Public Document Pack

NHS Oxfordshire Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL

healthwatch Oxfordshire

To: Members of the Health Improvement Partnership Board

Notice of a Meeting of the Health Improvement Partnership Board

Thursday, 22 November 2018 at 11.00 am

Town Hall, Oxford

Yvonne Rees
Chief Executive

Date Not Specified

Contact Officer: ***Sue Gibbens, Senior Business Management Support Officer***
Tel: (01865) 323580; Email: susan.gibbens@oxfordshire.gov.uk

Membership

Chairman – District Councillor Andrew McHugh
Vice Chairman - District City Councillor Louise Upton

Board Members:

Cllr Anna Badcock	South Oxfordshire District Council
Cllr Jeanette Baker	West Oxfordshire District Council
Dr Kiren Collison	Clinical Chair of Oxfordshire Clinical Commissioning Group
Christine Gore	West Oxfordshire District Council
Daniella Granito	District Partnership Liaison
Diane Hedges	Chief Operating Officer, Oxfordshire Clinical Commissioning Group
Richard Lohman	Healthwatch Ambassador
Cllr Monica Lovatt	Vale of White Horse District Council
Dr Jonathan McWilliam	Strategic Director for People and Director of Public Health
Cllr Lawrie Stratford	Cabinet Member for Adult Social Care & Public Health, Oxfordshire County Council
Jackie Wilderspin	Public Health Specialist

Notes:

- ***Date of next meeting: 14th February 2018, 2-4pm***

Declarations of Interest

The duty to declare…..
Under the Localism Act 2011 it is a criminal offence to
(a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
(b) provide false or misleading information on registration, or
(c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?
The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?.
The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *"You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself"* or *"You must not place yourself in situations where your honesty and integrity may be questioned….."*.

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:
Employment (includes"*any employment, office, trade, profession or vocation carried on for profit or gain*".), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Glenn Watson on **07776 997946** or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, but please give as much notice as possible before the meeting.

AGENDA

1. Welcome by Chairman, District Councillor Andrew McHugh

2. Apologies for Absence and Temporary Appointments

3. Declaration of Interest - see guidance note opposite

4. Petitions and Public Address

5. Note of Decision of Last Meeting (Pages 1 - 8)

11:05
5 Minutes

To approve the Note of Decisions of the meeting held on 13th September 2018 and to receive information arising from them.

6. Joint Health and Wellbeing Strategy (Pages 9 - 26)

11:10
10 Minutes

Report presented by Dr Jonathan McWilliam.

Draft report for noting.

7. Performance Report Proposal (Pages 27 - 38)

11:20
20 Minutes

Report presented by Val Messenger

To agree a new set of performance indicators and target outcomes to reflect the new priorities. Also to decide which are reported regularly to the HWB.

8. Housing and Homelessness, including Rough Sleeping (Pages 39 - 42)

11:40
20 Minutes

Report presented by Jo Barrett and Nerys Parry.

Latest performance report and update on rough sleeping from Housing Support Advisory Group.

9. Tobacco Control Alliance (Pages 43 - 48)

12:00
10 Minutes

Report presented by Eunan O'Neil.

Report on the purpose and actions of this new group.

10. Director of Public Health Annual Report 2019 (Pages 49 - 142)

12:10
10 Minutes

Report presented by Dr Jonathan McWilliam.

To Receive and discuss the annual report.

11. Public Health - Health Protection Forum (Pages 143 - 148)

12:20
15 Minutes

Report presented by Eunan O'Neil.

Report on performance on immunisation, screening, health protection and air quality.

12. Communications and Campaigns

12:35
10 Minutes

Verbal update from Mish Tullar.

Discussion on potential for working together on health promotion campaigns.

13. Domestic Abuse Strategy Group (Pages 149 - 156)

12:45
15 Minutes

Annual report presented by Sarah Breton and Sarah Carter.

14. Healthwatch Ambassador Report (Pages 157 - 164)

13:00
10 Minutes

Report presented by Richard Lohmann.

Update from the Healthwatch Ambassador.

15. Government Letter (Pages 165 - 166)

13:10
5 Minutes

Letter presented by Cllr Lawrie Stratford.

Approval required for sending letter to the Secretary of State for Health and Social Care.

16. Any Other Business and Forward Plan (Pages 167 - 168)

13:15
5 Minutes

Presented by Cllr Andrew McHugh

The Forward Plan is presented by District Cllr Andrew McHugh, Chairman of the Health Improvement Board. The Board is asked to note the items on the forward plan and propose any areas for future discussion.

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HEALTH IMPROVEMENT PARTNERSHIP BOARD

OUTCOMES of the meeting held on 13th September 2018 commencing at 2:45pm and finishing at 4:45pm

Present:	As below (Board members) plus Donna Husband, Sarah Carter, Kate Austin, Rosie Rowe, Azul Strong, Tom McCulloch
Apologies:	Richard Lohman
Board members:	Councillor Andrew McHugh, Chairman and District Councillor, Councillor Louise Upton, District City Councillor, Councillor Laurie Stratford, Cabinet Member for Adult Social Care & Public Health, Oxfordshire City Council, Councillor Anna Badcock, South Oxfordshire District Council Councillor Jeanette Baker, West Oxfordshire District Council Councillor Monica Lovatt, (Vale of White Horse District Council Diane Hedges, Oxfordshire Clinical Commissioning Group Christine Gore, West Oxfordshire District Council Dr Jonathan McWilliam, Oxfordshire County Council Dr Kiren Collison, Clinical Chair of Oxfordshire Clinical Commissioning Group Jackie Wilderspin, Oxfordshire County Council Dani Granito, District Councils liaison
Officers:	
Agenda item 6	Keith Johnson, Active Oxfordshire and Paul Brivio, Active Oxfordshire
Agenda item 9	Donna Husband
Agenda item 10	Rosie Rowe, Azul Strong and Tom McCulloch
Agenda item 11	Kate Austin
Agenda item 13	Sarah Carter

These notes indicate the outcomes of this meeting and those responsible for taking the agreed action. For background documentation please refer to the agenda and supporting papers available on the Council's web site (www.oxfordshire.gov.uk.)

If you have a query please contact Susan Gibbins (Tel 07881 268232; Email: Susan.gibbens@oxfordshire.gov.uk

ITEM	ACTION
1. Welcome The Chairman, Councillor Andrew McHugh, welcomed everyone to the Board Meeting and thanked Councillor Anna Badcock, the previous Chairman and Cllr Marie Tidball, the previous Vice Chairman for making such a successful Committee. Thanks were also given to members who have stood down since the last meeting – Cllr Hilary Hibbert- Biles (County Council) and Cllr John Donaldson (Cherwell DC) It was noted that the representative of West Oxfordshire DC continues to be Cllr Jeanette Baker, not Cllr Norman McRae as advised on the agenda for this meeting. Cllr Louise Upton, Cllr Lawrie Stratford, Christine Gore and Kiren Collison were welcomed to their first meeting.	
2. Apologies for Absence and Temporary Appointments Apologies were received from Richard Lohman.	
3. Declaration of Interest There were no declarations of interest at this meeting.	
4. Petitions and Public Address No petitions or public addresses were received.	
5. Introduction to the Health Improvement Board and update on changes to the Health and Wellbeing Board Dr Jonathan McWilliam explained that the Health Improvement Board (HIB) has been in existence for 6 years. It has a primary focus on prevention, health improvement and health inequalities. He believes that we have kept our focus over the past 6 years and that we are in a strong position. The Board is now entering a time of change with more joined up planning. Jonathan explained that there has been a review of the role and membership of the Health and Wellbeing Board which has an impact across the system. However, the review concluded that the HIB is doing a valuable job as one of the sub-partnerships and should continue as it is. The review has resulted in an expanded membership of the HWB as Oxfordshire moves towards an integrated health and social care system. This will be reflected in the new Joint HWB Strategy and the HIB will make a significant contribution to that, through an ongoing focus on prevention and addressing the wider determinants of health. Organisations are working well together contributing to the Health and Wellbeing Board. In addition to the HIB this is through the Children's Trust and Joint Management Groups focussing on Health and Adult social care. In conclusion Jonathan urged members of the Board to continue their good	

work and persist with their long term aims	
6. Note of Decision of Last Meeting Councillor Andrew McHugh stated that all action points from the previous meeting have been actioned apart from Jo Barrett's report on rough sleeping, which is being brought forward to the November. Councillor Anna Badcock queried why this item has not been presented today by someone else and the Board agreed that if the report is ready that it will be circulated by email as soon as possible. **Action - Jackie Wilderspin to check if the report is ready for circulation by email prior to the November meeting.** **<u>Active Oxfordshire update presented by Keith Johnson and Paul Brivio (Chief Executive for Active Oxfordshire)</u>** Keith Johnson introduced Paul Brivio as the new Chief Executive for Active Oxfordshire. He explained that they are one of 40 County Sports Partnerships in the country, which are funded by Sport England. Additional funding in Oxfordshire comes from Public Health and the CCG. Keith Johnson then provided an update on the proposed changes that were outlined at the last meeting. The transition is now completed and Active Oxfordshire is a new organisation and will be based in Kidlington. They have an upcoming engagement event with decision makers on 14th September. Members of the HIB congratulated the team on this progress and asked who they would plan to collaborate with, how they will measure progress and whether there is any conflict of interest amongst funders. Paul Brivio stated that they are keen to establish credibility and build strong working relationships with all partners. The focus for their work will be people who are currently inactive so that risk of ill health is reduced, especially diabetes and for people with disabilities. There will be a further report in early 2019 including some information on how progress will be monitored.	**Jackie Wilderspin**
7. Performance Report – end of year 2017 – 18 Jackie Wilderspin discussed the performance report and highlighted any indicators rated red or amber. The Board members discussed obesity level in year 6 children (rated red) and what the future plans are to address that. Dr Jonathan McWilliam explained that we are above the national average statistically and that there is a role for everyone in tackling this issue. For example, the Government are focusing on advertising/food labelling and school curricula regarding physical activity and promoting active travel. At county level, we have active	

travel and input into planning decisions and initiatives in schools such as WOW active travel in primary schools and the Daily Mile. Councillor Anna Badcock stated that there is fundamental change across the country (many decisions beyond the control of Oxfordshire) and that we should be proud of the content in the board papers. Sport in schools is key and the work Paul and Keith for Active Oxfordshire are doing will be fundamental in the years to come. Councillor Andrew McHugh believes there is a lot of room for improvement to target those that are reluctant to exercise. There are familial factors and the subject is of a multi factorial nature. Jackie Wilderspin said that Oxfordshire will pilot the new whole systems approach to Healthy Weight and that we expect to hear more about that in the future. Councillor Anna Badcock stated that the Bowel Cancer Screening Programme has lowered the age to 50+ and the key focus is on the figures going forward. It was noted that details of actions to improve poor performance will be presented to the HIB in future, in the form of "Report Cards" as at previous meetings.	
8. Future priorities for the Health Improvement Board Jackie Wilderspin presented a paper on future priorities for the HIB, building on decisions made at the meeting in May. 3 priority areas for future work were suggested which are 1. Keeping Yourself Healthy (Prevent) 2. Reducing the impact of ill health (Reduce) 3. Healthy Place Making It was acknowledged that the work the HIB was already leading fitted into these 3 priority areas but that 3 additional areas of work could be added. These are mental wellbeing, alcohol advice / treatment and diabetes prevention. This approach was welcomed by the members of the Board and the proposed priorities were agreed. In addition it was agreed that the work should always address inequalities and imbed prevention. In order to deliver this work it was acknowledged that several working groups are already set up and others may need to be added. This might cause some difficulties for partners to participate in several groups which would be worked through. The need for a performance framework to monitor progress was set out in the report and it was agreed that proposals for a final set of indicators should be brought to the next meeting. **Action point - Proposals for performance indicators will be brought to**	**Jackie Wilderspin**

the meeting in November. **<u>Social Prescribing</u>** Dr Kiren Collison presented her paper and explained the definition of Social Prescribing - Health Care Professionals such as GPs refer patients to non-medical services e.g. Classes/clubs for a more holistic approach to improve mental health, social connectivity and physical activity. There is evidence to show benefits to health and wellbeing and it can also reduce demand on health services. Social Prescribing enables GPs to refer patients to a Link Worker, who would then refer the patient on to other appropriate services. Dr Collison asked the HIB to consider including Social Prescribing in the set of new priorities for their work. Councillor Andrew McHugh declared a past interest in a pilot scheme and said that he is 100% behind the idea. Councillor Anna Badcock raised the issue of social prescribing in rural areas where access to services may be difficult due to transport problems. Councillor Jeanette Baker is fully supportive of the idea but also shared a concern over courage of patients to attend events. Councillor Louise Upton stated that the Link Worker is key for getting people to engage but the evidence is still "sketchy". She asked if the scheme could include health walks this can link into other programmes i.e. diabetes. After discussion the Board members agreed that Social Prescribing should be added to the priorities for the HIB. **Action: Performance indicators for this aspect of work should be added to the HIB performance framework which will be proposed at the next meeting.**	**Kiren Collison**
9. Mental Wellbeing Framework Donna Husband presented the paper that had been circulated with the agenda. She outlined the definition of mental wellbeing, the proposal that the HIB should use the concept of CLANGERS (Connect, Learn, be Active, Notice, Give, Eat well, Relax, Sleep) to illustrate the determinants of good mental wellbeing. There were four proposals for discussion a. Agree the approach of focusing efforts on promoting and supporting mental wellbeing b. Recognise that this is in addition to the mental ill-health overview provided by other partnerships (Joint Management Group for Adults and Children's Trust) c. Recommend the Health and Wellbeing board to endorse the consensus statements of the Prevention Concordat programme. d. Set up a working group to develop an Oxfordshire Mental	

Wellbeing Framework including actions needed for HIB partners to sign up to the Prevention Concordat and proposed indicators that can be used to measure progress Board members welcomed the paper and expressed support for the proposals. Discussion focussed on the difficulty of measuring the mental wellbeing of the population and the impact of any initiatives. It was also agreed that individual organisations had a lot to contribute and that signing up to the Prevention Concordat would be a good way of illustrating that – but that it should also be a meaningful process and show added value, building on what was already in place. It was noted that Cllr Stratford is the Mental Health Champion for Oxfordshire County Council and that is it possible for every organisation to also have a named champion. It was proposed that Dani Granito can help in liaison work on this topic across the District councils All the recommendations were agreed by the board. **Action: Donna Husband to prepare a proposal for the HWB to enable the whole system to sign up to the Prevention Concordat** **Action: Donna Husband to oversee set up of a Task and Finish Group to take this work forward, including further proposals for performance monitoring.**	**Dani Granito** **Donna Husband**
10. Healthy New Towns – learning from work in Bicester and Barton and Community Placemaking Charter Tom McCulloch presented the slides that had been circulated with the agenda and introduced the Placemaking Charter. He explained that research by Communities First has led to 6 steps to effective placemaking: 1. Involve the community in the development process 2. Design 3. Provide indoor community meeting spaces 4. Invest early in community development support 5. Build and release capacity 6. Support community management of assets and facilities Azul Strong presented details of the learning emerging from Barton Healthy New Town which were included in the paper circulated with the agenda. The presentation included a video with feedback from local residents which can be viewed in full by this link: http://www.oxford.gov.uk/bhntWHO Rosie Rowe continued the presentation by outlining the approach and new models of care adopted in Bicester Healthy New Town. Diabetes has been a focus with the 'go active get healthy programme' which has been identifying opportunities in the community for people with long-term conditions. Statistics on the impact of partnership work and the core elements of healthy place making were shown to the Board. The results show that these courses	

of action work well in areas of deprivation. A Survey has been done in Bicester regarding social isolation and loneliness, which will be shared with the Social Prescribing Team. Councillor Andrew McHugh stated that this is going to make a big difference and Dr Jonathan McWilliam called for the Board members to accept the recommendations and take this work forward in other areas. Discussion focussed on how the HIB can pick up this work and embed new practice in planning and service delivery. Rosie informed the group that all the learning from the Healthy New Towns will be published in March 2019. Rosie also recommended that performance monitoring should include levels of participation in activities and events as these gave more immediate indications of success than high level health outcomes. This could include local residents' surveys. It was noted that funding will be required for community activation work in new or existing communities and this needs to be secured across the county. **Action: Further information and discussion at the HIB once the national guidance has been published in March 2019.** Councillor Monica Lovatt outlined a local initiative called 'Healthy Abingdon' where some of these principles are already being applied. E.g. benches within the community and a dementia friendly town. This is not costing the council anything as they are getting grants. **Action point - Councillor Monica Lovatt would like to circulate a short paper about healthy Abingdon, which the Board agreed to review.**	**Jackie Wilderspin** **Councillor Monica Lovatt**
11. Making every contact count – overview and current work Kate Austin presented her paper on the Making Every Contact Count (MECC) programme across the county. It was noted that MECC training is taking place within the Fire Service, libraries, health service and Healthy New Towns in Bicester and Barton. The next steps are to take this wider e.g. with the ambulance service. It was suggested that other workers could also be trained e.g. pharmacy staff and delivery people, those working with refugees etc. Measurement of the impact of MECC is a challenge and Kate was asked to consider how this can be reported in future.	
12. Healthwatch Ambassador's Report The report was noted.	
13. Domestic Abuse Strategy Group update Sarah Carter gave an update on recent work that has been completed,	

including a. Establishment of newly commissioned services, giving a consistent offer across the county b. Accommodation based services including Refuge provision (mainly used by people from outside Oxfordshire) and a dispersed model of housing units. c. Young people pathway with training available from October. d. Training for the general workforce and more detailed training for support workers – available in November The report was welcomed and progress noted. It was also noted that the HIB and district community safety partnerships have been asked to report to the Safeguarding Boards on progress of the Domestic Abuse Strategy Group. **Action: Jackie to seek opinions from HIB members and prepare a report in collaboration with Community Safety Officers from districts**	**Jackie Wilderspin**
14. AOB The Chairman stated that there were no other items of business to consider.	
The meeting closed at 4.45pm	

..... in the Chair

Date of signing

Oxfordshire Joint Health and Wellbeing Strategy (2018-2023)

Draft for discussion at the Health and Wellbeing Board

15th November 2018

To the people of Oxfordshire,

This strategy is all about you, the people who live in, work in and visit Oxfordshire.

It tells the story of how the NHS, Local Government and Healthwatch work together to improve your health and wellbeing. We work together as the Oxfordshire Health and Wellbeing Board. The membership has just been reviewed, and so we see this as our chance to begin a fresh conversation with you.

The strategy paints a picture of the things we intend to do, but it needs input from you and so it is written as the start of that conversation with you.

It paints a picture, but we don't start with a blank canvas – health in Oxfordshire is good compared with the national picture. Residents live longer here than elsewhere and remain healthy into older age for longer than the national average. Local people take more exercise than in neighbouring counties and carry less excess weight. We consistently outperform other areas for measures such as breast feeding, teenage pregnancy and immunisation rates. These positive factors give us a solid foundation on which to build local services.

There is much already going on in our services and how they work together too. For example, we have some of the leading health sevice and academic organisations in the country on our doorstep, and many highly rated services. Levels of satisfaction from patients and users of our services consistently say that overall they are satisfied with the services they receive.

Yet we face challenging times. The population is growing and ageing. The number of people with chronic complex diseases is growing. Demand for all our services is increasing. House prices locally are high and this exacerbates staffing shortages. Money is very tight, and frankly we struggle to consistently support people well and deliver good outcomes.

We know we can do better than this and know we have to work together to find our way through these challenges. We are confident that we can. Our major asset is our willingness to work together and to work with you to find new solutions to old problems.

That's what this strategy is all about.

We have drafted a vision to guide us on our journey forward, it is our touchstone and our compass.

Our Shared Vision is: "To work together in supporting and maintaining excellent health and well-being for all the residents of Oxfordshire"

We have reviewed the current issues affecting us and have picked out the most urgent priorities for our renewed focus on delivery through partnership. We aim to: prevent ill health before it starts; give people a high quality experience as they use our services; work with you on re-shaping your local services and tackle our chronic workforce shortages.

The priorities can be summarised as:

- **Agreeing a coordinated approach to prevention and healthy place-shaping.**
- **Improving the resident's journey through the health and social care system (as set out in the Care Quality Commission action plan).**
- **Agreeing an approach to working with the public so as to re-shape and transform services locality by locality.**
- **Agreeing plans to tackle critical workforce shortages.**

In addition to these priorities for the Board we will be developing our work together on a wide range of issues that affect different groups in the population. These are set out in the body of the strategy using an approach which covers all ages and stages of life– ensuring *A Good Start in Life*, enabling adults to continue *Living Well* and paving the way for *Ageing Well*. Many factors underpin our good health and we will work together to address these too under the heading *Tackling Wider Issues That Determine Health.*

And written through all these priorities is our absolute commitment to *tackling health inequalities* and *shifting the focus to prevention*.

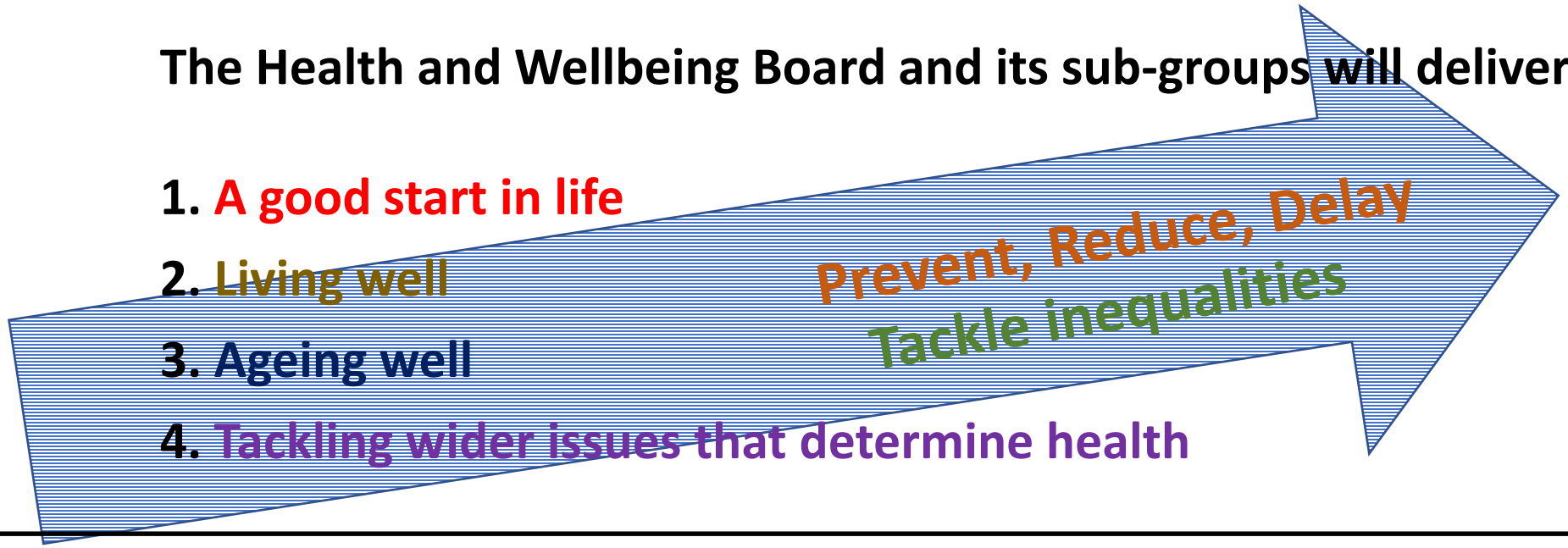
We hope our approach piques your interest, and look forward to sharing our ideas with you in the pages that follow…….

Overview of our priorities

The Health and Wellbeing Board's Priorities are:

- Agreeing a coordinated approach to prevention and healthy place-shaping.
- Improving the resident's journey through the health and social care system (as set out in the Care Quality Commission action plan).
- Agreeing an approach to working with the public so as to re-shape and transform services locality by locality.
- Agreeing plans to tackle critical workforce shortages

The Health and Wellbeing Board and its sub-groups will deliver



The next few pages explain what we mean when we say we are focussing on
A good start in life, Living Well, Ageing Well and Tackling wider issues that determine health.

A Good Start in Life

Why is this important?

The best start in life starts with a baby's mother being healthy before and during pregnancy and childbirth. There is a lasting impact in future years from what happens in the early years of a child's life – influencing future physical and mental health, safety, educational achievement and a successful work life.

Schools, the influence of peers and social relationships are formative too. Brain development, attitudes to risk taking and controlling feelings and emotions that develop in adolescence and have consequences for health.

What do we need to do to make a difference?

