?

- Identify barriers to involvement, particularly for vulnerable groups

- Make use of strategic recruiting / forward planning / integration into formal membership
- Explore (and require) different models of engagement
- Commit resource; provide the support people need to get involved
- Provide information in formats that people can understand
- Encourage and support co-production

13. What barriers might get in the way and how can they be removed?

Potential barriers include:

- Relationship issues - cultural and organisational
- Insufficient engagement of community groups
- Competing board priorities
- Less inclusive membership
- The wrong people within the membership
- Budget pressures

Potential solutions include:

- Develop the board strategically and effectively, to address barriers and then board function/roles
- Proactively engage community groups, and explore mechanisms to do this effectively
- Provide a clear system flowchart, with terms of reference for each sub group
- Include voluntary sector providers on the board, and get key agency representation

There is a real opportunity to re-invigorate the HAWB and drill down into RAG areas rated ‘red’ to move provision forward. Refreshed board membership will allow an extended group of ‘critical friends’ to move forward on priorities where progress has been static. Taskforce groups as described above, with a clear ‘task and finish’ remit which allow for peer interventions and evidence from expert service users, will enable dynamism and expedite problem solving. Reports back from such specialist taskforce groups with recommendations for a HAWB with increased decision-making functions could break cycles of ‘red’ RAG issues returning to the board unresolved. This will be strengthened with a revitalised and clear board vision on a forward plan of difficult priorities. Increased engagement from a wider sector of stakeholders will also help to increase momentum, as will engagement from senior stakeholders and systems leaders outside the geographic locality. Some of these changes will require

brave leadership and acknowledgement of what could work better, but this consultation provides an exciting opportunity to drive this important course of action.

As part of this review, the HAWB should seek to incorporate learning from elsewhere, particularly those HAWBs in two-tier areas who are seen as effective, such as Suffolk. The LGA has commissioned a series of reports on progress of HAWBs with key recommendations for effective working. See for example: https://www.local.gov.uk/search?query=health+wellbeing+boards&op=Search&form_build_id=form-Xq9AZE3II9StxNkBHxXgc03mvtnWtd4LRD44mUCBL7w&form_id=search_form_input