- Enable children and young people to be well educated and grow up to lead successful, happy, healthy and safe lives.
- Schools and universal services working together with local, targeted and specialist services is key to improving outcomes.
- Shift the focus to prevention and early help through real partnerships and using resources effectively.
- Support the most vulnerable, including children with Special Educational Needs or Disabilities, to make sure everyone has an equal opportunity to become everything they want to be.
- Deliver responsive services that place children, young people and families at the heart of what we do.
- Work with all generations in families and communities.

The Joint Strategic Needs Assessment shows us that

- Children and young people aged 0 to 17 made up 21% of Oxfordshire's population as of mid-2016, a similar proportion to that in 2006. The greatest increases were in the age groups 0-4's and 5-9's.
- Childhood obesity in Oxfordshire is lower than the national average and is remaining stable, unlike the national rising trend.
- 14,000 children in Oxfordshire were affected by income deprivation.
- In the past year, there has (again) been an increase in the number of people referred for treatment to mental health services, particularly children and young people
- Oxfordshire has seen increases in the number of children referred to social care, children on protection plans and children who are looked after.
- Care leavers in Oxfordshire are less likely than average to be in employment, education or training.
- The proportion of Oxfordshire's disadvantaged pupils aged 10-11 achieving the expected standard at Key Stage 2 was below the England average in 2017
- Oxfordshire has a relatively high rate of unauthorised absences from school

Living Well

Why is this important?

Oxfordshire is above the national average for many health outcomes, but many people still live with avoidable conditions such as heart disease, cancer and diabetes. Risk of contracting these illnesses can be reduced through adopting healthy lifestyles. Early detection of long term conditions leads to better outcomes.

People who are already diagnosed need to be supported to stay as well as possible and enjoy life.

There are some groups of people who are more at risk because of where they live, their age, ethnicity, gender, mental health or other factors. Appropriate targeting of services is needed for them. There needs to be care closer to home and smooth flow between services.

What do we need to do to make a difference?

- Shift the focus to prevention, enabling people to get the information and support they need to make healthy choices.
- Nurture healthy communities where people are able to participate, contribute and be healthy.
- Identify disease early and help people to manage their long-term conditions
- Deliver effective and high-quality services which are efficient and joined up.
- Make sure people are involved in the design and evaluation of services.
- Ensure that adults with care and support needs can access the services they need for holistic care, with parity of esteem for mental health.

The Joint Strategic Needs Assessment shows us that

- As of mid-2016, the estimated total population of Oxfordshire was 683,200. Oxfordshire County Council population forecasts, based on local plans for housing growth, predict an increase in the number of Oxfordshire residents of +187,500 people (+27%) between 2016 and 2031, taking the total population of the county from 687,900 to 874,400
- Life expectancy by ward for Oxford shows the gap in male life expectancy between the more affluent North ward and the relatively deprived ward of Northfield Brook has increased from 4 years in 2003-07 to 15 years in 2011-15. Female life expectancy in these wards has remained at similar levels with a gap of just over 10 years.
- **89,800** people in Oxfordshire reported by the Census 2011 survey as having activities limited by health or disability
- The latest survey of carers shows that around a third (34%) of Oxfordshire carer respondents have had to see their own GP in the past 12 months because of their caring role. This was a similar proportion in carers of all ages.
- For the 3-year period, 2014 to 2016, total deaths of people aged under 75 from the four causes of: cardiovascular diseases, cancer, liver disease and respiratory disease in Oxfordshire was 3,396. Of these **1,959** (58%) were considered preventable
- The number and rate of GP-registered patients in Oxfordshire with depression or anxiety has increased significantly each year for the past 4 years.
- Rates of intentional self-harm in Oxfordshire are now statistically above the England average.
- In September 2017, there was a total of 644 advertised NHS vacancies (full time equivalents), 44% were for nurses/midwives and 22% were administrative and clerical.

Ageing Well

Why is this important?

The number of older people in the county is increasing and is projected to grow further, with the proportion of those aged over 85 increasing by 60-80% in the next 15 years. While people are living longer, many are spending more years at the end of life in poor health. The number of people with dementia is also growing.

The evidence shows that we should identify the people at risk, intervene earlier and develop multi-disciplinary working in new ways to support active ageing and prevent loneliness, ill health and disability among older people. There needs to be care closer to home and smooth flow between services.

What do we need to do to make a difference?

- Focus on prevention, reduce the need for treatment and delay the need for care by helping people to manage long term conditions
- Use innovative and appropriate aids, equipment and services
- Ensure services are effective, efficient and joined up and that the market for provider organisations is sustainable.
- Help people to maintain their independence and remain active in later life.
- Work in multi-speciality teams to ensure frail older people are cared for in the community
- Identify conditions early, including dementia, to enable people to manage their conditions and get the support they need from friends and family.
- Address seasonal and other pressures in the health and care system that can affect older people disproportionately

The Joint Strategic Needs Assessment shows us that

- As of mid-2016, the estimated total population of Oxfordshire was 683,2002.
    - Over the ten-year period, 2006 and 2016, there was an overall growth in the population of Oxfordshire of 52,100 people (+8.3%), similar to the increase across England (+8.4%).
    - The five-year age band with the greatest increase over this period was the newly retired age group 65 to 69 (+41%). There was a decline in the population aged 35 to 44.
    - By 2031, the number of people aged 85 and over is expected to have increased by 55% in Oxfordshire overall, with the highest growth predicted in South Oxfordshire (+64%) and Vale of White Horse (+66%).
- Isolation and loneliness have been found to be a significant health risk and a cause of increased use of health services. Areas rated as “high risk” for isolation and loneliness in Oxfordshire are mainly in urban centres.
- Oxfordshire’s comparative rates of injuries due to falls in people aged 65+ and for people aged 80+ has recently improved, from statistically worse than average to similar to the South East average
- There has been an increase in the proportion of older social care clients supported at home, from 44% of older clients in 2012 to 59% in 2017.
- Oxfordshire County Council estimates that: of the total number of older people receiving care in Oxfordshire, 40% (4,200) are being supported by the County Council or NHS funding and 60% (6,300) are self-funding their care
- Assuming the use of health and social care services remains at current levels for the oldest age group (85+) would mean the forecast population growth in Oxfordshire leading to an increase in demand of:
    - +7,000 additional hospital inpatient spells for people aged 85+: from 12,600 in 2016-17 to 19,600 in 2031-32.
    - +1,000 additional clients supported by long term social care services aged 85+: from 1,900 in 2016-17 to 2,900 in 2031-32.

Tackling Wider Issues that Determine Health

Why is this important?

We know that the physical environment, the quality of housing and opportunities for active travel have a big influence on health and wellbeing.

There will be a massive increase in new housing in Oxfordshire, creating new communities. The challenge is to find a better way to plan for and shape communities so that they actually promote health and wellbeing, learning from the Healthy New Towns in Bicester and Barton.

We know that, overall, these factors play a huge role in shaping our overall health and hold the key to prevention.

The support of friends and neighbours in communities is also good for physical and mental health and gets more crucial as the population ages. We also want to protect people affected by difficult issues such as domestic abuse.

Health and care workers form a significant proportion of the local workforce. High house prices in Oxfordshire (Oxford is the least affordable place to live nationally) mean that we have chronic and enduring challenges recruiting and retaining in health and care staff, without which our services cannot function

What do we need to do to make a difference?

- Learn from the experience of the Healthy New Towns in Barton, Bicester and further afield and work together to apply these ideas to all our planning.
- To work with the leaders of the 'Growth agenda' in Oxfordshire in partnership on this agenda
- Protect vulnerable people from the risk of homelessness, threat of violence and the reality of cold homes
- Work together to reduce demand for reactive services and shift the focus to prevention. This will improve quality of life for residents and also contribute to the financial sustainability of public services.
- We need to work successfully together with the public in an effective dialogue about the need to re-shape services across the County, building trust and collaboration.

The Joint Strategic Needs Assessment shows us that

- District Councils' plans for new housing in existing (adopted) and draft local plans set out an ambition for new housing in Oxfordshire of 34,300 by the end of March 2022 and a further 47,200 homes by end March 2031, a total of 81,500 new homes in the next 15 years
- House prices in Oxfordshire continue to increase at a higher rate than earnings
- Over the past 6 years there has been an increase in people presenting as homeless and of people accepted as homeless and in priority need in Oxfordshire, although the latest data for 2016-17 shows a decline. Loss of private rented accommodation is an increasing cause of homelessness.
- There has been an increase in the proportion of households defined as "fuel poor" in each district of Oxfordshire.
- Data from Thames Valley Police shows an increase in recorded victims of abuse and exploitation in Oxfordshire. The exception was the number of recorded victims of Child Sexual Exploitation which declined from 170 in Oxfordshire in 2016 to 106 in 2017

Prevent, Reduce, Delay

Prevent, Reduce, Delay. Prevention measures throughout the system will allow us to

- Live longer lives (**prevent** illness), by helping people keep themselves healthy and by creating a places for local people to live in
- Live well for longer (**reduce** need for treatment) by identifying any health issues early and supporting people to manage their long term conditions
- Keep us independent for longer (**delay** need for care) by providing the right support at the right time

What do we need to do to make a difference?

- To combat increasing chronic disease, we need to shift towards more preventative services. We need to join up NHS and County Council preventative services better with District Council preventative services, making it easy for people to choose healthy lifestyles.
- Funding preventative services is a challenge in the face of rising demand for treatment services but needs to be addressed
- Spread the learning from our Healthy New Towns through 'healthy place-shaping.

What the Joint Strategic Needs Assessment says

- An estimated 55% of people aged 16 or over in Oxfordshire are classified as overweight or obese.
- Smoking prevalence in adults in routine and manual occupations was estimated at 24.5% in Oxfordshire, over double the rate of all adults and similar to the national average.
- The rate of hospital admissions for alcohol-related conditions gives a mixed picture in different age groups. By and large the rates are reducing, except for women aged under 40. In addition the alcohol-specific admissions for females under 18 in Oxfordshire has remained statistically above the national average in the latest data. The rate for males in Oxfordshire was similar to average.
- Oxford and Vale of White Horse were each better than the England average on the proportion of people who were inactive according to the Active Lives survey. Cherwell, South and West Oxfordshire districts were similar to the national average.
- The Joint Strategic Needs Assessment has no figures on numbers of people with high plasma glucose levels but does record In 2016-17 there were around 29,500 GP-registered patients in the Oxfordshire Clinical Commissioning Group with a recorded diagnosis of diabetes, up from 27,900 in 2015-16
- In 2016-17 there were around 89,900 GP-registered patients in the Oxfordshire Clinical Commissioning Group with a recorded diagnosis of Hypertension, up from 85,800 in 2015-16. The prevalence increased from 12.29% of patients to 12.31%, remaining below the national and regional averages

Tackle Inequalities

Why is this important?

Addressing health inequalities is essential because we know there are 2 main issues:
Inequalities in opportunity and / or outcome – some people don't get a good start in life, live shorter lives or have longer periods of ill health
Inequalities of access – some people cannot get to services, don't know about them or can't use them

What do we need to do to make a difference?

- We need to use information well to identify communities and groups who experience poorer outcomes and ensure the right services and support are available to them, measuring the impact of our work.
- We need to work together to build on the success of recent years in coordinating our approach to wellbeing challenges which are the responsibility of multiple agencies. Examples of this are coordinated work for homeless people and people suffering domestic abuse with City and District Councils
- We need to continue to develop the ways we work with the voluntary sector, carers and self-help groups.
- We have to address the challenge of funding in all areas and ensure that decisions on changing services do not adversely affect people with poor outcomes

What the Joint Strategic Needs Assessment says

- Earnings remain relatively high for Oxfordshire residents. Despite relative affluence, income deprivation is an issue in urban and rural areas.
- 14,000 children in Oxfordshire were affected by income deprivation.
- Snapshot HMRC data (Aug14) shows almost 1 in 5 children aged 0-15 in Oxford were living in low income families.
- 13,500 older people in Oxfordshire were affected by income deprivation, 68% of whom were living in urban areas and 32% in rural Oxfordshire.
- ONS analysis has demonstrated higher life expectancies and greater life expectancy gains for people in the higher socio-economic groups.
- Out of the 407 lower super output areas in Oxfordshire, the clear majority (80%) were ranked within the least deprived 50% in England on the income deprivation domain. The most deprived areas of Oxfordshire on income deprivation were 3 areas within Oxford (parts of Rose Hill & Iffley, Blackbird Leys and Northfield Brook wards).
- The Education and Skills domain of the Indices of Multiple Deprivation 2015 had 25 areas within Oxfordshire ranked in the top 10% most deprived nationally
- People diagnosed with severe and enduring mental disorders are at increased risk of deprivation due to the challenges of maintaining employment, housing and social connections.
- Common reasons for self-harm are: difficult personal circumstances; past trauma and social/economic deprivation together with some level of mental disorder. Self-harm can be associated with the misuse of drugs or alcohol.
-
- Out of the total of 407 Lower Super Output Areas135 (LSOAs) in Oxfordshire, 101 (31%) were 2 miles or more (3.2km) from the nearest GP surgery, covering a total population of 157,000 (25%) as of 2011.
-
- There were no areas of Oxford City classified as 2 miles or more from a GP surgery. Areas classified as 2 miles or more from a GP surgery in rural districts in Oxfordshire covered:
    - 3,700 households with no car (23% of total households in rural districts)
    - 30,300 people aged 0-15 (32% of the total in rural districts)
    - 28,800 people aged 65 and over (34% of the older population in rural districts).

What will we do to improve matters for local people?

1. A good start in life

Aim: 'Oxfordshire – a great place to grow up and have the opportunity to become everything you want to be'

Strategic Objectives

- **Be Successful –** This looks to ensure children have the best start in life; have access to high quality education, employment and motivational training; go to school feeling inspired to stay and learn; and have good self-esteem and faith in themselves.
- **Be Happy and Healthy** – Children can be confident that services are available to promote good health, and prevent ill health; learn the importance of healthy, secure relationships and having a support network; have access to services to improve overall well-being, and easy ways to get active.
- **Be Safe** – This looks to ensure children are protected from all types of abuse and neglect; have a place to feel safe and a sense of belonging; access education and support about how to stay safe; and have access to appropriate housing.
- **Be Supported** – Children are empowered to know who to speak to when they need support, and know that they'll be listened to and believed; can access information in a way that suits them; have inspiring role models; and can talk to staff who are experienced and caring.

Prevention of illness through promoting

- Healthy living
- Healthy weight
- Physical activity
- Mental wellbeing
- Childhood immunisations

Inequalities issues to be addressed by targeting particular groups with worse outcomes

- childhood obesity
- Identify hotspots for children missing out on education
- Inequalities in opportunity and life chances

Areas of Focus for the Children's Trust (2018-2020)

- Focus on children missing out on education
- Focus on social and emotional wellbeing and mental health
- Focus on young people affected by domestic abuse

Areas of Focus for the Health Improvement Board (2018-2020)

- Childhood immunisations
- Preventing childhood obesity
- Promoting physical activity including active travel
- Mental wellbeing for all
- Supporting Healthy place-shaping

Delivery Mechanisms include

1. ***Children's Plan*** - The implementation plan, within the CYPP, focuses on one theme within each of the four areas of focus each year. These are updated on an annual basis and are continually monitored by the Children's Trust Board throughout the year
2. ***The Health Improvement Board*** which oversees work on immunisation, obesity, physical activity and mental wellbeing for all ages

What will we do to improve matters for local people?

2. Living Well

Aim: Adults will have the support they need to live their lives as healthily, successfully, independently and safely as possible, with good timely access to health and social care services.

Strategic Objectives

- **Prevent the development of long term conditions** by helping people to live healthy lives, live in healthy places and avoid the need to go to hospital
- **Identify ill health early,** through comprehensive screening programmes, good access to services and targeting those least likely to attend.
- **Ensure Parity of Esteem for mental health**
- **Deliver sustained and improved experience** for people who access services, by working together to deliver effective services and using the expertise of our customers and other key stakeholders to design, procure and evaluate services.
- **Ensure services are effective, efficient and joined up**, available when needed and that movement through the "system" is seamless
- **Nurture healthy communities** that enable people to participate, be active, give and receive support.

Prevent, Reduce, Delay

Keeping Yourself Healthy (Prevent)

- Promote healthy lifestyles including Reduce Physical Inactivity / Promote Physical Activity, Enable people to eat healthily, Reduce smoking prevalence, Promote Mental Wellbeing
- Ensure Immunisation coverage remains high

Reducing the impact of ill health (Reduce)

- Prevent chronic disease (e.g. diabetes) though tackling obesity
- Screening for early awareness of risk - cancer & heart disease
- Alcohol advice and treatment

Inequalities issues to be addressed

- Identify those at risk of premature and preventable disease and deaths and working to reduce that risk
- Improving the physical health of people with Learning disabilities or mental illness

Areas of Focus for the Health Improvement Board (2018-2020)

- Healthy Weight Whole Systems approach
- Reduce physical inactivity
- Mental Wellbeing and Prevention Concordat
- Public Health, Health Protection - immunisation and screening, air quality
- Housing and Homelessness
- Supporting Healthy place-shaping

Areas of Focus for the Joint Management Groups /Integrated Services Delivery Board

- Identify risk groups and design integrated services to meet their needs
- Provide care close to, or at, home, reduce urgent admissions to hospital
- Improve the satisfaction of service users
- Increase the number of people supported at home
- Improve the quality and sustainability of care providers in Oxfordshire
- Involve more local people and organisations in the development of services

Delivery Mechanisms	1. The Adults of Working Age Strategy – to be developed 2. The Health Improvement Board -work on social prescribing, mental wellbeing, public health protection and healthy lifestyles.

What will we do to improve matters for local people?

3. Ageing Well

Aim: to ensure that Oxfordshire is a place where individuals, whatever their age, are valued and empowered to live healthy, active and socially fulfilling lives, connected to the communities they live in.

Strategic Objectives

- **Increase independence, mobility and years of active life** for those aged 75+ through healthy lifestyles as well as using digital aids, equipment and adaptations and making tools for self-management available and easily accessible.
- **Ensure services are effective, efficient and joined up**, available when needed and that movement through the "system" is seamless
- **Support the care of frail older people** by developing multi-speciality provider teams in the community
- **Identify and diagnose dementia** at an early stage and support people, their families, carers and communities to help them manage their condition.
- **Support carers** in their caring role and in looking after their own health
- **Deliver preventative services** in the community to reduce or delay the need for health and care services

Prevent, Reduce, Delay

- **Prevent** ill health by addressing the growing problems of Loneliness and promoting mental wellbeing; Supporting carers; increasing coverage of immunisations and screening
- **Reduce** the impact of ill health through Falls prevention; tools for self-management
- **Delay** the need for services and care through services close to home;

Inequalities issues to be addressed

There are pockets of deprivation and significant numbers of ethnic minority groups within Oxfordshire. People in these groups often suffer the worst health and poorer health outcomes and need to be identified and targeted by appropriate services

Areas of Focus for the Joint Management Groups / Integrated Services Delivery Board

- The new Older People strategy will reflect the needs of a changing demographic and the increase in the numbers of people who are growing older across the county, particularly those aged over 85 years.
- It will also support those over 65 years that are currently fit and healthy whom we need to support to remain well, for as long as possible, whilst promoting early intervention and access to health and care services when they are needed.
- The new strategy will also address the needs of people suffering from dementia and people who are living into older age with a learning disability.

Delivery Mechanisms include	• Older People Strategy Carer's Strategy The Better Care Fund Plan There are also links to the Oxfordshire's Adult strategy, and a range of Health Improvement strategies. The Older People strategy also links to relevant pathways of care including Oxfordshire's Frailty, Mental Health (including Dementia), Learning Disability and End of Life pathways.

What will we do to improve matters for local people?

4. Improving Health by Tackling Wider Issues

Aim: to work together to ensure that living, working and environmental conditions enable good health for everyone

Strategic Objectives

- **Healthy Place Shaping –** which means ensuring the physical environment, housing and social networks can nurture and encourage health and wellbeing; learning from the Healthy New Towns in Bicester and Barton and applying this to other new and existing developments
- **Housing and Homelessness** – preventing homelessness and reducing rough sleeping
- **Protect vulnerable people** – from the impact of domestic abuse, cold homes and other factors
- **Contribute to financial sustainability** in the long term for public services by reducing demand

Prevent, Reduce, Delay

- **Prevent poor health outcomes through** good spatial planning for community interaction and active travel
- **Reduce** the impact of Domestic abuse, poor air quality, fuel poverty and other factors which have a negative impact on health

Inequalities issues to be addressed

- Focus on particular groups or locations where people have worse health
- Housing and homelessness
- Domestic abuse

Areas of Focus for the Health Improvement Board

- Healthy Place Shaping - Learn from the Healthy New Towns and influence policy
- Social Prescribing, including community and voluntary services
- Housing and homelessness prevention
- Health Protection
- Domestic Abuse services and training
- Affordable Warmth

Delivery Mechanisms include

1. Bicester and Barton Healthy New Towns
2. Housing Support Advisory Group
3. Domestic Abuse Strategy Group
4. Public Health, Health Protection Forum

Oxfordshire Health and Wellbeing Board

Shared Vision: *"To work together in supporting and maintaining excellent health and well-being for all the residents of Oxfordshire"*

Joint Health and Wellbeing Strategy & our 4 priorities:

1. ***Prevention and healthy place-shaping.***
2. ***Improving the resident's journey through the health and social care system.***
3. ***Agreeing an approach to working with the public so as to re-shape and transform services locality by locality.***
4. ***Agreeing plans to tackle critical workforce shortages***

The Integrated System Delivery Board

Integrated System Delivery Plan
(to be created)

The Adults with Support and Care Needs Joint Management Group

Adults of Working Age Strategy
(to be created)

The Better Care Fund Joint Management Group

The Better Care Fund Plan

Carers Strategy

The Older People's Strategy
(under review)

The Children's Trust

The Children and Young People Plan 2018-2021

The Health Improvement Board

- ***Healthy Weight Action Plan***
- ***Public Health Protection***
- ***Affordable Warmth***
- ***Housing Related Support***
- ***Mental Wellbeing Framework***
- ***Domestic Abuse Strategy Group***

Monitoring arrangements (1)

The role and responsibilities of the Health and Wellbeing Board sub groups
Sub groups of the Health and Wellbeing Board are responsible for developing a suite of strategies and action plans to deliver this overarching Joint Health and Wellbeing Board Strategy. They will report their progress at every meeting of the Health and Wellbeing Board and will keep up to date performance dashboards to enable the Health and Wellbeing Board to monitor progress and hold partners to account. The boxes below give details of the performance indicators to be included in these dashboards.

The Health Improvement Board

The Health Improvement Board will monitor progress in 4 priority areas at all their meetings. They will report a range of indicators and progress towards outcome targets to the Health and Wellbeing Board including:

1. Keeping Yourself Healthy (Prevent)
    - Percentage of the population who are inactive (less than 30 mins / week moderate intensity activity)
    - Smoking quitters per 100,000 population
    - Smoking in pregnancy – smoking at time of delivery
    - Households in temporary accommodation
    - Immunisations rates including MMR, Flu
2. Reducing the impact of ill health
    - Uptake of NHS health checks
    - Children overweight or obese in Reception Class and Year 6
    - Uptake of cancer screening programmes
    - Diabetes prevention
3. Shaping Healthy Places and Communities
    - Participation in active travel
    - Making Every Contact Count
    - Outcomes from social prescribing

The Children's Trust Board

A performance dashboard is monitored routinely at the Children's Trust. A sub-set of these indicators will be reported to the Health and Wellbeing Board along with a narrative report on performance and any concerns. The measures are under review and could include the following areas in line with the Children and Young People's Plan

1. Be Successful
    - Attainment
    - Absence
    - Exclusions
2. Be Happy and Healthy
    - Access to CAMHS
    - Early Help
    - Hospital admissions
3. Be Safe
    - Domestic abuse
    - Looked after children
    - Child Protection Plans
    - Children as victims of crime

If other areas are identified from the wider Children's Trust dataset and need escalating, these will be included in the report to the Heath & Wellbeing Board

Monitoring arrangements (2)

The role and responsibilities of the Health and Wellbeing Board sub groups

Sub groups of the Health and Wellbeing Board are responsible for developing a suite of strategies and action plans to deliver this overarching Joint Health and Wellbeing Board Strategy. They will report their progress at every meeting of the Health and Wellbeing Board and will keep up to date performance dashboards to enable the Health and Wellbeing Board to monitor progress and hold partners to account. The boxes below give details of the performance indicators that are likely to be included in these dashboards.

The Joint Management Groups (JMGs) and Integrated Service Delivery Board (Integrated Services Delivery Board)

The Joint Management Groups (JMGs) and Integrated Service Delivery Board (ISDB)

The JMGs and ISDB will continue to report on a group of indicators with outcome targets to be achieved. Three areas of work are outlined below, with a few examples of indicators for each:

1. Working together to improve quality and value for money in the Health and Social Care System

- Reduce the number of avoidable emergency admissions for acute conditions that should not usually require hospital admission for people of all ages
- Increase the percentage of people waiting a total time of less than 4 hours in A&E. Target 95 %.
- Proportion of all providers described as outstanding or good by CQC remains above the national average

2. Living and working well: Adults with long term conditions, physical or learning disability or mental health problems living independently and achieving their full potential

- Increase the number of people with mild to moderate mental illness accessing psychological therapies
- Increase the proportion of people referred to Emergency Departments Emergency Department Psychiatric Service seen within agreed timeframe
- Reduce the number of deaths by suicides
- Increase the number of people with severe mental illness in employment / settled accommodation
- Increase the number of people with learning disability having annual health checks in primary care to 75% of all registered patients by 2019

3. **Support older people to live independently with dignity whilst reducing the need for care and support**

- Reduce the average number of people delayed in hospital to 83 or fewer
- Ensure the 90th percentile of length of stay for emergency admissions (65+) remain better than elsewhere
- Increase the proportion of older people (65+) who are discharged from hospital who receive reablement / rehabilitation services
- Increase the estimated diagnosis rate for people with dementia

Engagement approach for the Joint Health and Wellbeing Strategy

Engaging the public and key stakeholders on the renewed strategy will ensure its profile remains high and will help to indicate where further communications will be necessary to ensure all those with an interest are familiar with the challenges and priorities.

Have your say!

It is proposed that a short survey is developed that will be made available on the Oxfordshire Clinical Commissioning Group's "Talking Health" website and the Oxfordshire County Council website.

People from across Oxfordshire will be encouraged to respond to the survey.

Stakeholder event

An event will be organised for key stakeholders who together will have a role to play in delivering the strategy.

This event will provide an opportunity for participants to refresh their understanding of the issues and priorities set out in the strategy and how they relate to their community and organisation.

And finally…… following these engagement activities

The final draft Joint Health and Wellbeing Strategy will be discussed, finalised and approved at the Health and Wellbeing Board meeting in March 2019.

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Health Improvement Board, 22nd November 2018

Draft Performance Dashboard, Discussion paper

Introduction

At the meeting of the Health Improvement Board in September 2018 the priorities for the work of the Board were agreed. These are grouped under the headings of Keeping Yourself Healthy (Prevent), Reducing the impact of ill-health (Reduce) and Healthy Place Shaping and Healthy Communities.

A summary of these Health Improvement Board priorities is included at Annex 1.

The role of the Health Improvement Board includes monitoring delivery of these priorities. This paper sets out a proposed framework to enable that monitoring through a set of outcome indicators and process measures related to the priority areas of work. It is also proposed that progress in reaching the target outcomes will be reported to the Health and Wellbeing Board on a regular basis.

The work to deliver the changes required will be done by a range of sub-groups who report back regularly to the Health Improvement Board. These reports include updates on performance for each meeting and more detailed narrative reports at least once a year. Details of how they will report are set out in the forward plan elsewhere on the agenda for this meeting. The principles for how these working groups deliver their work were agreed at the last meeting and are included in Annex 2 as a reminder.

In addition, it is suggested that the Board members could keep an overview of population health through a Surveillance Dashboard of key indicators (a small sub-set of the indicators reported through the JSNA). This will enable us to be aware of population level indicators such as life expectancy, prevalence of particular conditions or wider determinants of health. This will enable the Board to identify any changes or issues that might be of concern.

Recommendations: The Health Improvement Board are asked to

1. **Discuss and comment on the proposed Performance Framework detailed in Tables 1 and 2 of this paper and reach agreement on a final list to be monitored.**
2. **Agree the outcome indicators to be reported regularly to the Health and Wellbeing Board (some or all of the list in Table 1).**
3. **Ask officers from partner organisations and working groups to contribute to a final version of this Performance Framework so that it can be in operation by the next meeting of this Board in February 2019**
4. **Discuss the proposal on having a Surveillance Dashboard for information in addition to the Performance Dashboard.**

Performance Framework: Table 1. Outcome Measures

The measures listed in this table relate to the priorities of the Health Improvement Board. Target outcomes will be set for each area of work and progress towards the target will be reported at each meeting. Some of these outcomes are already proposed below. Where possible these outcomes will also include specific improvement of health inequalities issues. Some or all of these measures will also be reported to the Health and Wellbeing Board as they monitor delivery of the Joint Health and Wellbeing Strategy.

	Priority area	Indicator	Oxfordshire Baseline and variation (with date)	Proposed target (by when)	(a) Working Group and (b) responsible organisation
	PREVENT				
1	Physical inactivity	Active Lives Survey: Percentage of the population who are inactive (less than 30 mins / week moderate intensity activity)	<u>Active Lives Survey</u> 105,700 physically inactive people in Oxfordshire (May 2018) which is 19.1% of adult population of Oxfordshire Variation • Cherwell 22.3% • Oxford City 16.3% • South Oxfordshire 18.2% • Vale of White Horse 17.4% • West Oxfordshire 22.3%	An annual 0.5% reduction in inactivity across the county. Therefore reduce to 18.6% *by May 2019 /and to 18.1% by March 2020* [1] *Also a "Stretch" target of reducing to 20% in Cherwell and West Oxon by 2020 to be agreed, subject to discussion with the Local Authorities/CCG and Public Health*	(a) Active Oxfordshire working with all partners including Public Health and the CCG through a Physical Inactivity Task Force (b) Active Oxfordshire with LAs, PH and CCGs

[1] Further specific targets on reduction in number of inactive people to be defined. These could include a focus on people with disabilities, long term conditions, low mental wellbeing, children and young people or people on low incomes.

2	Smoking prevalence	**a.** Number of Smoking quitters per 100,000 adult population **b.** Smoking in pregnancy – percentage smoking at time of delivery	a. Baseline is 2337 quitters / 100,000 population (2017/18) b. Baseline is 8% women smoking at time of delivery.	a. Target is to increase this rate to more than 2337 / 100,000 by Mar 19 b. Target is to reduce this by 0.5% to 7.5% by the end of 2018-19	(a) Tobacco Control Alliance (b) Public Health, County Council and Maternity Services
3	Housing and homelessness	a. Households in temporary accommodation **b.** Single homeless pathway and floating support clients departing services to take up independent living **c.** Rough sleeping **d.** Prevention Duty owed (threatened with homelessness) **e.** Relief Duty Stage (already homeless) **f.** Total number of households eligible, homeless and in priority need but intentionally	Baselines to be reported and outcome targets to be set d. Baseline - total number of cases where positive action was successful in preventing homelessness. tbc e. Baseline -.total number of successful cases in relieving homelessness. tbc f. Baseline tbc	Housing Support Advisory Group to advise on all baselines and outcomes for this section	(a) Housing Support Advisory Group (b) District and County Councils

		homeless			
4	Immunisations	a. Measles, Mumps and Rubella dose 1 b. Measles, Mumps and Rubella dose 2 c. Flu immunisation for at risk groups under 65 yrs d. Flu immunisations for 65+	a. Baseline 93.5% (Q1 18-19) b. Baseline 90.1% (Q1 18-19) c. Baseline 52.4% (2017-18) d. Baseline 75.6% (2017-18)	a. 95% b. 95% c. 55% d. 75%	(a) Public Health, Health Protection Forum. (b) NHS England
	REDUCE				
5	Childhood Obesity	Children overweight or obese in Reception and Year 6	a. Baseline: In Reception year 7% children were obese (2017-18) b. Baseline: In Year 6, 16.8% children were obese (2017-18) Variation in Year 6 pupils: Cherwell 18.8%; Oxford 21.3%; South Oxfordshire 12.9%; Vale of White Horse 16%; West Oxfordshire 14.7%	a. Maintain at 7% b. Target to reduce to 16%	(a) Whole System approach to obesity Working Group (b) Public Health, County Council
6	NHS Health Checks	a. NHS Health Checks invite % (over 5 Years)	a. Baseline 98.8% in 2017/18	a. Achieve at least 97% eligible population invited	(a, b) Public Health, County Council

		b. NHS Health Checks uptake % (over 5 years)	b. Baseline 50.2% in 2017/18	by the end of 2018/19[2] b. Achieve 50.5% uptake by the end of 2018/19	
7	Cancer screening	Percentage of those sent bowel screening packs who will complete and return them (aged 60-74 years) Cervical Screening - percentage of the eligible population (women aged 25-64) screened in the last 3.5/5.5 years Breast screening - Percentage of eligible population (women aged 50-70) screened in the last three years (coverage)	Baseline 56% (Q3, 2017-18) Baseline 68.2% (Q4, 2017-18) Baseline 74.1% (Q4, 2017-18)	National Target 60% National Target 80% National Target 80%	(a) Clinical Commissioning Group (b) NHS England

[2] From 2019/20, following a consultation, Public Health England (PHE) are planning to change the way total invitations for health checks is reported. They will use GP Practice Populations as the denominator instead of ONS population data. We have started to report in this new way. As a result these reports cannot be compared with last year's data. The outcome target appears to be lower than the baseline as a result of this change but this doesn't represent an actual reduction in performance. Future reports will be needed to show overall progress.

Performance Framework Table 2. Process measures

The areas of work set out in this table show our ambition to deliver new or revised programmes. Because of the developmental nature of this work progress will be measured by milestones rather than outcomes. Therefore this table will be developed to give clear process measures which can be monitored by the Health Improvement Board. Where outcome measures can be set in the course of that work they will be added to Table 1 above.

	Priority area	Project or initiative	Proposed target (by when)	Who is responsible?
	PREVENT			
	Whole Systems Approach to Obesity	Implement Whole Systems Approach to Obesity in 2019 (published by PHE and Leeds Beckett University)	No outcome target proposed Monitor progress through updates at HIB	Partnership working group to be established. Led by Public Health, County Council
	REDUCE			
	Diabetes Transformation	Equitable access to structured education for all patients Multi-disciplinary teams in primary care to give early specialist advice Multi-disciplinary foot teams in hospitals	To be advised	Clinical Commissioning Group
	Domestic abuse	Progress against 9 recommendations from the Domestic Abuse Review and devising 5-year strategic plan 2019-2024.	To be advised	Joint Management Group of local authorities; Oxfordshire County Council

	Healthy Place Shaping and Communities			
	Healthy Place shaping	Process measures are to be finalised. The following are suggestions to consider: a. Process against 10 Healthy New Town principles in Putting health into Place[3] (final publication to be launched March 2019). b. Plan for Health in All policies to be considered c. Proposed introduction of Health Impact Assessment into planning policy to be considered d. Evidence of effective system wide working	To be advised	Working arrangements to be confirmed
	Social prescribing	Process measures to be included	CCG to advise	Clinical Commissioning Group
	Making Every Contact Count	Process measures to be included	Oxfordshire MECC Network to advise	
	Campaigns	Plan for joint campaigns to be agreed and implemented with process measures to be included here	Communications teams to advise	

[3] *https://www.england.nhs.uk/publication/putting-health-into-place/*

Proposal for a Health Improvement Board Surveillance Dashboard

It is proposed that Health Improvement Board could receive updates on a range of indicators for surveillance purposes i.e. not linked to performance and not used to monitor progress on a project. These indicators would be high level population health measures which are unlikely to be influenced by any specific initiatives or projects, but which show the general health of the population. This dashboard could also highlight inequalities issues by reporting the best and worst affected groups or areas of the county. This will be useful information to enable targeting of initiatives to tackle health inequalities.

Additional reports could be brought to the Board on request, but the proposal is that ongoing surveillance is conducted on a set of core indicators, agreed by the Board at the start of each year.

This dashboard could also be laid out to give more information on the HIB priorities to "Prevent and Reduce" but with some overarching indicators added. Additional surveillance will continue to draw from the JSNA and the Basket of Inequalities Indicators[4]

Some suggested indicators are included in the draft below, for discussion:

	Priority area	Oxfordshire Baseline (with date) (from the JSNA Annual Report 2018[5]
Overarching indicators		
1	Life expectancy at birth	Between 2013-15 and 2014-16, Life Expectancy for males and females in Oxfordshire each increased. • Male Life Expectancy increased from 81.2 to 81.4 (+0.2 years) • Female Life Expectancy increased from 84.3 to 84.6 (+0.3 years) Between 2001-03 and 2014-16, the gap between male and female Life Expectancy decreased from 4.1 years to 3.2 years.
2	Gap in life expectancy between best and worst wards	Life expectancy by ward data for Oxford shows a significant increase in **male life expectancy** in the more affluent North ward and no change in male life expectancy in the more deprived ward of Northfield Brook. The gap in male life expectancy between these two wards has increased from 4 years in 2003-07 to 15 years in 2011-15. **Female life expectancy** in these wards has

[4] http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment

[5] https://insight.oxfordshire.gov.uk/cms/system/files/documents/JSNA%202018%20FINAL%20Apr18%20FULL.pdf

		remained at similar levels with a gap of just over 10 years.
3	Disability Free Life Expectancy (DFLE) This is the average number of years an individual is expected to live free of disability if current patterns of mortality and disability continue to apply.	Data for the combined years 2009 to 2013 shows that for males there was a 10-year gap between the most and least deprived areas for Disability Free Life Expectancy. For females, the gap was just under 10 years.
4	Preventable deaths. The basic concept of **preventable mortality** is that deaths are considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause (subject to age limits if appropriate) could potentially be avoided by public health interventions in the broadest sense.	For the 3-year period, 2014 to 2016, total deaths of people aged under 75 from the four causes of: cardiovascular diseases, cancer, liver disease and respiratory disease in Oxfordshire was 3,396. Of these **1,959** (58%) were considered preventable
	Prevent	
5	Physical inactivity for children and young people	New data on physical activity rates for children are due soon
6	Mental wellbeing Every year since 2011, the ONS has asked a sample of UK adults aged 16 to answer 4 personal wellbeing questions: • overall, how satisfied are you with your life nowadays? • overall, to what extent do you feel the things you do in your life are worthwhile? • overall, how happy did you feel yesterday? • overall, how anxious did you feel yesterday?	Adults: In Oxfordshire, the average wellbeing scores for: life satisfaction, "things you do are worthwhile" and happiness, are slightly lower in 2016-17 compared with 2015-16 and the anxiety mean is higher Children: no local data
7	Air quality	District Councils to advise
8	Immunisations	To be considered
	Reduce	
9	Obesity Percentage of adults (aged 18+) classified as overweight or obese (PHOF 2.12)	An estimated 55% of people aged 16 or over in Oxfordshire are classified as overweight or obese. This is below the national average
10	Diabetes prevention	Up to 58 per cent of Type 2 diabetes cases can be delayed or prevented through a healthy lifestyle. National survey data (HSE 2015) shows the prevalence of diabetes is higher for men

		than women and significantly higher in those who are overweight or obese
11	Alcohol a. Admission episodes for alcohol related conditions (Broad definition) (Male and female) Alcohol profile b. Admission episodes for alcohol specific conditions aged under 18 (Male, female) Alcohol profile	2016/17 baseline: 1684 per 100,000 people (England 1804 / 100,000). Oxfordshire is significantly better. 2014/15 – 16/17 baseline: 40.7 per 100,000 Population (England 34.2 / 100,000). Oxfordshire is significantly worse
12	Domestic abuse	**To be advised**
13	Fuel Poverty Using the Low Income High Costs (LIHC) indicator, a household is considered to be fuel poor if: • they have required fuel costs that are above average (the national median level). • were they to spend that amount, they would be left with a residual income below the official poverty line.	Between 2014 and 2015, an additional 1,600 households in Oxfordshire were classed as being "fuel poor" taking the total to 25,915 households in fuel poverty in the county. There was an increase in the proportion of households defined as "fuel poor" in each district of Oxfordshire Oxford is one of 9 (out of 67) local authority districts in the South East to be significantly worse than the national average on fuel poverty (2015). The greatest increase in the estimated number of fuel poor households was in Cherwell (+13%), similar to the regional average (13%)

Next steps
Subject to the discussion at the Health Improvement Board in November the Performance Framework and Surveillance Dashboard will be finalised for use by the Board at the meeting in February 2019.

Recommendations: The Health Improvement Board are asked to

1. Discuss and comment on the proposed Performance Framework detailed in Tables 1 and 2 of this paper and reach agreement on a final list to be monitored.
2. Agree the outcome indicators to be reported regularly to the Health and Wellbeing Board (some or all of the list in Table 1).
3. Ask officers from partner organisations and working groups to contribute to a final version of this Performance Framework so that it can be in operation by the next meeting of this Board in February 2019
4. Discuss the proposal on having a Surveillance Dashboard for information in addition to the Performance Dashboard.

Jackie Wilderspin, November 2018

Annex 1 Priorities of the Health Improvement Board (agreed in September 2018)

1. Keeping Yourself Healthy (Prevent)

- Reduce Physical Inactivity / Promote Physical Activity
    - Promote activity in schools to make it a lifetime habit
    - Promote active travel for all ages
    - Provide excellent leisure services including access to green spaces and the countryside

- Enable people to eat healthily
    - Starting with breastfeeding
    - Sugar Smart
    - Access to healthy food for all

- Reduce smoking prevalence
    - In community groups with higher smoking rates
    - In pregnancy

- Promote Mental Wellbeing
    - 5 ways to Wellbeing / CLANGERS (Connect, Learn, be Active, Notice, Give, Eat healthily, Relax, Sleep)
    - Adopt the principles of the Mental Wellbeing Prevention Concordat

- Tackle wider determinants of health
    - Housing and homelessness
    - Air Quality

- Immunisation
    - Routine childhood immunisations
    - Seasonal immunisations, such as influenza
    - Immunisations for vulnerable groups such as Pregnant women (including whooping cough) or ‘at risk’ groups, such as pneumococcal

2. Reducing the impact of ill health (Reduce)

- Prevent chronic disease though tackling obesity
    - Weight management initiatives
    - Diabetes prevention

- Screening for early awareness of risk
    - NHS Health Checks
    - Cancer screening programmes (e.g. Bowel, cervical, breast screening)

- Alcohol advice and treatment
    - Identification and brief advice on harmful drinking
    - Alcohol liaison in hospitals

- Alcohol treatment services

- Community Safety impact on health outcomes
  - Domestic abuse

3. Healthy Place Shaping and Healthy Communities

- Healthy Environment and Housing Development
  - Learn from the Healthy New Towns and influence policy
  - Ensure our roads and housing developments enable safe walking and cycling
  - Ensure spatial planning facilitates social interaction for all generations – giving opportunities for people to meet who might not do so otherwise

- Social Prescribing
  - Referral from Primary Care to non-medical schemes e.g. for physical activity, social networks, support groups

- Making Every Contact Count
  - In NHS settings
  - In front line services run by local authorities e.g. libraries, Fire and Rescue, leisure centres
  - In local communities and through the voluntary sector

- Campaigns and initiatives to inform the public
  - Through workplaces including the Workplace Wellbeing Network
  - The media, including social media, or community initiatives using local asset

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Annex 2 Principles for working groups

- Develop working groups that involve a range of relevant individuals and organisations who are equipped and active in delivering the agenda.
- Gain a clear understanding of population health needs and inequalities issues from the latest Joint Strategic Needs Assessment, and identify “at risk cohorts” whose outcomes could be improved.
- Define the outcomes to be achieved for the population segments.
- Devise and deliver targeted interventions to meet the outcomes agreed for segments of the population identified.
- Apply knowledge of effective and cost-effective interventions to be sure we are leading initiatives that are affordable and will have a positive impact.
- Ensure the proposed priorities reflect (or can be incorporated into) each partner’s own organisational priorities.
- Report regularly to the Health Improvement Board on progress, performance and tackling inequalities.

Health Improvement Board – 22 November 2018

Report on Single Homelessness and Rough Sleeping in Oxfordshire

1. Purpose

1.1 To update the Health Improvement Board (HIB) on single homelessness and rough sleeping in Oxfordshire.

2. Main Report

2.1 Measure 10.5 of the suite of HIB performance indicators is to 'ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure from 2016/17' (baseline 79). Each November all local housing authorities in Oxfordshire complete either a rough sleeper count or estimate. In November 2017, the total number of people estimated to be sleeping rough was 117 (over the 2016/17 baseline).

2.2 The HIB received a performance exception report regarding rough sleeping in Oxford on 8 February 2018. At this meeting members of the HIB requested further information on the single homeless pathway, single homelessness and rough sleeping at a future meeting.

Single Homeless Pathway Performance

2.3 The latest performance information on the homelessness pathway covers the period 01/02/2017 to 31/01/2018.

2.4 In 2017-18 the pathway supported 490 people, 298 of whom moved into the services during the year. This represents throughput of 241.4% and evidences that these services continue to be short term in nature as planned.

Demographics

2.5 The demographics of people in the pathway is changing. There is a continuing trend that we see more women, more young people, more people over 65 and more people with a BME background. The HIB specifically requested information regarding older single homeless people and single homeless women.

2.6 The gender details of people in the pathway over the period 2015-16 to 2017-18 is as follows:

	2015-16		2016-17		2017-18	
Gender	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**
Female	14	11.7%	105	21.3%	66	22.1%
Male	106	88.3%	389	78.7%	232	77.9%
Total	**120**	**100.0%**	**494**	**100.0%**	**298**	**100.0%**

The case management system for the pathway records the key support needs (secondary needs) of people in the pathway by gender. The main support needs of females in the pathway are mental health problems (18%), drug misuse problems (15%), generic complex needs (14%) and alcohol misuse problems (11%). It should be noted that one person can have more than one support need.

2.7 The age details of people in the pathway over the period 2015-16 to 2017-18 is as follows:

	2015-16		2016-17		2017-18	
Age Group	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**
18 to 24	2	1.7%	40	8.1%	27	9.1%
25 to 64	117	97.5%	445	90.1%	267	89.6%
65+	1	0.8%	9	1.8%	4	1.3%
Total	**120**	**100.0%**	**494**	**100.0%**	**298**	**100.0%**

Unfortunately no further information about people in the pathway is captured by age.

Pathway Effectiveness

2.8 Another area that the HIB requested information about was the effectiveness of the pathway and details of any pressure points in the pathway. Despite considerable changes in the pathway, provider organisations and front-line staff have worked hard to keep people safe and to help them move off the pathway into more permanent accommodation within 6 to 9 months. For most people (58.4%) this outcome has been achieved. 31.70% of service users are staying for 12 months and over, which is more than in the first year of the pathway, where it was 29.9%.

2.9 As a general trend it appears that moving people on to alternative accommodation is becoming more difficult year on year. This is due to people having more support needs and less move on options. The result of this is the assessment beds remain full, there are notable blockages at Mayday Trust and in the Cherwell provision.

2.10 The lack of affordable realistic housing options remains the biggest challenge in finding sustainable move on provisions. Whilst move on into supported housing and Local Authority tenancy is still by far the highest move on option, the numbers have gone down from 40.6% to 38.3%; whilst the percentage of people finding private rented move on accommodation remained constant with 4.5%.

2.11 There has been a shift in the length of time people stay in the assessment centre at O'Hanlon House. More people (24.0% compared to 19.4%) get moved on within 0 to 4 weeks. At the same time, the percentage of people staying over 12 weeks has also increased from 45.2% to 48.8%. It is likely that the length of stay varied across localities as in some cases the number of move on options has decreased.

2.12 It is positive that particularly in O'Hanlon House throughput has increased from 353.6% in the first year of the pathway to 375.0% this year. This seems to be particularly remarkable considering the reduction in move on options across the pathway.

People leaving the pathway

2.14 In 2017-18, 64.2% of external departures were planned moves compared to 54.5% in 2016-17. The details of these departures were as follows:

Planned or Unplanned	Count	Percent
Planned	156	64.2%
Evicted (behaviour)	37	15.2%
Neutral	18	7.4%
Evicted (arrears)	16	6.6%
Abandoned	12	4.9%
Unplanned - other	4	1.6%
Total	**243**	**100.0%**

The neutral unplanned moves include 8 people taken into custody, 7 people died, 1 moved to stay with family, 1 moved to stay with friends and for 1 person the reason was unknown.

Case Studies

2.15 The HIB requested some case studies of people that are currently in or have been through the pathway, these are attached at Appendix A.

Pathway priorities for 2018-20 (years 2 and 3)

2.16 *Profile of people needing support* – The demographics and complexity of people in the pathway are changing and at the appropriate point the provision commissioned may need to change to reflect these changing needs. There is an opportunity for reshaping services we have recommissioned.

Lack of supply - across the county there is a common issue that it is becoming increasingly difficult to move people on from the pathway due to individuals having more support needs, Registered Provides are becoming more commercially minded so may not be willing to accept ex-pathway residents and there is a very limited number of private landlords who will accept people with complex needs.

Suitable housing options - the lack of affordable, realistic housing options for people moving out of the pathway. From an affordability perspective do local housing authorities need to ensure more supply of affordable accommodation i.e. social rent rather affordable rent. Is the standard general needs social housing the best model of accommodation for people moving out of the pathway or do we need to look at different models?

Up to date Rough Sleeping data

2.17 The latest annual rough sleeper counts and estimates are being completed in November 2018. A verbal update on the figures will be provided at the meeting.

Funding and Joint Commissioning Arrangements for the pathway

2.18 The current pathway arrangements are jointly funded by the five local housing authorities (City Council and district councils), the County Council and the Clinical Commissioning Group. These parties have invested jointly £2,940,000 which has fully funded the pathway over the three years from 1 April 2017 to 31 March 2020. There are ongoing discussions about the extension of the current programme for joint

commissioning of homelessness services into 2020-22. There is a clear commitment from all parties involved in the pooled budget arrangements to extend the joint commissioning arrangements for a further two years, to the end of March 2022. Infrastructure to extend the current arrangement is already in place. A further update on the latest position regarding joint commissioning of the pathway into 2020-22 will be provided at the meeting.

Health Improvement Board Paper – Oxfordshire Tobacco Control Alliance 7th November 2018

Report on the purpose and actions of this new group

1.Summary

1.1 The Oxfordshire Tobacco Control Alliance (OCTA) provides focus and support to help stakeholders reduce tobacco usage in the county. Its aim is to raise the profile and impact of a broader tobacco control approach. This report will outline the purpose and actions of OCTA

2. Background

2.1 Tobacco Control is an umbrella term used to describe a broad range of activities aiming to reduce smoking prevalence. In 2017, the Government published a new Tobacco Control Plan for England[1] with a vision to pave the way for the first 'smoke free generation'

2.2 Oxfordshire has made great strides in reducing the harms caused by smoking in recent decades, the leading cause of preventable illness and premature death in England. The prevalence of adults who smoke in Oxfordshire is currently estimated to be around 11%, which is lower than the national prevalence of around 15%. Although this overall smoking prevalence continues to decline, and is what we want to see, the picture is not so positive for all groups and communities across Oxfordshire. For example, the level of smoking in routine and manual workers in the County is 24.4%, more than double the overall average. Smoking remains highest among populations who already suffer from poorer health and other disadvantages

2.3 If we are to achieve the first smokefree generation, at a local level, the Tobacco Control Plan for England recommended that areas come together to agree local ambitions around which collective action can be organised.

2.4 Between 2014 and 2018 there was no active tobacco control alliance after the original Oxfordshire Alliance of Smoking Issues was wound up. In recent years, efforts were traditionally focussed on providing a local stop smoking service rather than addressing the broader tobacco control agenda.

2.5 It is recognised, and recommended by WHO[2] that there needs to be a comprehensive approach to reducing smoking rates. This is achieved through the MPOWER model, which includes the following types of intervention:

- **M**onitoring tobacco use and prevention policies
- **P**rotect people from tobacco smoke
- **O**ffer help to quit tobacco use
- **W**arn about the dangers of tobacco

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[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/630217/Towards_a_Smoke_free_Generation_-_A_Tobacco_Control_Plan_for_England_2017-2022__2_.pdf

[2] http://www.who.int/fctc/text_download/en/

- **E**nforce bans of tobacco
- **R**aise taxes on tobacco.

2.6 Tobacco Control involves creating the environments and norms, where children don't start smoking and adults are motivated and supported to quit.

2.7 Tobacco has a significant impact on a person's health, either as smokers or through second hand (or third hand) smoke. Illicit and illegal tobacco, may not meet safety standards and can increase the likelihood of fires, linked to organised crime and increase the possibility of young people coming into contact with criminals and is a potential safeguarding issue.

2.8 At a local Oxfordshire level, local stakeholders are working together to tackle illegal[3] and illicit[4] tobacco, providing smokers every opportunity to start a quit attempt and create smoke free environments, particularly for young people, to stop them starting (** of smokers started before they were 18 years*, 410 children start smoking each day in England*).

3. Purpose of the Oxfordshire Tobacco Control Alliance

3.1 The Alliance has been set up in line with national guidance[5],[6] and officers reviewed how other local authorities run their local TCAs. The Terms of Reference have been agreed and can be found in Appendix 1. Dr Eunan O'Neill chairs the Alliance and it meets three times a year. The Alliance will report to the Health Improvement Board, about the activity of the group.

3.2 The OTCA aims to

- Adopt best practices in reducing tobacco usage in Oxfordshire
- Motivate local stakeholders to participate in local tobacco control activity.
- Support the work of the stop smoking service
- Create environments and norms that prevent smoking uptake and stimulate and facilitate quit attempts.
- Work with a wide range of stakeholders whilst working on shared agendas and avoiding duplication
- Make novel connections between different professions and organisations.
- Agree a shared approach on what stakeholders will do to reduce tobacco usage, particularly where there are inequalities, whether it be by geography or social demographic group.
- Share national and local information that helps local stakeholders act, effectively and efficiently on tobacco usage.

[3] Illegal – tax not paid
[4] Illicit – fake tobacco
[5] https://www.gov.uk/government/publications/alcohol-drugs-and-tobacco-commissioning-support-pack/tobacco-commissioning-support-pack-2019-to-2020-principles-and-indicators
[6] http://ash.org.uk/information-and-resources/local-resources/local-tobacco-alliance-resources-2/

3.3 The Oxfordshire Director of Public Health annual report for 2017/18[7] has recommended that:

- The Health Improvement Board should continue to monitor activities of local stop-smoking services and wider agencies to help people quit smoking and also not to start in the first place.
- The Oxfordshire Tobacco Control Alliance should develop coordinated plans to reduce the use of tobacco in Oxfordshire

4. Actions to date of Oxfordshire Tobacco Control Alliance

4.1 The OTCA has convened two meetings to date - 11th April 2018 and 13th September 2018. These meetings started to build relationships between stakeholders, which has included so far, Oxford NHS University Hospital Foundation Trust (midwifery service and public health), Oxford Health NHS Foundation Trust (health promotion unit and the respiratory service), District Councils (Cherwell District Council and Oxford City Council), Environmental Health, HMRC, Local Pharmacy Committee (LPC), Oxfordshire Clinical Commissioning Group (inequalities and access and planned care), Oxford University, Smokefreelife Oxfordshire (the Local Stop Smoking Service), Oxfordshire County Council (Public Health and Trading Standards), Thames Valley Cancer Alliance and Public Health England.

4.2 Invitations been extended to senior leadership at Oxford Health NHS Foundation and the mental health teams, OXLEP, maternity commissioners, mental health commissioners, NHS Pharmacy commissioners and the Local Medical Committee (LMC).

4.3 At the first OTCA meeting, members heard how Hertfordshire set up their Tobacco Alliance and what work they have completed, as well as the results of the NEMS survey, which provided information on the level and nature of illicit and illegal tobacco in Oxfordshire and across the South-East region. As part of building new relationships and identity of the group, the OTCA has collated a database of its assets.

4.4 The Tobacco Control Plan for England has recommended that local health and wellbeing partners participating in a CLeaR assessment (**C**hallenge, **Lea**dership and **R**esults) – a 'deep dive' self-assessment tool aimed to provide a stock take on current tobacco control work. It was agreed at the first meeting that one of the first actions of the OCTA will be to complete this for Oxfordshire. Partners within the OTCA were invited to contribute electronically between

4.5 In the second meeting the results of the CLeaR assessment were reviewed and members identified barriers and solutions.

4.6 Alliance members have also seen (and smelt) for themselves the amount of tar in a cigarette and learnt about Carbon Monoxide levels in the blood associated with smoking, as well as the impact of smoking on their lung age.

[7] http://mycouncil.oxfordshire.gov.uk/documents/s43494/JHO_SEP2018R03%20-%20Independent%20Report%20of%20the%20Director%20of%20Public%20Health.pdf

5. Next steps for OTCA.

5.1 As the Alliance becomes more established it is intended to bring more stakeholders on board, such as Thames Valley Police and other departments of District Councils, such as street cleansing and littering. The Alliance would welcome any suggestions and named contacts for membership of the group.

5.2 The CLeaR assessment is due to be externally peer reviewed in March 2019. This will also identify actions, that will feed into a local strategy or action plan. Actions could include, signing the Local Authority[8] and NHS[9] Declaration.

5.3 The Oxfordshire CLeaR assessment will also be shared at the BOB STP, along with the other local authorities' assessments for the area.

5.4 At the meeting in September 2018, the Alliance identified the following actions to address the need for the Alliance to have better visibility.

- Explore logo/branding options for the Oxfordshire Tobacco Control Alliance.
- Raise the profile of smoking and tobacco issues, some suggestions include, share your tobacco/smoking good news stories. Be it through this alliance, internal team meetings or manager briefings. More widely, build some "noise/chatter" with posts, tweets, use "handles" to allow social media types to share the messages. Give OTCA members a heads up of any press releases you may be releasing. Talk to your social media comms leads to find out how to get messages shared. (All, by now and next meeting – likely early Feb)
- Develop a communications plan – decide on the common messages all can share
- Establish a task and finish sub group on savings reduced smoking rates can have on the team/organisation
- Establish a task and finish sub group on respective KPIs/targets etc related to smoking (may be part of or proceed the above point)

5.5 The next OCTA meeting is scheduled to be in February, where it is proposed to increase the knowledge and awareness round vaping/Electronic cigarettes, report on the branding/logo. The OTCA will convene a a task and finish group to develop a strategy which will be informed by the outcome of the peer review from the CLeaR process.

6. Recommendations

The Board are requested to consider the content of the paper regarding the OTSA and the activity of the group.

Kate Eveleigh, Health Improvement Practitioner
Eunan O'Neill, Consultant in Public Health

[8] http://smokefreeaction.org.uk/wp-content/uploads/2017/06/Declaration.pdf
[9] http://smokefreeaction.org.uk/wp-content/uploads/2017/06/NHSstatement.pdf

Appendix 1 – Terms of Reference

Oxfordshire Tobacco Alliance

Terms of Reference

Purpose

The UK is a world leader in tobacco control but smoking remains the biggest preventable killer. Smoking, the effects of second hand smoke and illicit tobacco use are primary causes of preventable death and illness in Oxfordshire. Tobacco use has substantial financial costs outside of health, costing the wider society in England more than £13.9 billion. This includes significant costs to Local Authorities such as costs from increased social care needs as a consequence of smoking tobacco.

The Government published a new tobacco control plan in July 2017[10], to pave the way for a smoke free generation. The wide-ranging plan sets out to achieve the following ambitions by 2022:

- Reduce smoking rates from 15.5% to 12% or less
- Reduce the prevalence of 15 year olds who regularly smoke from 8% to 3% of less
- Reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less.

Local stakeholders have a critical role in working collaboratively to achieve the ambitions of the national tobacco control plan and achieve a smoke free generation in Oxfordshire. The Oxfordshire Tobacco Alliance (OTA) will

- provide a platform for partners to advocate, coordinate and monitor activities and projects that contribute to creating a healthier Oxfordshire.
- serve as a forum for information exchange between partners.
- Link with regional and national control networks
- Commit resources to develop and implement local action plans

Membership

Membership of the Alliance includes but is not exclusive to

- Director of Public Health, Oxfordshire County Council (Chair)
- Oxfordshire County Council Portfolio Holder for Public Health
- Deputy Director of Public Health England Centre- Thames Valley (or nominated representative)
- Commissioning team for stop smoking services OCC
- Commissioning lead 0-19 years OCC
- OCC trading standards
- OCC Fire & Rescue Service
- Oxfordshire Clinical Commissioning Group

[10] https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england

- Oxfordshire Stop Smoking Services
- Oxfordshire School Health Nurse and College Health Nurse Services
- Oxfordshire Health Visitor Service
- Oxfordshire District Council Environmental Health teams
- Oxford Health NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Thames Valley Police
- HMRC
- Oxfordshire Healthwatch

Other advisers and organisations will be invited to attend when necessary.

Quoracy

- Director of Public Health OCC or delegate
- One other senior member of public health team OCC
- One other member from other partner agency

Frequency

The Oxfordshire Tobacco Alliance will meet three times a year. Extraordinary meeting will be called to deal with urgent issues.

Reporting

The Oxfordshire Tobacco Alliance shall report to the Health Improvement Partnership Board. Individual members will be responsible for reporting to their own organisation.

DIRECTOR OF PUBLIC HEALTH FOR OXFORDSHIRE

ANNUAL REPORT XI

Reporting on 2017/18
Produced: August 2018

Contents

Foreword

Every Director of Public Health must produce an Annual Report on the population's health.

This is my 11th Annual Report for Oxfordshire.

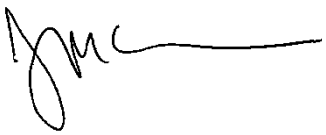
It uses science and fact to describe the health and wellbeing of Oxfordshire and to make recommendations for the future.

It is for all people and all organisations.

I hope you find it interesting, but more than that I hope it is found to be useful in stimulating debate and in shaping the County's services for the future.

I am responsible for its content, but it draws on the work of many colleagues. I thank you all for your help, support and encouragement.

With best wishes,



Dr Jonathan McWilliam
Director of Public Health for Oxfordshire.
August 2018

Acknowledgements

Compiling this report would not be possible without the administrative and statistical support of Alan Rouse, Sue Lygo, Margaret Melling and Philippa Dent – thank you all.

I would also like to thank Rosie Rowe from Cherwell District Council and Azul Strong Corcoran from Oxford City Council for their help in compiling the information for Healthy New Towns in chapter two – thank you.

Introduction and Overview

This is an independent report about the health and wellbeing of Oxfordshire residents in the broadest terms. It focusses on the two main questions which we face as a County, namely:

How do we cope with demographic growth and change
and
How do we adapt to the stresses and strains of modern life that affect our health.

The solutions lie in:

- Working together to meet the challenges of population growth and ageing by creating communities which help to promote good health, prevent disease and which encourage a stronger sense of community.
- Joining up our efforts to prevent ill health more coherently.
- Adapting lifestyles to increase physical activity and reduce obesity.
- Looking after our mental health by learning how to promote our mental wellbeing.
- Focussing on services for all which also target disadvantage.
- Remaining on our guard about infectious diseases.

My assessment of progress in the last year is positive overall:

- There is strong evidence that health and wellbeing in Oxfordshire is good compared with England as a whole and indicators of disadvantage on the whole are improving. Nonetheless pockets of disadvantage remain to be tackled.
- Unemployment remains low and the economy relatively prosperous.
- Organisations are working together more smoothly and creatively – there are many green shoots.
- We are working well with Government to attract investment and keep the value of the 'Oxfordshire Pound' high.

Relative prosperity also brings with it challenges, particularly around high house prices and workforce shortages.

The increasing number and proportion of older people remains a major challenge for services as does the rising rate of obesity.

The report documents these themes throughout.

The challenge is to now press home the gains we have made for the benefit of all while tackling the challenging topics and areas of persistent disadvantage.

In summary the main message is:

From a health and wellbeing point of view, the old distinctions between health planning, place planning, infrastructure planning and economic planning no longer hold good. They are inextricably intertwined and we must deal with them as a whole to ensure our future health and prosperity.

Chapter 1: Meeting the Demographic challenge

Demographic change is having an impact on the way we live in Oxfordshire. The big question is, how do we cope with it?

We all know that life is changing rapidly…….

Everyone says the pace of life has never been so fast. Many of us are busier than ever, our roads are crowded, many things are done on-line, and if it can't be delivered next day we are disappointed…….and you need a pretty good job (often with a partner) to get on the housing ladder at all.

Our young people are 24/7 plugged into electronic devices.

Food shops display a bewildering array of goods catering for a myriad of global cuisines.

GPs are hard pressed and instead of the traditional appointment you may well have a phone call, skype call or be seen by a nurse instead.

Our forebears simply wouldn't have recognised it.

Despite everything though, we are living longer and many diseases which carried people off 25 years ago (heart attacks and many cancers) are more under control…… this is great in itself, but brings its own 'new crop' of issues in its wake – loneliness, an ageing population of carers and the rise of diseases such as dementia.

Also, there are still the 'haves' and 'have-nots' in our County: there are still disadvantaged groups in which good health is less likely.

So, as this report is all about a factual, current portrait of the health of people in Oxfordshire, I want to use it to take a look at some of these issues and how we might tackle them.

Chapter 1 looks at the biggest issue – demographic change - and what that means for us all.

Chapter 2 looks at how we can cope with change by improving the design of our towns and villages. This is called creating healthy communities and it is one of the most promising new developments to emerge over the last decade.

Chapter 3 looks more closely at disadvantage and how it affects us

Chapter 4 looks at the contribution of modern lifestyles and the particular impact of obesity.

Chapter 5 considers how to be mentally healthy in a fast-moving world

Chapter 6 takes a look at infectious disease - the *'Captain of the Men of Death'* still biding its time in the wings.

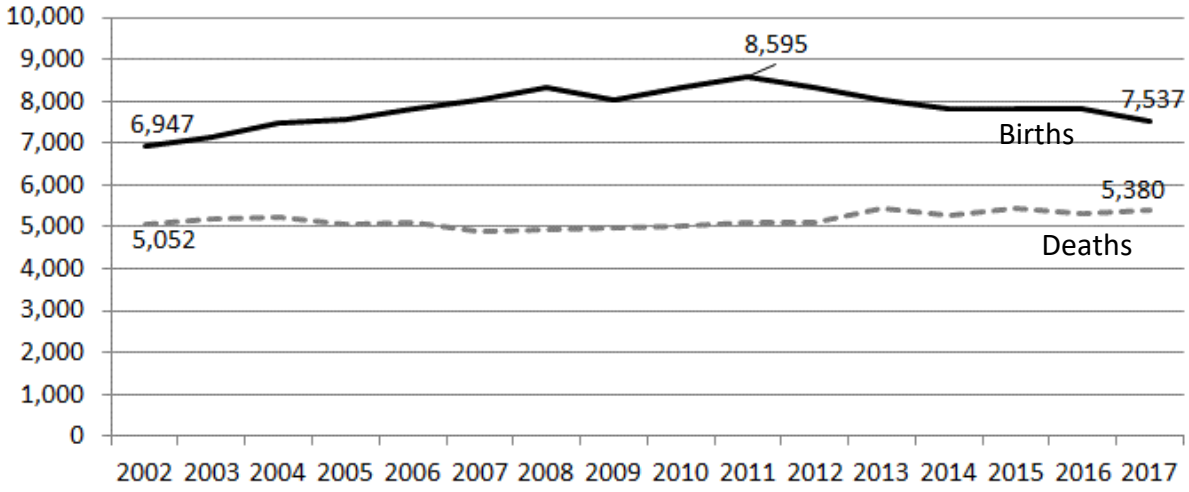
So, looking at demographic change directly, what do the facts show?

First, we'll take a look at the engine that drives demographic change: population growth. Basically, populations grow for two reasons which make common sense:

1) More people are born each year than die each year and;
2) More people move into a place than move out.

We can look at each in turn. First, births and deaths. The chart below shows the recent trends:

Oxfordshire: total number of births and deaths per year 2002 to 2017



ONS mid-year population estimates

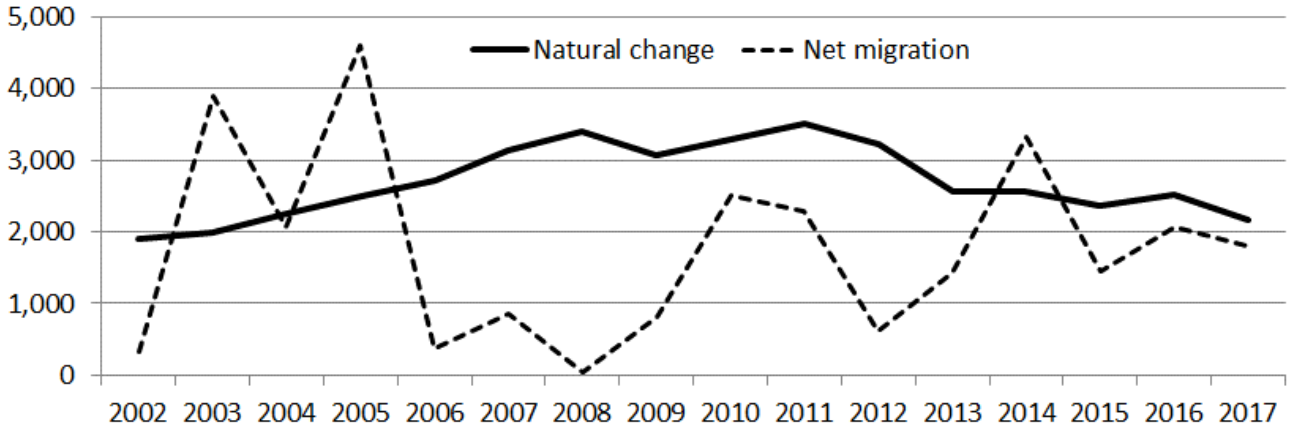
The chart shows that:

- The number of births has grown overall from 6,947 per year to 7,537 per year and has fluctuated over time with a peak around 2011. This is a rate of 57.1 births per 1,000 women aged 15 to 44 (called the general fertility rate).
- The number of deaths has been fairly constant over the last 25 years at just over 5,000 deaths per year.
- **The number of births is greater than the number of deaths by roughly 2,500 per year – so, if all else were equal, the population would grow.**

However, people don't just stay put all their lives. They move around a lot within the UK and go overseas. Similarly, new migrants arrive from other countries. This is summed up in 'migration statistics'. Over the last 15 years, Oxfordshire has had 'net inward migration' of roughly 2,000 additional people per year.

Putting together population increase due to more-births-than-deaths (called 'natural change' in the jargon) and change due to migration gives the following picture:

Oxfordshire: Natural Change and Net Migration (ONS)



ONS mid-year population estimates

The chart shows that:

- The population of Oxfordshire is increasing each year.
- The size of the increase fluctuates widely from a minimum of around 2,200 more people per year to a maximum of around 7,200 more people per year.
- The average increase is around 5,000 more people per year.
- Almost every year births and deaths contribute more to the total than does migration.
- Natural change (births minus deaths) has been above net migration (internal and international, in-migration minus out-migration) for each year since mid-2002 with the exceptions of 2003, 2005 and 2014.

This is the engine of population growth. This is why Oxfordshire is growing.

Of course, some migrants settle in Oxfordshire and start families here too. The table below shows births in 2016 in Oxfordshire by their mother's country of birth.

Births by Mothers Country of Birth
Births in Oxfordshire by mother's country of birth (2016)

	within UK		EU incl. 'New EU'*		New EU*		Rest of Europe (non EU)		Middle East and Asia		Africa		Rest of World	
Cherwell	1,328	72%	249	14%	179	10%	28	2%	114	6%	56	3%	61	3%
Oxford	894	49%	315	17%	165	9%	57	3%	325	18%	102	6%	118	7%
South Oxon	1,229	80%	159	10%	105	7%	14	1%	51	3%	43	3%	44	3%
Vale of WH	1,098	76%	139	10%	77	5%	9	1%	86	6%	56	4%	48	3%
West Oxon	959	85%	102	9%	66	6%	7	1%	24	2%	20	2%	22	2%
Oxfordshire	5,508	71%	964	12%	592	8%	115	1%	600	8%	277	4%	293	4%
England		*71%*		*11%*		*8%*		*1%*		*10%*		*5%*		*2%*

Source: ONS live births by parent's country of birth; *The 'New EU' constitutes the countries which joined the European Union (EU) between 2004 and 2016.

The table looks a bit dry on the face of it, but it hides some interesting facts as follows:

- 7 out of 10 births are to mothers born in the UK and 3 out of ten mothers aren't born in the UK.
- This is the same as for England as a whole and shows just how mobile people are these days.
- In Oxfordshire as a whole, 21% of births in 2016 were to mothers born in Europe (excluding UK), 8% from the middle East and Asia and 4% from Africa.
- The same figures differ widely between the Districts: in Cherwell for example, 16% of mothers were from Europe (excluding UK), 2% from the Middle East and Asia and 2% from Africa.
- In the City a very different picture is seen, with 29% of mothers coming from Europe (excluding UK), 18% from the Middle East and Asia and 7% from Africa.
- This means that in the City, just over half of all births are to mothers not born in the UK.

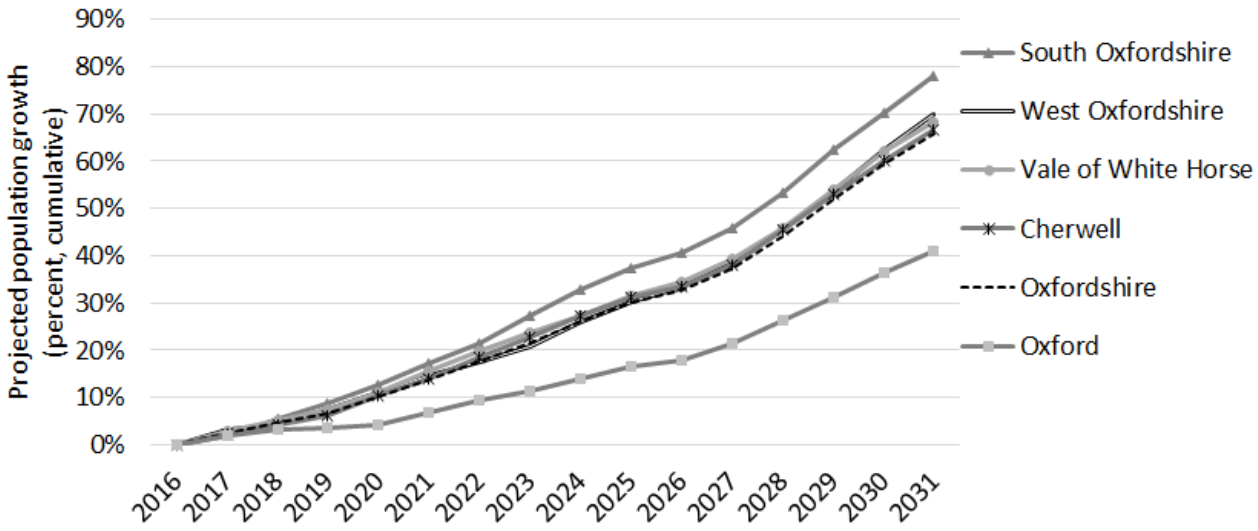
Demographic Change in the 85 plus age group

Let's drill down now into some of the more specific changes which demographic change brings.

The first big change is by now very familiar – the increase in older people as a result of living longer on average – fantastic news, which also brings challenges for services.

What does it look like across Oxfordshire for those aged 85+?

Cumulative growth in population aged 85+ in Oxfordshire 2016 to 2031



Office for National Statistics 2016-based population projections

The chart shows that:

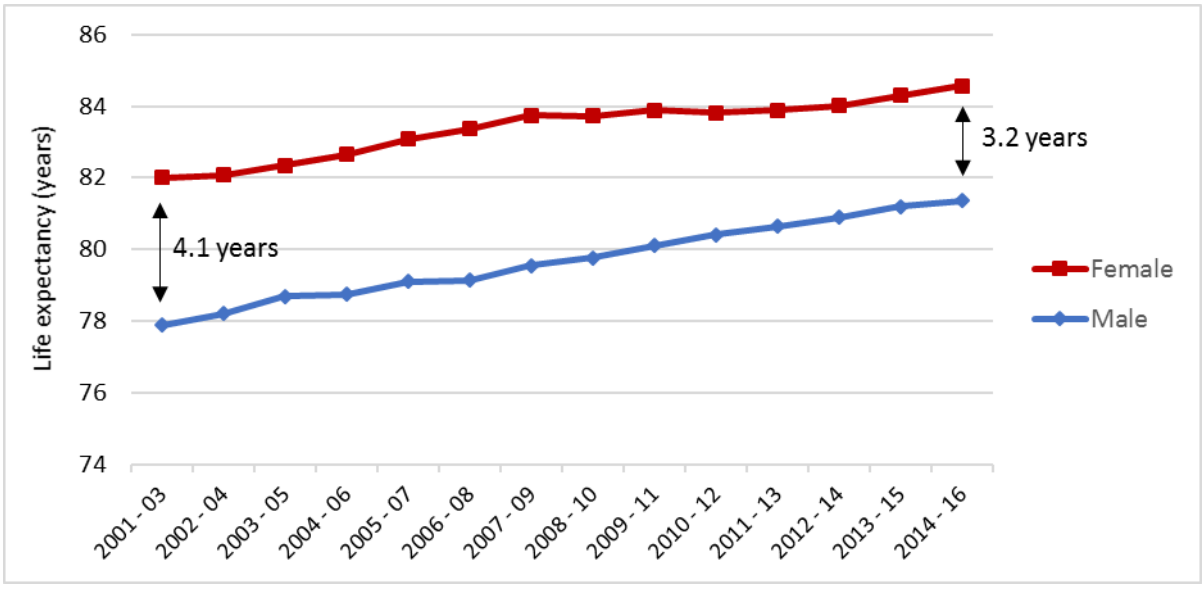
- Over the next 15 years the 85+ population will continue to increase rapidly at between 60%-80% in all Districts.....
- Except for the City where the growth will be lower – at around 40% - because of a younger population

This means that services will continue to find difficulty in coping with this most needy section of society in terms of health and social care. New methods of delivering care will need to be found which do not require intensive travel and which rely as little as possible on centralised hospital beds. New ways of keeping people healthier for longer will need to be found. The pressures on services experienced over the last decade are set to continue.

Life Expectancy

I've said already that this change is driven by longer lifespans and the chart below gives more information on life expectancy:

Change in Life Expectancy in Oxfordshire – males and females to 2014-16



Source: ONS Figures are based on the number of deaths registered and mid-year population estimates, aggregated over 3 consecutive years. Note that scale does not start at 0

The chart shows:

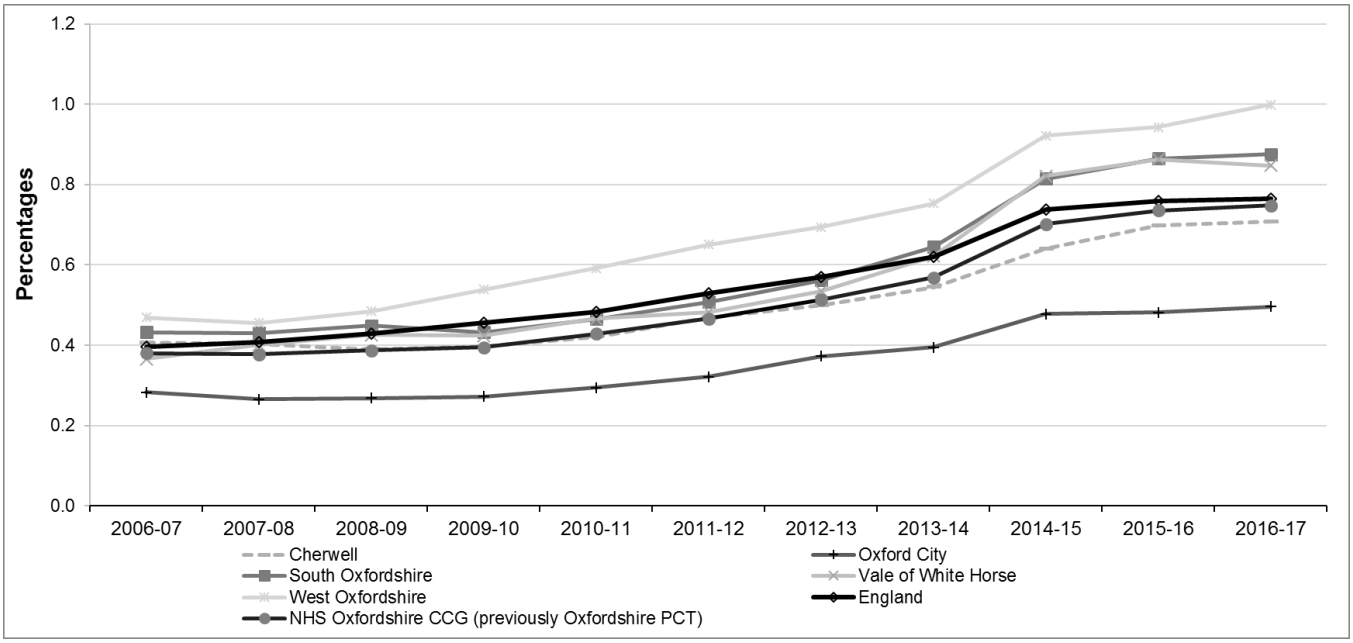
- Both males and females are living longer – the trend looked to be plateauing out a few years ago, but now is swinging up again so that women are now living on average to over 84 and men to just over 81.
- Women live longer on average than men - the gap is now 3.2 years, a slight increase on 3.1 years last year.

An ageing population is to be celebrated, but it also brings challenges. For example, longer life and a decline in heart disease and some cancers means that more people live for long enough to suffer from dementia.

Dementia

The chart below shows the current recorded cases of dementia as a percentage of those on GP's books.

**Percentage of patients with a recorded diagnosis of dementia in the GP registered population –
2006/07 to 2016/17**



Source: Quality Outcomes Framework 2016/17

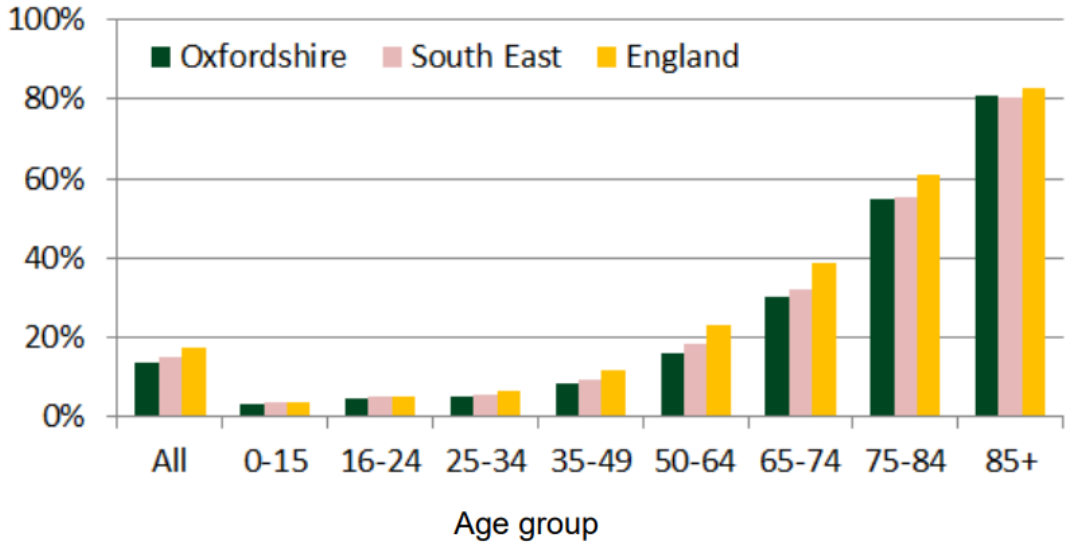
Some of this increase is due to better awareness of dementia in general, and better detection of dementia by GPs and some of it will reflect that there are more people surviving into the age groups where dementia is more common.

Chapter 2 looks at how communities might be designed better to help with this, and Chapter 5 looks at promoting mental wellbeing and positive mental health and looks at how dementia might be prevented or delayed.

Physical Disability

Old age also brings with it, on average, more physical disability. The chart below shows the percentage of people by age group who feel that they are limited by ill health or disability.

Percentage of residents in households* by age with daily activities limited by ill health or disability (a little or a lot) 2011, Oxfordshire vs South East and England



Source: ONS Census 2011 from nomis, table DC3302 *excludes people living in communal establishments such as care homes

The chart shows that:

- The percentage of people affected rises sharply with age – up to around 80% of people aged 85+ report ill health or disability of some kind.
- The figures for Oxfordshire are slightly better than for England as a whole but broadly mirror the national and regional pictures.

The positive message in these statistics is that there is scope to work with people in their 50s and 60s to find ways to prevent or delay chronic disease and disability.

Impact on carers

The other impact of an ageing population is the impact on carers of older people, many of whom are in their 60s and 70s themselves. The national survey of carers, carried out in 2016 gives a rough indication of the numbers of local carers.

- Around 60,000 Oxon residents provide unpaid care for others, of whom around 17,000 provide 20 or more hours per week.
- Many of the carers are over 65 and are suffering from ill health themselves.

- Around 35% of those who responded to the survey said that they had seen their GP because of their caring role.

These figures are inexact, but show that as a society we are heavily reliant on the ability of carers (usually family members or spouses) to care. Looking after their wellbeing remains a high priority. Continuing to work with this group to help them to stay healthy for longer is essential.

Ageing - there is good news!

Ageing brings its difficult issues but there would also seem to be compensations – Chapter 5 Promoting Mental Wellbeing and Positive Mental Health, shows that many measures of wellbeing and contentment shoot up following retirement age.

Loneliness

Another fact of modern life is that many people experience loneliness.

A report on the Impact of Loneliness from Public Health England in 2017 highlighted the impact on individuals and for services:

Impact on individuals:

- Social isolation and loneliness are harmful to physical and mental health and increase the risk of illness and early death.

- Social isolation and feelings of loneliness can also cause stress resulting in behaviour that is damaging to health - such as drinking too much.

- Having good social networks and friendships not only have an impact on reducing the risk of early death or developing certain diseases, but they also help individuals to recover better when they do fall ill.

In terms of impact on services, lonely people are likely to:

- visit their GP more often;

- have higher use of medication;

- use accident and emergency services more;

- use adult social care more;

- make more use of mental health services;

- have early admission to residential or nursing home care.

Public Health England also found evidence to suggest a strong relationship between low socioeconomic status and social isolation. *In other words, disadvantage and loneliness go hand in hand – yet another reason for continuing to tackle social disadvantage. Social disadvantage experienced earlier in life can also increase the risk of isolation in younger age groups.*

Using national figures from the Community Life Survey the table below shows that it is estimated that 20,400 (around 1 in 6) older people in Oxfordshire (aged 65+) experience loneliness at least some of the time, of which **3,500** older people experience loneliness "often or always".

Table 1 Estimate of the number of older people (65+) in Oxfordshire experiencing loneliness

		Lonely often/always		Lonely some of the time		
	Oxfordshire population mid-2016	Percentage	Oxfordshire estimate (count)	Percentage	Oxfordshire estimate (count)	TOTAL estimate
people aged 65-74	65,500	2.89	1,900	11.38	7,500	9,300
people aged 75+	55,500	2.95	1,600	17.04	9,500	11,100
TOTAL	121,000		3,500		16,900	20,400

Sources: ONS mid 2016 population estimate original release; Percentages are from ONS 2016-17 Community Life Survey (not including confidence intervals) as cited in ONS Analysis of characteristics and circumstances associated with loneliness in England

Developing new national measures of loneliness

The government is developing a strategy to alleviate loneliness in response to the report of the Jo Cox Commission on Loneliness published in December 2017. As part of this, the Office of National Statistics (ONS) is working on new national measures of loneliness with the help of a cross-government group, charities, academics and other stakeholders. This is to be welcomed.

A recently published (April 2018) ONS analysis, found three profiles of people at particular risk from loneliness:

- Younger renters with little sense of belonging to their area
- Unmarried, middle-agers with long-term health conditions.
- Widowed older homeowners living alone with long-term health conditions.

As this work develops it should give us better information with which to plan future communities and future services to help tackle loneliness.

What about demographic changes in the population of young children?

Well, it depends on what you count! If you just use the current birth rate, you would predict a fall in the number of very young children by 2031, but if you add in planned housing growth you get an increase.

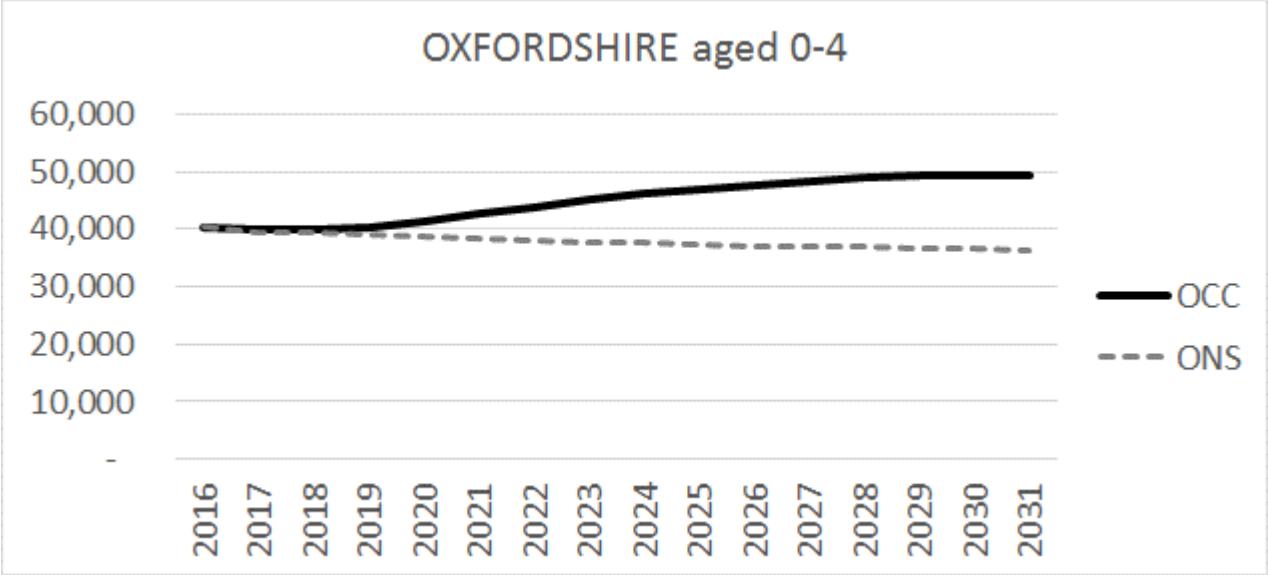
The chart below shows the disparity – looking at Vale of White Horse District and Cherwell District for example, without housing growth one might expect a decrease but with housing growth one would expect a 36% increase – that's 2,700 more children in the Vale and 3,400 more children in Cherwell - a massive difference.

Count of children aged 0-4, 2016 and 2031, ONS vs Oxfordshire County Council projections

	ONS 2016-based				Oxfordshire County Council 2016-based			
	2016	2031	difference		2016	2031	difference	
Cherwell	9,269	8,346	-923	-10%	9,400	12,800	3,400	36%
Oxford	9,033	7,449	-1,584	-18%	9,100	8,000	-1,100	-12%
South Oxfordshire	8,161	7,638	-523	-6%	8,200	10,900	2,700	33%
Vale of White Horse	7,647	7,208	- 439	-6%	7,600	10,300	2,700	36%
West Oxfordshire	6,248	5,697	-551	-9%	6,200	7,500	1,300	21%
Oxfordshire	40,358	36,338	-4,020	-10%	40,300	49,300	9,000	22%
South East	542,383	515,877	-26,506	-5%				
England	3,429,046	3,269,597	-159,449	-5%				

The data in the table is shown below in a more user-friendly format and shows the difference housing growth is predicted to make to the County as a whole.

Count of children aged 0-4 2016 to 2031:
Oxfordshire County Council vs Office of National Statistics projections



The chart clearly shows an increase from 40,000 to 50,000 children in the 0-4 age group by 2031 if one takes housing growth into account. These are clearly the figures we need to use for planning and they will have a clear impact on our future need for schools, health visitors, social services and GP services.

Housing Issues

I want to turn now to look at the impact of housing on demographic growth. More people means that more accommodation is needed to house them. Oxfordshire's Strategic Housing Market Assessment sets out a need for 100,060 additional homes between 2011 and 2031.

In the 5 years 2011-12 to 2016-17, a total of 16,800 new homes have been built in Oxfordshire (an average of 3,000 per year). This leaves 82,300 to be built by 2031, this is equivalent to a rate of just under 6,000 homes per year.

The table below shows the number of houses planned by each District up to 2031. In total, 47,000 homes are planned.

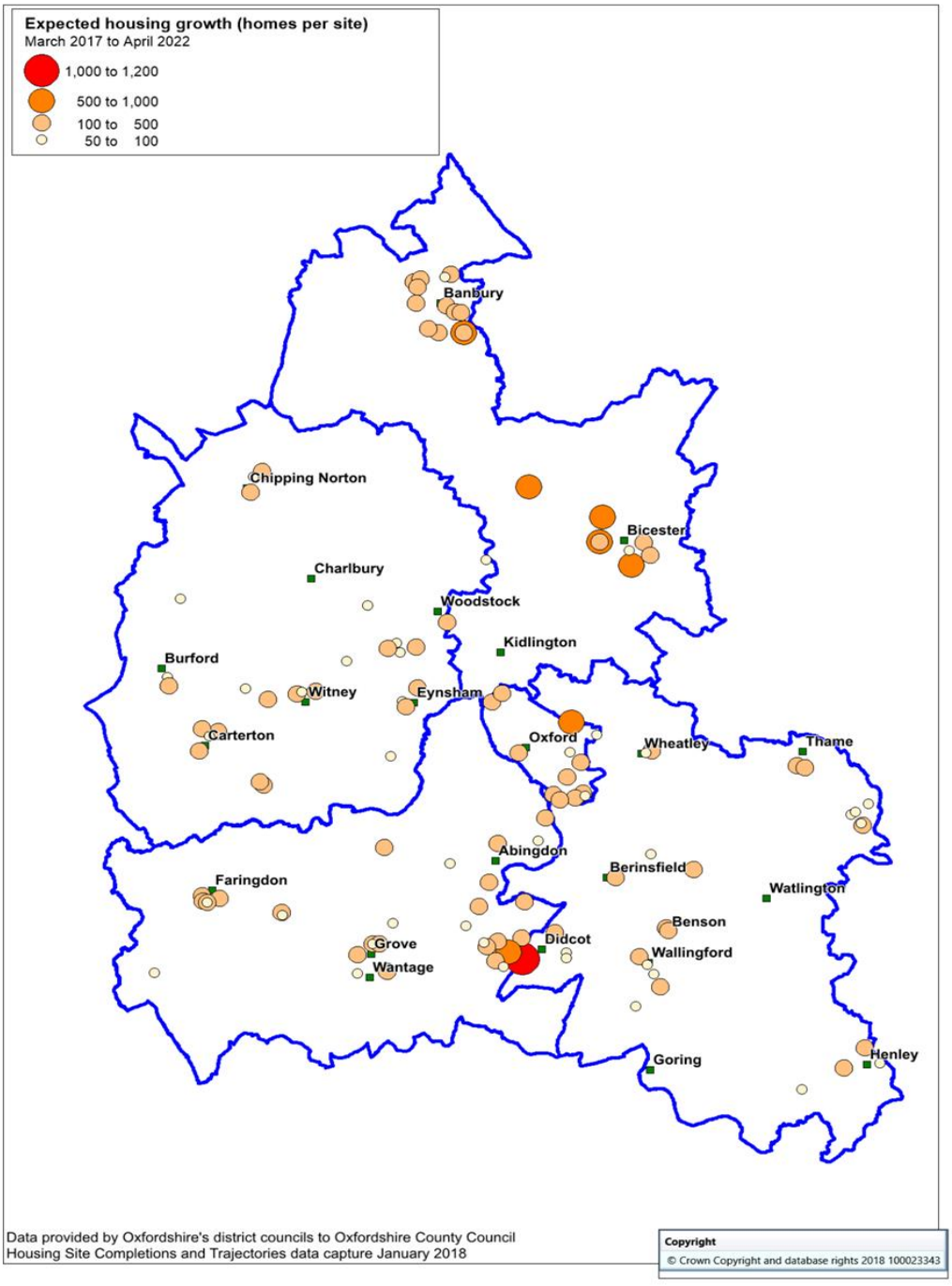
Homes built in Oxfordshire and expected housing growth in Oxfordshire 2011 to 2031

	Total new homes needed over 20 years 2011 to 2031 (inc re-allocation of Oxford's unmet housing need)	Homes built 2011/12 to 2016/17	Remainder by 2031 to meet 100,060 new homes
Cherwell	27,200	4,579	22,621
Oxford City	13,700	1,744	11,956
South Oxfordshire	20,450	3,397	17,053
Vale of White Horse	22,760	4,680	18,080
West Oxfordshire	15,950	2,369	13,581
Oxfordshire	100,060	16,769	83,291

The map on the next page shows where the areas of housing growth are most likely to be. The bigger and the darker the spot, the more houses are planned.

You can see at a glance that:

- Planned housing growth is spread across the County.
- Didcot and Bicester stand out as areas of particular growth with clusters of development around Banbury, Oxford and many of our market towns
- The expected growth around market towns such as Faringdon, Grove and Carterton is smaller but significant. The growth is less than elsewhere but is high compared to the number of existing homes, which may affect the character of the local community.



House prices and stresses in the care market

Of course, building houses is one thing. Being able to afford to live in them is another - and is a pressing problem in Oxfordshire. Expensive housing makes it difficult for lower paid workers and their families to live in Oxfordshire. This leads to the staff shortages we see across the County – for example, there are over 500 nursing vacancies in Oxfordshire at any one time and 'home care' workers are also strongly affected.

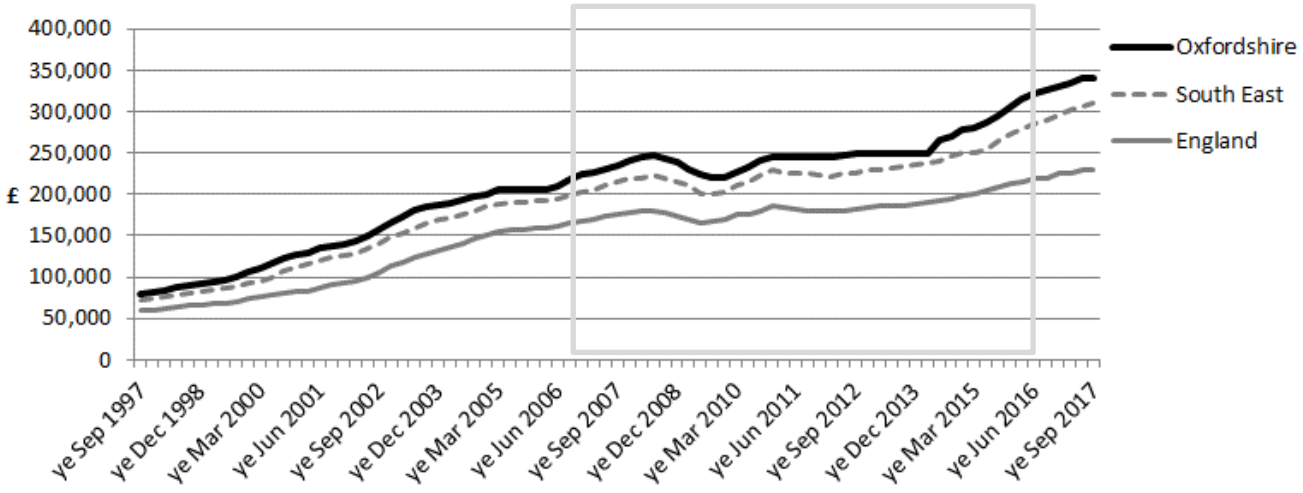
Unemployment is very low in Oxfordshire and the local economy is one of the most buoyant in the UK. This success has a down side however – an equally buoyant - and therefore expensive - housing market…….

The table below shows the latest data on average house prices.

Median house prices 2007 to 2017

The chart below shows how house prices in Oxfordshire have outstripped England's prices and topped the South-East Region's prices.

20 year trend in Median house prices (year ending) September 1997 to September 2017



Source: ONS Median house prices for administrative geographies, released April 2018

The table below shows prices across the Districts, looking at the cost of a mid-priced house.

Median house prices 2007 to 2017

	Year ending Sept 2007	Year ending Sept 2017	*Difference*	*%*
Cherwell	£195,000	£297,500	*£102,500*	*+53%*
Oxford	£250,000	£400,000	*£150,000*	*+60%*
South Oxfordshire	£270,000	£380,000	*£110,000*	*+41%*
Vale of White Horse	£244,950	£340,000	*£95,050*	*+39%*
West Oxfordshire	£230,000	£329,995	*£99,995*	*+43%*
Oxfordshire	**£235,000**	**£340,000**	***£105,000***	***+45%***
South East	£215,000	£310,000	*£95,000*	*+44%*
England	£175,000	£230,000	*£55,000*	*+31%*

Source: ONS Median house prices for administrative geographies, released April 2018

The chart shows that:

- Oxfordshire's average house price is well above the average for England and above the South East as a whole.
- Prices have risen sharply over the past 10 years – more sharply than in England or the South East - making a sort of 'Oxon inflation factor' of 45% compared with 44% in the South East and 31% for England as a whole.
- Within the County, prices in the City have risen faster than elsewhere, up 60%, making working in the city's hospital services and living locally even more difficult for lower paid staff.
- During the same period house prices in Cherwell have also risen dramatically by 53%

So, to sum up:

Demographic change presents a distinct cocktail of triumphs and challenges to Oxfordshire:

- Health is generally good and the local economy buoyant.
- The population is growing fast.
- House prices are high and recruitment to essential staff groups is difficult.
- Housing growth is set to continue which will bring more young families and children
- The population is increasingly culturally diverse.
- The population is ageing and new patterns of disease have emerged eg dementia.
- Carers are vital to service delivery.

So, what do we do?

We can't spend our way out of this situation given the current financial situation, so we have to innovate our way out.

For public services this means:

- Working together in a more joined-up way and working positively across organisational boundaries
- Linking the planning work of the NHS, Social Care, District and City Councils and Public Health together much more strongly
- Finding solutions which use the new technologies now available to support people electronically rather than face to face contacts.
- Helping communities and residents to help themselves.
- Preventing problems before they start and joining up our preventative services more coherently.
- Systematically targeting services at those who are already ill and in whom further deterioration can be prevented. This means getting 'upstream' and working with people who have chronic diseases or care needs to stabilise them and keep them healthier for longer.
- Using all of these factors to create a new range of services
- Using all these factors to design communities which support good health.

These issues and solutions are amplified throughout this report. The next chapter looks at bringing together health concerns with local planning to create healthy communities. Chapter 3 looks at the challenges of those particularly at risk – the disadvantaged. Chapter 4 looks more closely at obesity and its impact on disease patterns, and chapter 5 looks at promoting good mental health which is a key ingredient to staying well for longer.

What did we say last year and what did we do about it?

Last year's recommendations called for a much more joined-up planning system overall across Oxfordshire. And there are many positive initiatives to report. All local authorities are working together to create a Joint Strategic Spatial Plan. This is good progress. We also secured a Growth Deal with Government enabling infrastructure to keep pace with housing growth (see chapter 2 for details)

The Healthy New Towns approach (also discussed in detail in the next chapter) has also moved forward and the shared learning from this has begun to influence planning of new and existing settlements in the County -this is very good news.

NHS, Social Care and Public Health services are now working much more closely together under a re-designed Health and Wellbeing Board. A new strategy for services for older people is being drafted as I write. This change was helped by a Care Quality Commission review of services for

people going into, through and out of the hospital system which strongly supported better joined-up working under a re-organised Health and Wellbeing Board. All organisations are responding strongly and positively.

The NHS nationally has the bit between its teeth when it comes to promoting preventative initiatives at scale through a policy known as 'Population Health Management' which is also being embraced by Local Government. This means looking at whole populations, or subgroups, identifying why people become ill, and creating services aimed at preventing further deterioration. This is a very important shift in thinking and is to be welcomed. This includes the coordination of preventative services across the County recommended in last year's report.

The NHS has begun to change the basis on which it works in a helpful way. Health policy five years ago was dominated by creating 'internal markets' in health care with distinct commissioning and providing organisations linked by negotiated contracts. This policy is now giving way to a more collegiate approach in which all organisations work together for the good of Oxfordshire, drawing on one 'bag' of tax-payers' money. This also includes finding new ways of working with social care and public health services. This is a positive development.

Recommendations

1. The Health and Wellbeing Board should develop as a priority a Joint Health and Wellbeing Strategy which embraces the philosophy of 'population health management' as well as creating a new strategy for older people and targeting inequalities.

2. Joint work between the NHS, County Council and District Councils to get health and wellbeing issues into the planning of places and highways should continue apace.

3. Work already begun to coordinate preventative services better between all Local Authorities, the NHS and Social Care should continue as a priority.

Chapter 2: Creating Healthy Communities

There has been a sea change in thinking about how we should plan communities over the last decade – and it is still gathering pace. It is no longer a matter of simply planning houses and sewers and roads, it is a matter of planning vibrant communities which support people to live healthier lives – and it is a vitally important issue.

If we are to cope as a society we need to integrate health and wellbeing issues into the way we plan our communities locally, regionally and nationally.

I'm talking here about health concerns on the large scale - issues such as:

- coping with demographic growth
- building health promotion into community design to prevent obesity, chronic disease and loneliness and to be 'dementia friendly'.
- coping with an ageing population structure and planning for a projected 2 million cases of dementia nationally by 2030.
- hard-wiring provision of future health services into planning systems
- designing community facilities and schools which reach out to engage the whole community
- considering ambulance journeys and patient access in the design of new roads
- planning major roads that make the best use of hospitals across the country and beyond

All easy to say, but difficult to do without teamwork, creativity and political will at all levels - and harder to do in times of financial restraint.

Why is it a challenge?

The existing planning system is complex and labyrinthine, depending as it does on a cocktail of government policy, local plans, agreements between Local Authorities, deeply held public views, developer contributions, legislative frameworks and the commercial interests of developers.

Major schemes are even more complex, requiring the interaction of many government departments, multiple agencies, pressure groups and many local authorities across neighbouring counties.

Money is scarce, and the prizes go to schemes which also deliver more economic growth and more houses for more people who must then also be catered for in terms of health and social care, schools and amenities.

The goal is to achieve a 'winning hand' combining future economic prosperity with communities one actually wants to live in. These in turn must make healthy lives easier to lead and build in access to the facilities we will all need.

I want to use this chapter to review some of the key stages of our local journey along this path and to showcase the contribution of the Cherwell District Council and City Council led Healthy New Towns.

The initiatives of local leaders to put health issues into planning.

The key stages I have seen in recent years towards these goals have been:

- Closer working between key organisations to achieve important deals from Government resulting in road improvements around the County (e.g. at Harwell and the Oxford ring road), the Growth Deal and current work on a Housing Infrastructure Fund bid. Close working between all Local Authorities, the Local Enterprise Partnership and the Universities has been an important success factor.

- Strategic infrastructure planning has also benefitted, first with a shared assessment of Oxfordshire's strategic requirements and secondly through the agreement to have a Joint Strategic Spatial Plan for Oxfordshire which will be put together over the next few years and which will incorporate health and wellbeing issues from the outset.

- The successful bidding for two of the ten Healthy New Town pilot sites in England led by Cherwell District Council and Oxford City Council (see more below).

- The initiative of local leaders to generalise the lessons learned from putting health into planning through local conferences culminating in an event earlier this year hosted by Cherwell District Council and the City Council. At this event Leaders and senior officers from Local Authorities, the NHS, the Local Enterprise Partnership and other key organisations met to review progress made through the Healthy New Towns and began to discuss how to generalise the emerging lessons.

- Discussions held over the last 18 months between Chief Executives of our two large NHS Trusts, Local Government the Local Enterprise Partnership and our Universities to discuss the long-term planning aspirations of those bodies.

- During this time, the Public Health team have worked closely with the County Council Communities team so that it is now second-nature to include active travel and features such as cycle paths in new developments. This can be seen clearly in our Local Transport Plan.

- The recent re-design and strengthening of the Health and Wellbeing Board also improves opportunities for it to work alongside the Growth Board as part of a constructive dialogue.

- ……And last but not least, the recent difficult discussions over the recent consultation about re-shaping health care across the County really did serve to put the issues of transport, travel and access issues at the top of the agenda, showing that these issues cannot be considered in isolation.

In all this I need to say that I am a doctor, not a planner. I come at this from a public health point of view, but over the last five years there has been a really creative exchange of ideas between us as the penny has dropped that we won't cope with population growth and ageing unless we plan for health and wellbeing as part of infrastructure and housing planning.

The acid test for all these approaches to get health and wellbeing into planning is: do they actually work on the ground?

That is where the value of the Healthy New Town pilots comes in - they are practical experiments in what can actually be done and are therefore extremely valuable to us all. ***The learning from these two sites is pure gold and a real gift to Oxfordshire.***

Focus on the Healthy New Towns in Bicester and Barton.

I believe that many of the initiatives in the Healthy New Towns can be applied in other areas across the County and that they help point the way forward for the County as a whole. I think it is vital that this learning is shared so I am going to go into the topic in some detail.

The Healthy New Towns chime with so many of the concerns raised in this report and link to:

Chapter 1 on population growth, house prices, dementia and loneliness

Chapter 3 on tackling inequalities and disadvantage

Chapter 4 on obesity and healthy lifestyles and 'shifting to prevention'

Chapter 5 on mental wellbeing.

The Healthy New Towns offer new solutions to some of the key problems facing Oxfordshire over the next decade – that is why they are vital and that is why they are exciting, and that is why the learning should be sustained.

To push the point home, I am including below a checklist of the types of issue that can be tackled. You will see that they are the pressing priorities for the County as a whole:

Potential Benefit to Oxfordshire of the Heathy New Towns: Checklist	
Plan healthy communities and healthy housing growth: bring organisations together with a common ambition	
Engage local people in planning and health care	
Encourage exercise	
Fight obesity	
Help to cope with dementia	
Fight loneliness	
Bring together NHS and Local Authority planners and developers	
Involve the voluntary and community sector	
Work with local schools to improve children's health	
Find new ways of delivering health services	
Help tackle chronic diseases like diabetes	
Reduce social disadvantage and inequalities	
Promise help to an overburdened NHS	

What does the term 'creating healthy communities' mean?

As set out in the previous chapter we know that one of the key challenges for Oxfordshire is population growth linked to the need to provide more housing. The shortage of affordable homes is particularly acute in Oxfordshire and this has been one of the driving forces for the county and district councils agreeing a Growth Deal with national government to build 100,000 new homes by 2031.

The scale of the Growth Deal means that Oxfordshire now has a great opportunity to ensure that it supports the creation of healthy communities, not just large housing estates. Creating healthy communities is described as:

'a collaborative process which aims to create sustainable, well designed communities where healthy behaviours are the norm and which provide a sense of belonging, a sense of identity and a sense of community'

Crucially, creating healthy communities is not just about new developments; it applies to any place experiencing significant housing growth and is a mechanism for integrating new estates with existing communities so that all residents have the opportunity to benefit in terms of health and wellbeing.

Over the past two years Bicester and Barton in Oxford have been testing out how to create healthier communities as two of ten demonstrator sites for NHS England's Healthy New Towns programme. NHS England has provided three years of modest funding for these sites to test out innovative ways of shaping communities to promote health and wellbeing, prevent illness and rethink the way that health and care services are provided. They are the test beds for all our futures.

The following section describes the progress that both sites have made over the past two years in testing innovations in the built environment, working creatively with local people through 'community activation', and developing new models of care, and how they have started to share the learning with a view to replicating this approach across Oxfordshire.

Barton Healthy New Town

Barton is an area on the western outskirts of Oxford, just outside the ring road, bounded by the A40 only 3.5 miles from Oxford City Centre. Built in 1946, the estate was originally developed to provide social housing for residents of Oxford. The population of the Barton and Sandhills ward has grown by 9% since 2006 and now stands at 7,411. With a further 885 new homes planned at Barton Park (delivered by Barton Oxford LLP a joint venture between Oxford City Council and Grosvenor) in the next 7 years, a further 3,000 new people are likely to move into the area as a result of the new development.

The 2015 Index of Multiple Deprivation showed Barton to be among the 20% most deprived areas in England. Life expectancy at birth in Barton and Sandhills is 77.5 years for males, 81.6 for females. For males this is 12.6 years less than North Oxford ward (about 4 miles away) and 5.5 years less for females.

The Barton Healthy New Town programme is being delivered through a partnership between Oxford City Council, which is the lead delivery partner, Grosvenor Developments Ltd, Oxfordshire County Council's Public Health team and Oxfordshire Clinical Commissioning Group. The project aim was set early on in year one for '***All Barton residents (Barton and***

Barton Park) to have an equal opportunity to good physical and mental health and good health outcomes.'

Bicester Healthy New Town

Bicester Healthy New Town

Bicester is a market town located within Cherwell District Council's administrative area in North Oxfordshire. The town currently has approximately 13,000 dwellings and a population of about 30,000 people. Over the next 20-30 years a further 13,000 homes are planned to be built which will effectively double the size of the population. Cherwell District Council has recently adopted its Local Plan (July 2015) which allocates housing and commercial sites for development in Bicester and covers the period from 2011- 2031. Bicester was designated as a Garden Town in 2014 under the government's Garden Cities initiative and is a strategic location for growth within the Oxfordshire Strategic Economic Plan.

The programme is a partnership initiative led by Cherwell District Council, Oxfordshire Clinical Commissioning Group, Oxford Academic Health Science Network, A2 Dominion (developer of the ecotown Elmsbrook at North West Bicester), and supported by a further 25 different community organisations, health and care providers and Bicester schools and businesses. In Bicester the two key priorities are:

- **To increase the number of children and adults who are physically active and a healthy weight. (In Bicester 1 in 4 of children aged 2-10 are overweight or obese and 58% of women and 65% of men are overweight or obese)**

- **To reduce the number of people who feel socially isolated or lonely in order to improve their mental wellbeing (17% of older people are in contact with family, friends and neighbours less than once a week).**

How can the built environment encourage healthy living?

The ***Neighbourhood Centre located in Barton*** is undergoing a major refurbishment, funded through pooling of 'section106 funding' (the money developers pay to contribute to new infrastructure like schools and road access), City Council funding from capital investment from the 'Investing in Barton' regeneration programme and from its maintenance programme. This will see the ***expansion of the medical practice***, which will ***triple primary care space*** from 74m^2 to 249m^2, providing enough capacity for existing and new residents in Barton. This is alongside the ***modernisation of the community and youth spaces***, including the installation of youth art, ***dementia friendly signage and improvements*** to the reception area. All of this will convert the Neighbourhood Centre into a ***Health and Wellbeing Hub***, with additional capacity to cope with the increased demands from the new population within six months of the first occupants moving in.

Over the last year Barton took part in the Town and Country Planning Association's (TCPA) Developers and Wellbeing project to look at how working with developers improves health. The project culminated with a parliamentary launch in February 2018 which featured a profile on Barton. This initiative was also featured by the Local Government Association as part of its 'Planning Positively through Partnership' publication.

As a result of the project, spatial planners now have a much richer understanding of how development can shape the health and wellbeing of future generations and the project has had a permanent impact on planning policy within the City Council including a policy within the Oxford Local Plan 2036 stipulating that '*for major development proposals of more than 9 dwellings or 1000m^2 the Council will require a health impact assessment to be submitted to include details of implementation and monitoring*'.

Other initiatives at Barton include *a* ***wayfinding project with three new dementia-friendly trails*****.** These provide opportunities for people to be more active, create routes between community facilities and link the new development with existing areas in Barton and neighbouring communities. These are due to be launched in spring 2019 when Barton's Park opens (a 3.84 hectare linear park) connecting Barton and Barton Park.

In Bicester ***three 5K circular Health Routes for walkers, joggers and runners*** have been marked out in blue in residential areas of the town to encourage people to get active. There is no cost to participation and it is suitable for a wide range of ages, at any time of the day. When ***'Bicester's blue lines'*** were launched they attracted over 50,000 views on Facebook, resulted in an increase in footfall of 27% along one of the routes, and are supporting community cohesion with people walking them with family and friends and using them to explore different parts of Bicester. ***They have been so popular that a new Discovery Walk is planned*** for Bicester town centre to encourage people to take a ***brisk 15 minute walk during their lunchbreak***. The graphic below gives the idea:

Other built environment initiatives in Bicester include the installation of ***wayfinding signs*** across the town which provide ***information on cycling and walking times*** to key local destinations, and the opening of ***a 'community house'*** at Elmsbrook, to provide an early facility for residents to support them to come together and run community events and activities and develop a sense of community in the eco development in Bicester.

Building social cohesion and enabling people to live healthier lives through 'Community Activation'

Community activation builds on the idea of actively engaging communities to be partners in the development of new ideas which will benefit both individuals and the whole community. The notion was floated in the NHS's 'Five Year Forward View' and, is about putting into practice the principles set out in the graphic below through the real and dynamic involvement of local people and communities:

fyfv@nationalvoices.org.uk 2016. Six principles for engaging people and communities

Over the last year ***Bicester's primary and secondary schools*** have been actively supporting young people in a range of ways to increase both their physical and mental wellbeing. ***Five primary schools have introduced the 'Daily Mile'*** into the school day with the result that 2,000 children now run a mile a day at school promoting not just their physical health but aiding concentration and mental wellbeing. All schools in the town took part in ***Walk to School Week*** in May to encourage parents and children to leave the car at home for their school commute and ***Cherwell's Sports Activators have trained play leaders to increase active play*** at break time providing more playtime equipment and activities.

Encouraging children to be active outside of school hours is equally important and ***St Edburg's school has successfully tested a family fun club*** in the early evening to get families together and take part in fun and healthy activities. Across the 10 week programme there was a total of 173 attendances with new friendships formed between families as well as enthusing them to have active family time. There has been a 50% increase in children attending the ***active fun clubs run in the school holidays*** by Cherwell District Council.

Addressing the ***mental health of young people*** is equally important and ***Healthy New Town Ambassadors in the secondary schools have provided input into the development of a website by the local mental health trust offering access to mental health advice and services for young people, parents and teachers.***

Training has also been provided to primary school teachers to promote the mental wellbeing of under 11s, with practical 'SATS relax' sessions provided in all schools to help reduce any stress felt by Year 6 children as they took their exams.

In Barton, there has been a particular emphasis on building and embedding community resilience using an 'asset-based community development approach'. In practice, this means working with local voluntary and community groups to use their strengths to address health issues in their community supported by small grants. Through the grants programme in year one, 11 pilot projects were funded, supporting over 1,800 people, with several project levering in additional external funding to continue the projects when NHS funding comes to an end in March 2019.

The funding was complemented with special training for 122 professionals and in community development skills to support directly those who need help the most. Skilling-up local people and professionals in this way will make the legacy of the project last longer than the end of NHS England's funding. The fruits of this are shown by the local Community Association having health and wellbeing as their number one priory in their strategy for 2017 – 2020.

One of the local organisations funded was Getting Heard, which was piloting an 'Appointment Buddies' project. This project provided advocacy for older people attending a health appointment to ensure that they understood the information they received, especially around medication or any secondary care referral. The project was successful and went on to successfully apply for *£204,326* of Big Lottery funding to expand the project over a 3 year period.

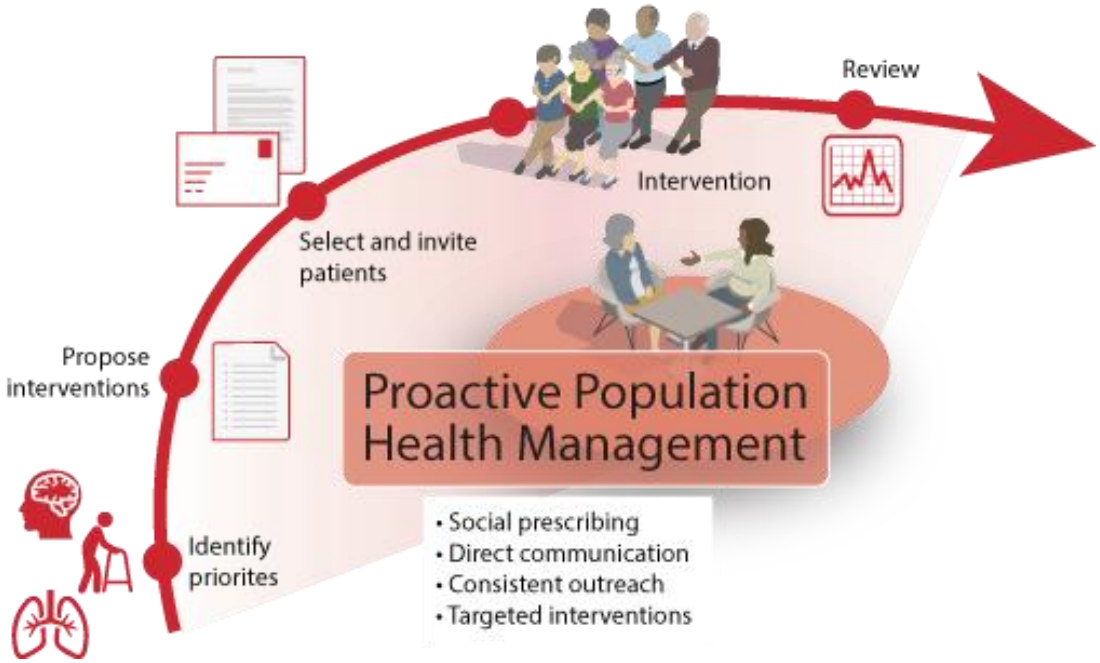
Year two saw an increase in 'social prescribing' (prescribing activities like exercise and hobbies instead of the traditional 'pills and powders') and led to commissioning a range of physical

activity sessions. For example, a Zumba session started in late 2016 in partnership with Barton Community Association and Oxford City Council's Sport and Physical Activity Team and has now been running for two years and attracts around 30 local residents each week.

Testing new ways of delivering health and social care

In both Barton and Bicester, a range of **service innovations** have been tested designed to ***prevent problems and to reach out to people before crises occur***. The emphasis has been on providing services in a community setting and promoting self-care.

In Barton an 'asset mapping' exercise was undertaken to understand current services, how well-used they are and service gaps. A range of new services started in January 2018 to fill those gaps. This included local GP Practices running a **Proactive Population Health Management** initiative (defined in Chapter 1). This involved the ***two GP surgeries which serve Barton sending proactive, direct invitations to patients with long term conditions inviting them to attend the practice for preventative and early interventions*** specific to their health needs. In schematic form it works like this:



A promising example is the prevention of falls which often lead to hospital admission in the elderly. In a small pilot project, local GPs sent out invitations to people at risk of falls to take part in dance sessions designed to improve their balance and coordination. In the three months this pilot project ran, 53 patients with long term conditions took part with 29 patients sustaining participation. This approach is now being scoped for replication in other Oxford localities, as part of a Health Inequalities Commission joint project between Oxford City Council and Oxfordshire Clinical Commissioning Group.

Other initiatives include:

- Oxfordshire Clinical Commissioning Group running the ***National Diabetes Prevention Programme*** and;

- ***coaching to 12 unemployed people experiencing mental health issues***, to support them back to employment.

The point here is to experiment with new ways of reaching out to people to improve health, prevent further deterioration and avoid crises. A key lesson is that the ***involvement of the voluntary sector*** can enhance health care and use the whole community's resources.

In year three in Barton, the programme has been specifically funded to develop and deliver a 'Team Around the Patient' (TAP) for frequent users of health and public services, linking in with a city-wide health inequalities project. GPs will work with the local Accident and Emergency Department, Ambulance Service, Social Housing providers and other partners to identify individuals who place the highest demand on services. A TAP meeting is convened to find the root causes of their frequent use of services, and a support package is provided to address these root causes, which may be more social than clinical.

In Bicester there has been a focus on ***improving care for people with diabetes***. ***Digital technology*** is now being used by GPs to ***access expert advice remotely*** from consultant colleagues, ensuring that ***patients only travel to Oxford for specialist care when they really need it***. Patients have been encouraged to get active to help control their diabetes, with practices in Cherwell making the most referrals in the county to ***motivational coaching support*** services run by the District Council and Active Oxfordshire so that people access activities that meet their interests. Practices have also been working closely with diabetic nurses and consultant colleagues to ***coordinate the care they provide with the result that there has been a 7% increase in people receiving all the care they need.***

For many people diabetes stems from being overweight and in efforts to prevent this Bicester has launched a ***'Healthy Bicester' Facebook Page to provide regular tips on how to be active and eat more healthily.*** It promotes self-care through the use of ***Public Health England apps*** and over the last year 414 people in the Bicester area have downloaded apps such as 'Active 10'.

Looking ahead to 2018/19

2018/19 is the last year of central funding from NHS England and so both sites will be focusing on completing delivery of planned short term initiatives, evaluating the impact of various interventions, sharing the learning from the programme and planning for development of creating further healthy communities in the next three years.

How do we keep this approach going?

We are reaching an important point for the Healthy New Towns. They have promised much, they have fulfilled their role as test-beds for innovation and the lessons learned are important. Realistically three years isn't long enough to demonstrate the full value of these trailblazing

projects – Titanics take time to turn, engaging communities is a lengthy process and finding the initiatives that really fly all require a degree of experimentation.

The real gain will come from generalising the learning across the whole planning system – and this is precisely what the recent event held in Bicester described above was intended to do.

So, the question is how do we keep this learning and this initiative going in some form? The answer to that question will be taxing leaders across the County during this year and into next. In my view, these projects press so many positive buttons for future success that between all organisations we need to find a way – and that is the basis for my recommendation for this chapter.

Recommendation

Leaders of all organisations should continue to find ways of keeping the learning from these initiatives alive until the long-term benefits emerge, and they should continue to explore ways to generalise the learning, making it an integral part of the planning system for new developments and for health services.

What did I say last year and what has happened since?

Last year I looked in detail at the health effects of poor air quality. There is little new health information about these effects during the year and last year's recommendation to see this as another way of 'getting health into planning' still holds good and reinforces the message of this chapter. If we can include health issues in planning, we can build in improved air quality too.

I also recommended close monitoring of progress for 'Healthy New Towns' and, as this chapter demonstrates, this has been achieved.

Chapter 3: Breaking the Cycle of Disadvantage

Part 1
Keeping the Torch aflame: The Health Inequalities Commission

What was the Health Inequalities Commission?

- The independent Health Inequalities Commission for Oxfordshire was commissioned by the Health and Wellbeing Board and carried out its work throughout 2016.
- The idea was to take an independent look at inequalities across Oxfordshire and to make recommendations for action.
- It took two years of persistent effort to create it.
- The Clinical Commissioning Group, the County Council's Public Health team, along with many other partners, including Oxfordshire Healthwatch, played a midwife role.
- The report of the Commission was presented by the independent Chair, Professor Sian Griffiths, to the Health and Wellbeing Board in November 2016 and at a launch event on 1st December, chaired by the Leader of the County Council, attended by the media and a wide range of partners.
- The Health Inequalities Commissioners were independent members selected from statutory and voluntary sector organisations and academia.
- The report made 60 recommendations covering a very wide range of topics. The recommendations were just that – recommendations – they have no force apart from our willingness to consider them and make changes where appropriate.
- The practical work is being taken forward by a multiagency implementation group.

This was an important piece of work and I want to use this report to keep the torch aflame

Progress has been reported regularly to the Health and Wellbeing Board and the Health Overview and Scrutiny Committee (HOSC) for the last 18 months.

So what is happening?

- The Health and Wellbeing Board agreed that organisations need to adapt and develop existing ways of working to ensure that health inequalities were identified and addressed. This will form part of the to-be-revised Joint Health and Wellbeing Strategy.
- Rather than set up a range of new, possibly short-lived projects, the Implementation Group wants to see existing projects develop a stronger focus on tackling inequalities, maybe by targeting particular localities or groups of people instead of just taking a general approach for everyone.

- The Commission also highlighted the need to step up the whole 'prevention agenda' aimed at including people who are likely to have worse outcomes. This is now gaining traction and the Clinical Commissioning Group are working with the Public Health Team to join up their preventative action across the County.

Has anything changed?
There are some good signs of progress but entrenched health inequalities will not be eradicated overnight. This is a long haul and it is only by sustaining the effort and really embedding inequalities in all our work that lasting improvements will be seen – hence my desire to keep the torch aflame. We need to keep going. It is about considering inequalities in every one of our new strategies and plans that will make the difference.

Q: Universal or targeted?
A: Both!

There is an old question: should we aim to reduce inequalities right across the board, or should we start off with those who are the worst-off? The answer is both – we need a general approach to increase benefit for everyone – and narrow the gap between best and worst….. and target those at the very end of the scale.

The good signs so far include:

- The big-ticket item is that health inequalities and their reduction are now included in all our major strategies. Increasingly, vulnerable groups are having specific work focussed on them e.g. people suffering from domestic abuse.

- Establishment of a (very modest) Innovation Fund through the Oxfordshire Community Foundation which will be used to fund projects to have a measurable impact on health inequalities. Working with Oxfordshire Community Foundation has already meant more money can be added to the pot.

- Social prescribing initiatives (prescribing things like walks or joining clubs rather than having a prescription for medicine) are being developed across the county, including a project in North and West Oxfordshire with West and Cherwell District Councils which has won national funding. More people will be "prescribed" activities instead of medicine to help with their health problems and prevent them getting worse. (see chapter two on Healthy New Towns for further examples).

- A new analysis of areas of the county which have worse outcomes for some health issues has been published and is being used to target services.

- Well@Work activities in the NHS, local authorities and the private sector are being used to raise awareness of mental wellbeing and the benefits of physical activity

What else is still needed?

- Reporting success and good practice will fuel the flame and keep the momentum going – we need to learn from each other.

- Better data for use in needs assessments and equity audits is coming on-stream and needs to be used more widely.

- The new Joint Health and Wellbeing Strategy and other major strategies need to address inequalities issues and be explicit about what can be done.

- The 'population health management' initiative mentioned in Chapter 1 will help to combat inequalities and spread preventative activity.

Part 2

Report on the Basket of Indicators

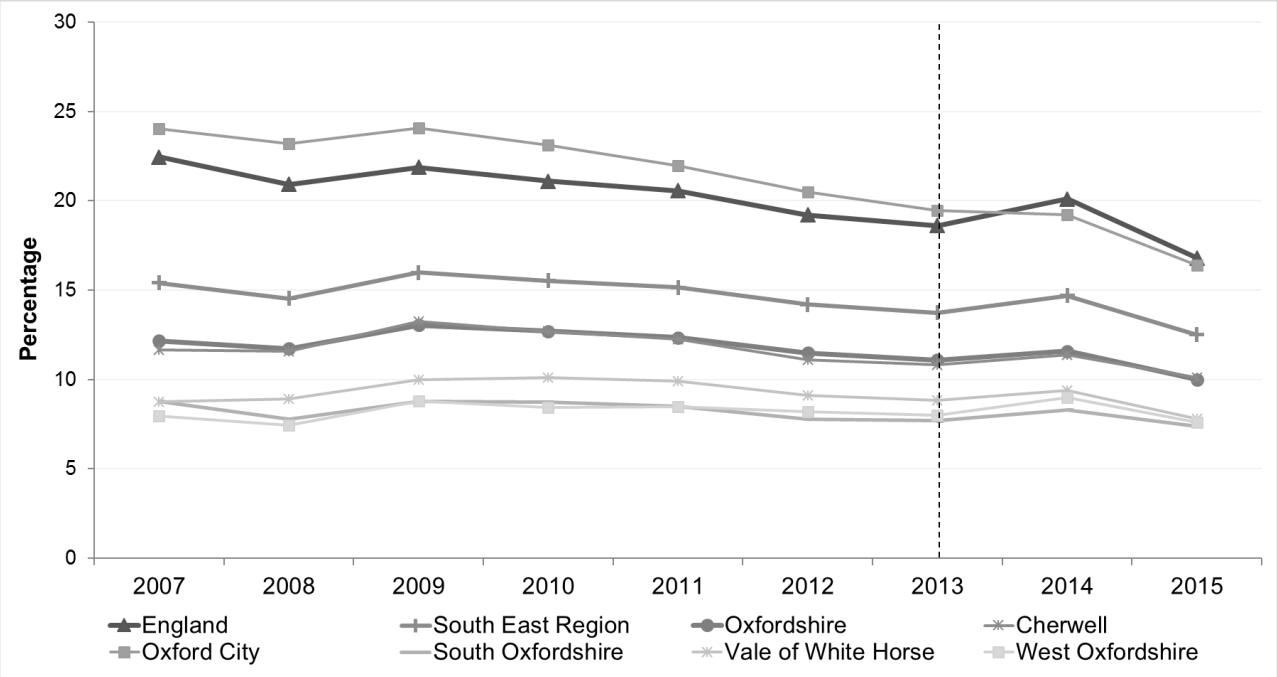
Two years ago I identified a basket of high quality indicators which would help us to measure progress in the fight against disadvantage. I set a baseline figure for comparison (shown as a vertical dotted line on the charts in this chapter) and will report on progress against these one by one.

Indicator 1. Child Poverty

The proportion of families classed as having 'children in poverty' fell both nationally and locally last year after a worrying upward' blip' last year. **This is good news.**

The correct name for this is indicator is 'relative poverty'. Poverty is not an absolute – it is a comparison of the best-off with the worst-off. Poverty in a 'wealthy' country might look like wealth in a 'poor' country. An individual is considered to be living in relative poverty if their household income is less than 60% of median national income. Nationally two-thirds of children classified as being in poverty are living in households where at least one adult is in work. The most up to date data comes from 2015.

Percentage of Children in poverty (Under 16 years)



Public Health Outcomes Framework, from PHE

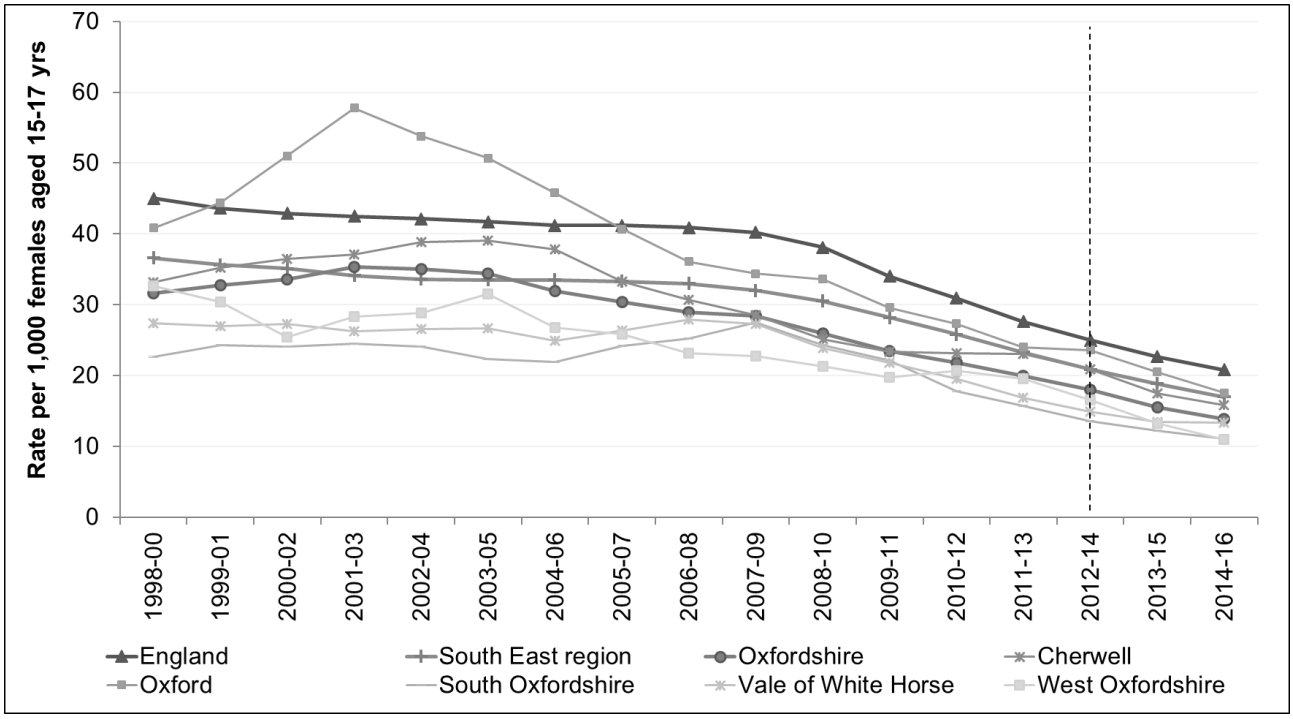
The chart shows that:

- There is a national and local trend downwards – this is very welcome.
- Overall Oxfordshire has a significantly lower percentage of children in low-income families than England. This is good news.
- Oxford City has had a significantly higher percentage of children in low-income families than England until more recently – it has been lower than or similar to the national figure for the last couple of years. This is encouraging.
- All other districts in Oxfordshire have significantly lower levels of children in low-income families.

Indicator 2. Teenage Pregnancy

This indicator measures all conceptions in females under 18 years of age whether the pregnancy ends in birth or termination.

Under 18 conception rate per 1,000 female population aged 15-17 years



Office for National Statistics

The chart shows that:

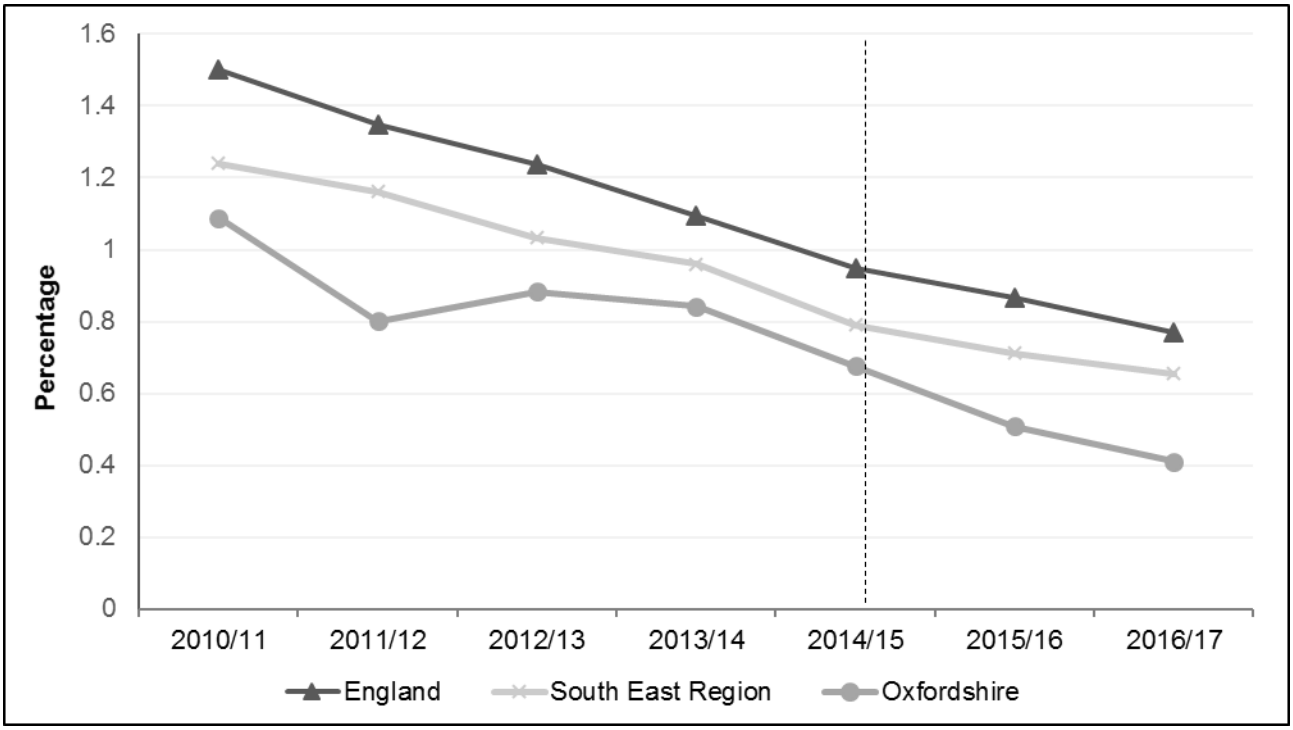
- The general downward trend in under 18 conceptions continues. More good news.
- The teenage conception rate in Oxfordshire is significantly lower than the national average and is decreasing broadly in line with national and regional trends.
- There has been a welcome sharp decline in Oxford City since 2001-03
- Most recent data (2014-16) continues on a downward trend across all geographies.
- This is a good result.

Indicator 3. Teenage mothers

Not all teenage conceptions end with a live birth. About half result in termination. This indicator measures live births to mothers under 18 as a percentage of all births. These children will, on the whole, be at risk of experiencing disadvantage and poorer life chances.

The chart below shows a percentage, but to give a more human context we are talking about 30 births to mothers in this age group in 2016/17 and this number has more than halved over the last decade.

Percentage of births where mother is aged <18 years



Hospital episode statistics (HES), from PHE

The chart shows that:

- In Oxfordshire, the proportion of births where the mother is under 18 is significantly lower than in the South East and England, and is decreasing.

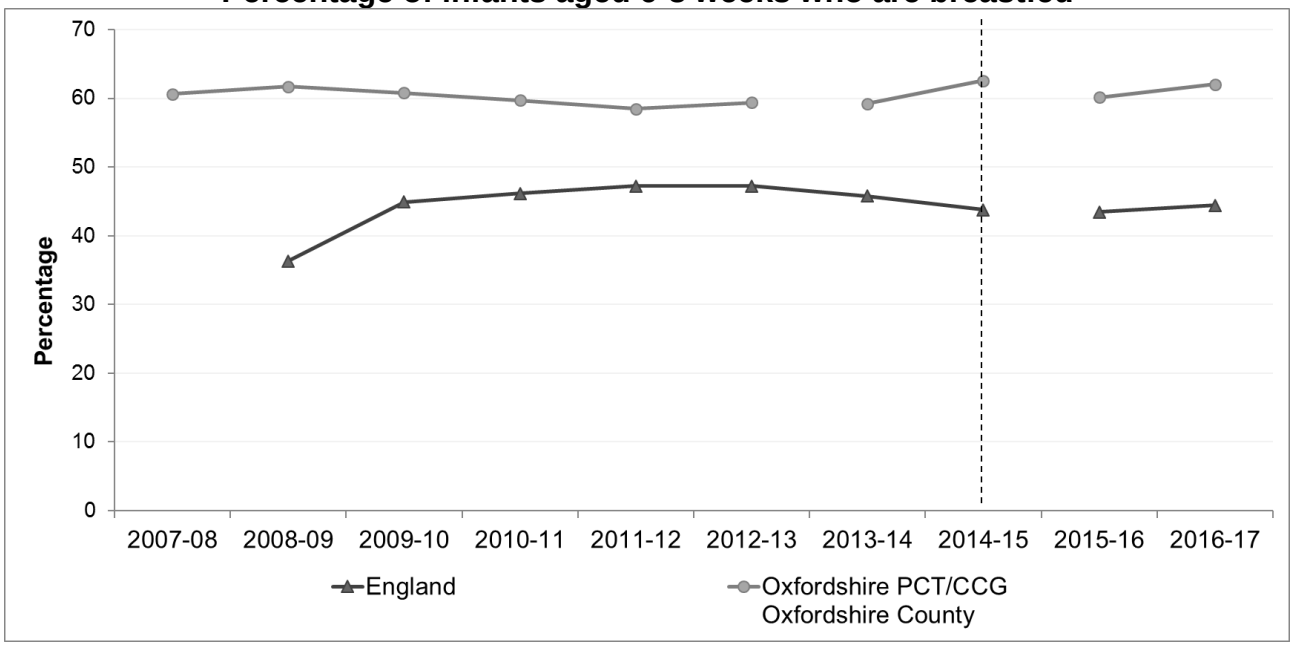
- This is very good news. It means that a lower proportion of children in Oxfordshire are at risk from this form of disadvantage.

Indicator 4. Breastfeeding at 6-8 weeks.

Breastfeeding gives children a great start in life. Its positive effects on health are long-lasting and as well as providing a perfect diet and providing immunity from disease. The breastfeeding rate at 6-8 weeks remains high in Oxfordshire compared to England at just over 60%. England's figure is 15 to 20 percentage points lower. We should remember however that despite best efforts not all mothers can breastfeed.

The challenge is to get the rates higher in the lowest areas which are historically: Banbury, Bicester, Kidlington, Didcot, Wantage and South East Oxford.

Percentage of infants aged 6-8 weeks who are breastfed



Public Health England National Child and Maternal Health Intelligence Network

NB Breaks in the Oxfordshire line indicate that 1) reorganisation from PCT to CCG, and 2) change in methodology which has not yet been backdated – breastfeeding data is now reported by county (i.e. residence) rather than CCG (i.e. GP population).

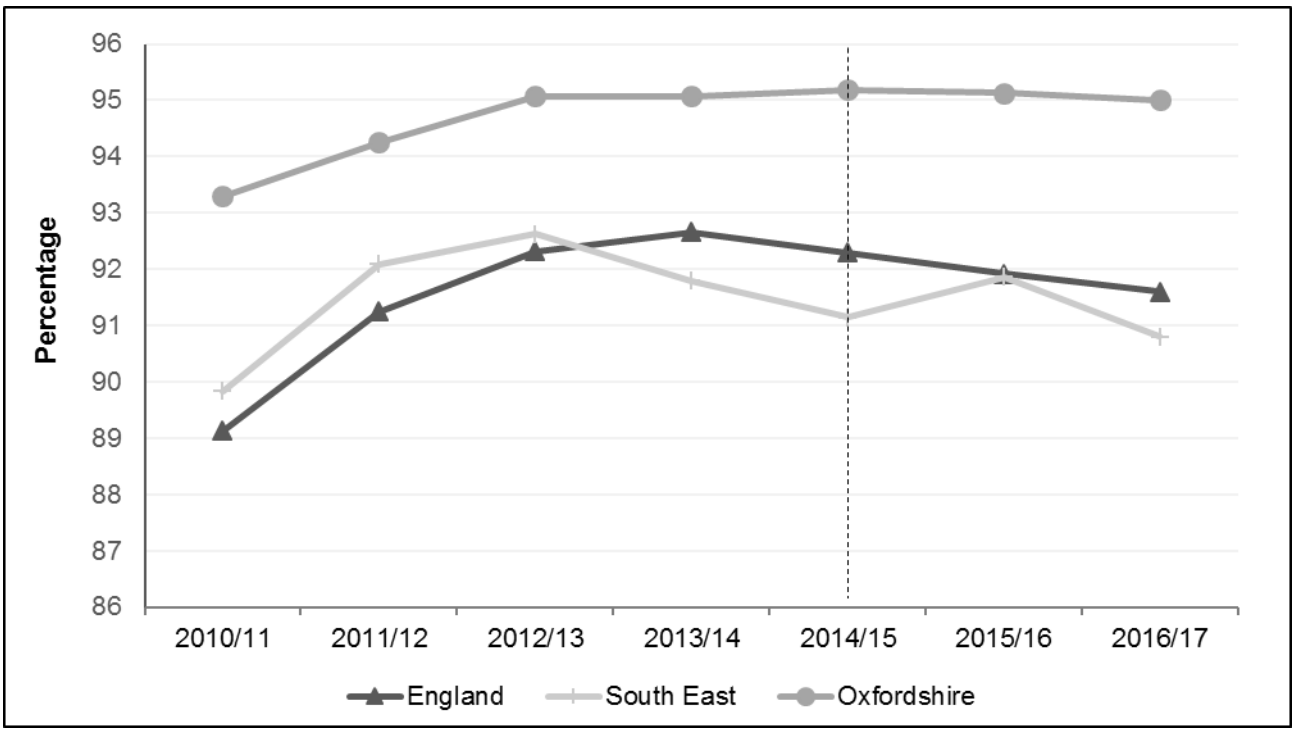
The chart shows that:

- Oxfordshire has a significantly higher percentage of infants breastfed at 6-8 weeks than the national and South-East averages.
- The Oxfordshire figure has increased slightly.
- Nationally the prevalence of breastfeeding at 6-8 weeks increased and now appears to be levelling off.
- This is another good result.

Indicator 5. Childhood Immunisation

Immunisation for Measles, Mumps and Rubella is a good proxy measure for the take up of all immunisations. Children should receive two Measles, Mumps and Rubella (MMR) vaccinations, the first by the time they are 2 years old and the second by 5 years old. All immunisation rates are monitored thoroughly through the Public Health Protection Board and through the Health Improvement Board. Oxfordshire's results are very good and NHS England and Public Health England are to be congratulated. The key is to monitor these figures really closely and respond to the smallest dip.

Percentage of 2 year olds that have received one dose of MMR vaccination



Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Please note axis does not start at zero.

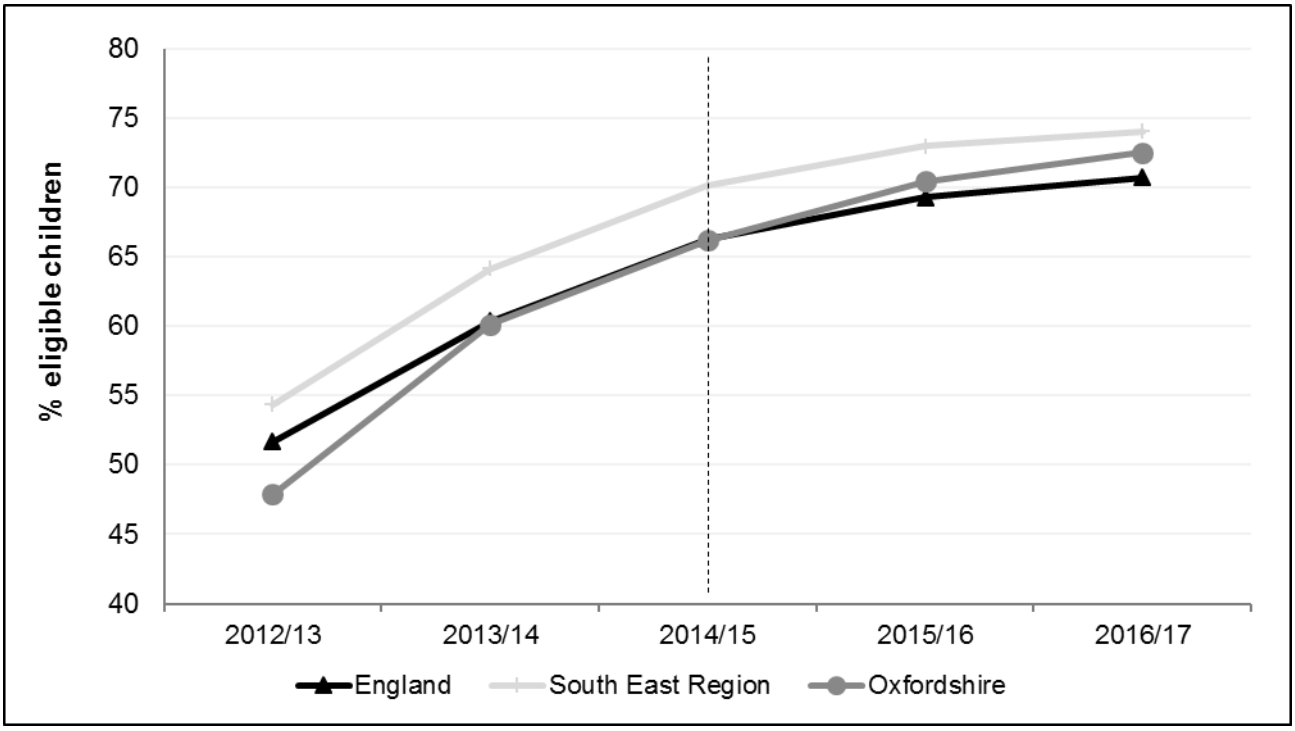
The chart shows that:

- The percentage of eligible children receiving MMR vaccination has consistently been better in Oxfordshire than in the South East and England overall.
- Vaccination coverage in Oxfordshire is among the highest in the region at 95% - the national target - which very few areas meet.
- Oxfordshire's coverage appears stable over the past five years, where regional and national coverage has decreased. This is due in part to the very close scrutiny we give to these figures quarter by quarter.

Indicator 6. School Readiness: the percentage of children achieving a good level of development at the end of reception year.

This is a useful measure of health in its broadest sense of 'life potential' and a useful marker for disadvantage between different groups of children. This indicator measures children defined as 'having reached a good level of development at the end of the Early Years Foundation Stage (EYFS) as a percentage of all eligible children'. Children are defined as having reached a good level of development if they achieve at least the expected level in their 'early learning goals' in the following areas: personal, social and emotional development; physical development and, communication and languages, as well as early tests of mathematics and literacy.

School Readiness: the percentage of children achieving a good level of development at the end of reception



Department for Education (DfE) EYFS Profile. Please note axis does not start at zero.

The chart shows that:

- Since 2012 Oxfordshire has been gradually 'catching up' with rest of our Region – this is very encouraging.
- In 'catching up', Oxfordshire's figure was 'lagging behind' the England figure but has now overtaken it – another good result.
- It should be noted that if one drills down into this data, the results for children in receipt of free school meals an indicator of disadvantage) are lower than the group who do not receive free school meals (see more detail below).

Indicator 7. School results

Educational attainment is a fundamental and profound indicator of disadvantage. **It is an indicator of a child's life chances.** How our children perform compared with all children nationally is important and helpful information.

The national system for measuring educational attainment is changing. Looking at our overall performance in GCSEs over the last decade shows two main trends:

1. Gradual improvement on an initially weak position compared with neighbours

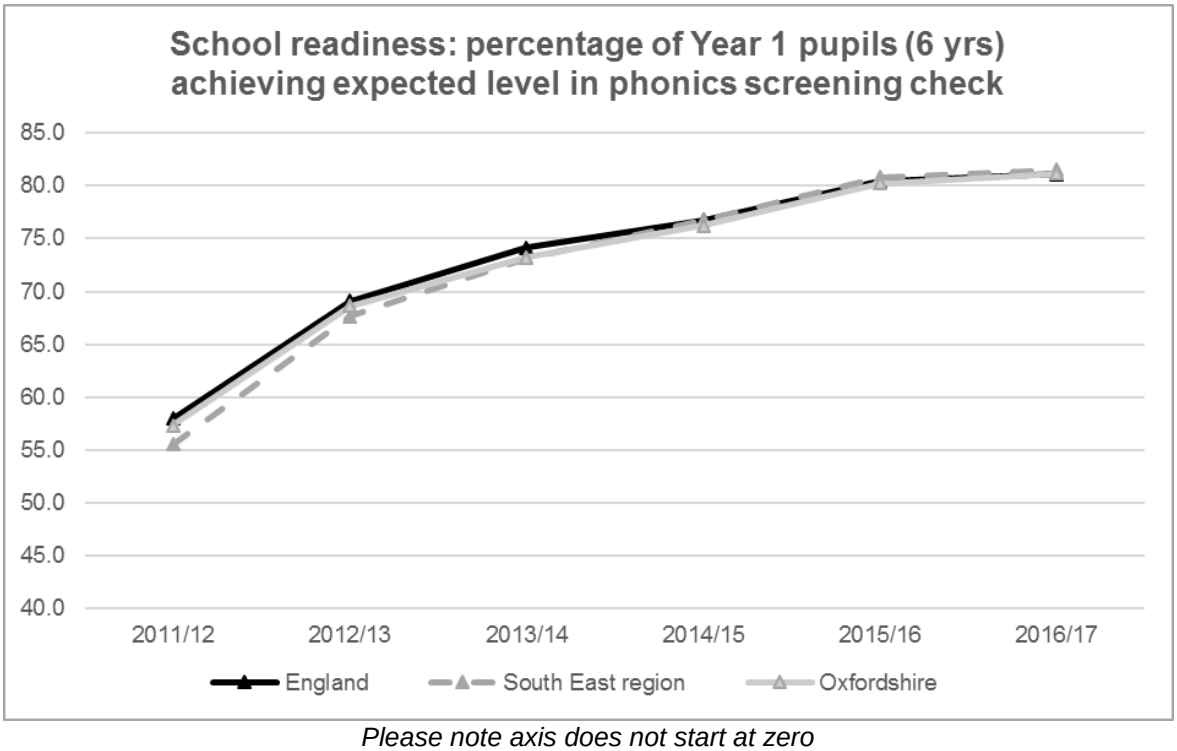
2. Concerns that (as elsewhere in the country) children identified as having a disadvantage either because of poverty or ethnicity performed less well on the whole.

The section below sets out some of the new ways of comparing our children's performance with elsewhere.

Because this is an important indicator I am going to explore the figures in some depth.

The first measure, in Year One (age 6), is the 'phonics screening check'. Phonics is a method of teaching people to read by learning the sounds that letters make. The test takes 5 to 10 minutes and tests children's ability to read short words or bits of words that form the building blocks for longer words e.g. cat, sand, windmill. It also includes nonsense words to make sure children can really link the writing to a spoken sound.

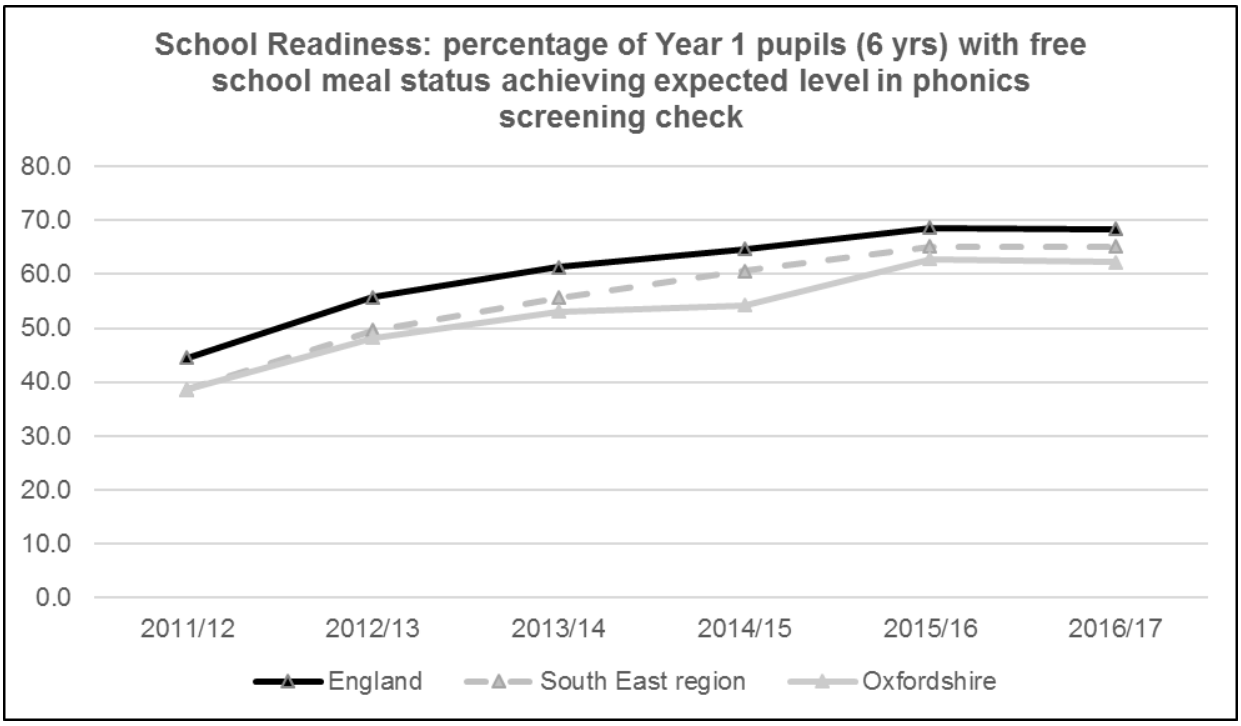
Oxfordshire's performance compared with regional and national figures looks like this:



Please note axis does not start at zero

The chart shows that there are no notable differences in the phonics test results across England, South East and Oxfordshire and all follow a similar upward trend.

However, if we look at the children who receive free school meals, we get the following picture:



The chart shows that:

- Oxfordshire's attainment for phonics for children receiving free school meals is lower than national and regional levels.

- This is a concerning result. It shows we have work left to do to at least catch up with, if not exceed, the national figure.

Ethnicity

The results for school readiness are not spread evenly across ethnic groups – highlighting a further source of potential inequality. Recent results are shown in the table below:

% achieving a good level of development	White	Mixed	Asian	Black
Cohort in Oxon.	6239	526	460	174
Oxfordshire	**74 (72)**	**74 (71)**	**68 (59)**	**68 (65)**
National	72 (70)	73 (71)	69 (68)	70 (68)
Similar Local Authorities (average score)	73 (72)	74 (71)	68 (70)	64 (63)

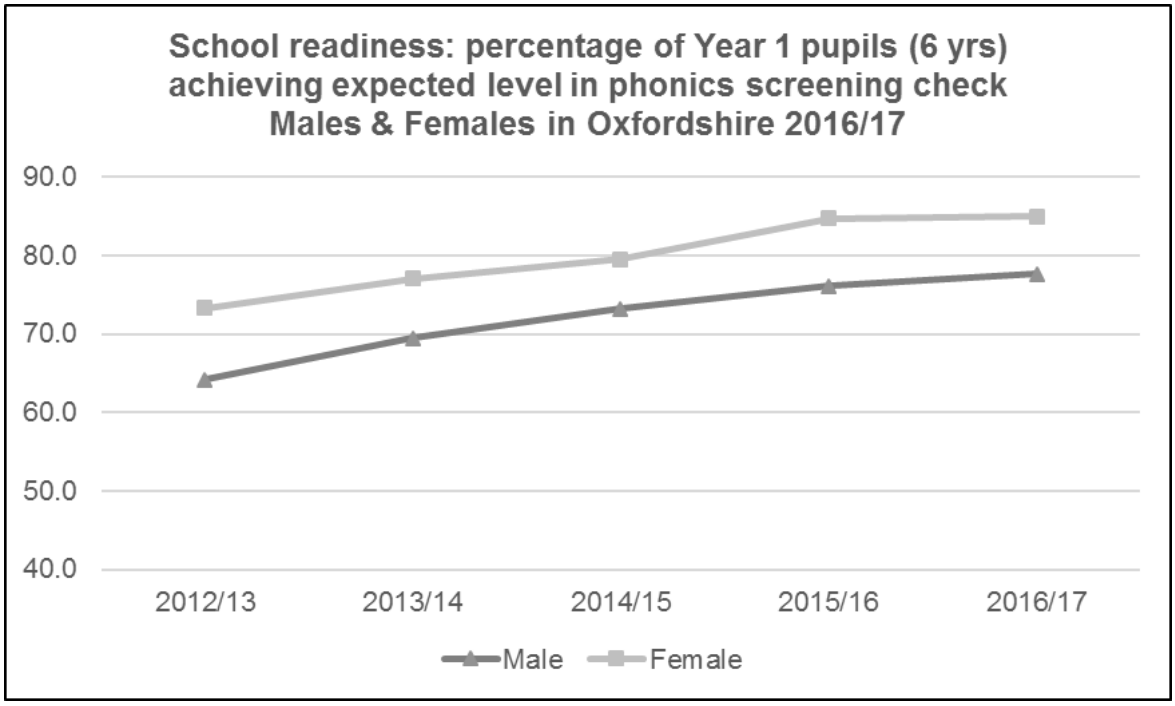
The figures in brackets show last year's results, so the picture is generally improving.

The table shows that a lower proportion of children from Asian and Black ethnic groups score lower on this measure.

This finding is similar to those seen in England and amongst similar Local Authorities and gives an indication of ongoing disadvantage.

Gender

There is a further inequality in this data regarding phonics – girls outperform boys overall. This may mirror underlying genetic and social differences in some way. The chart below shows the picture for measures of school readiness regarding phonics:



Please note axis does not start at zero

The chart shows that:

- Girls achievement stands at around 85%, boys' at around 78%
- Achievement for both genders has been steadily improving.

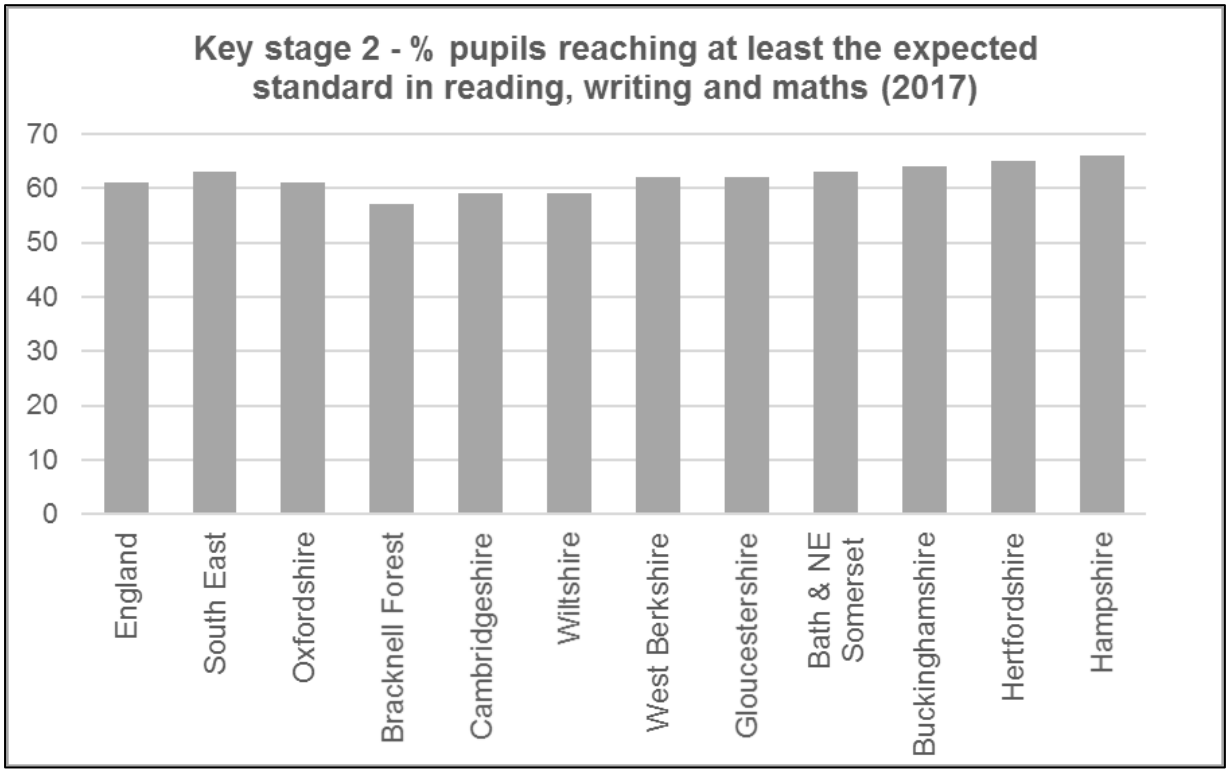
Other Key Stage 1 results

Summarising the other County's many other results at key stage 1 (6-7 years), in the interests of space, gives the following comparative position and shows mixed results. Taken as a whole, the figures are better than England and lower than in similar Authorities indicating again that there is room for improvement.

Test	Oxon compared to similar counties	Oxon compared to England
Maths	Just below	Just above
Reading	Just below	Above
Science	Similar	Above
Writing	Slightly below	Slightly below

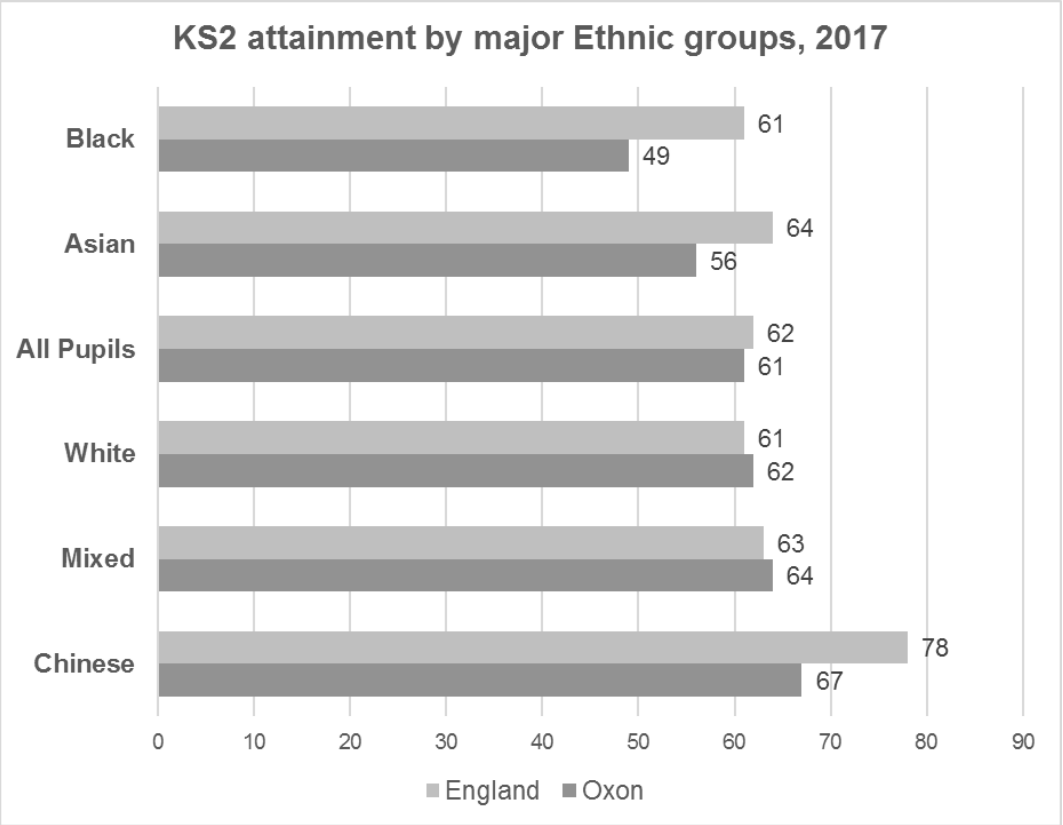
Results at Key Stage 2 (age 10-11 years)

At Key Stage 2 (10-11 years) the method of assessment has changed. Data for 2017 shows the following picture. It combines reading, writing and maths. The results look like this, comparing Oxfordshire with similar Local Authorities:



The chart shows that Oxfordshire's performance is around the national average and slightly below the regional average. The results for similar Local Authorities show a mixed picture with some performing less well than Oxfordshire and some better. It will be important to monitor these results to see what trend emerges over time.

Looking at Key Stage 2 results for ethnicity shows the following results:



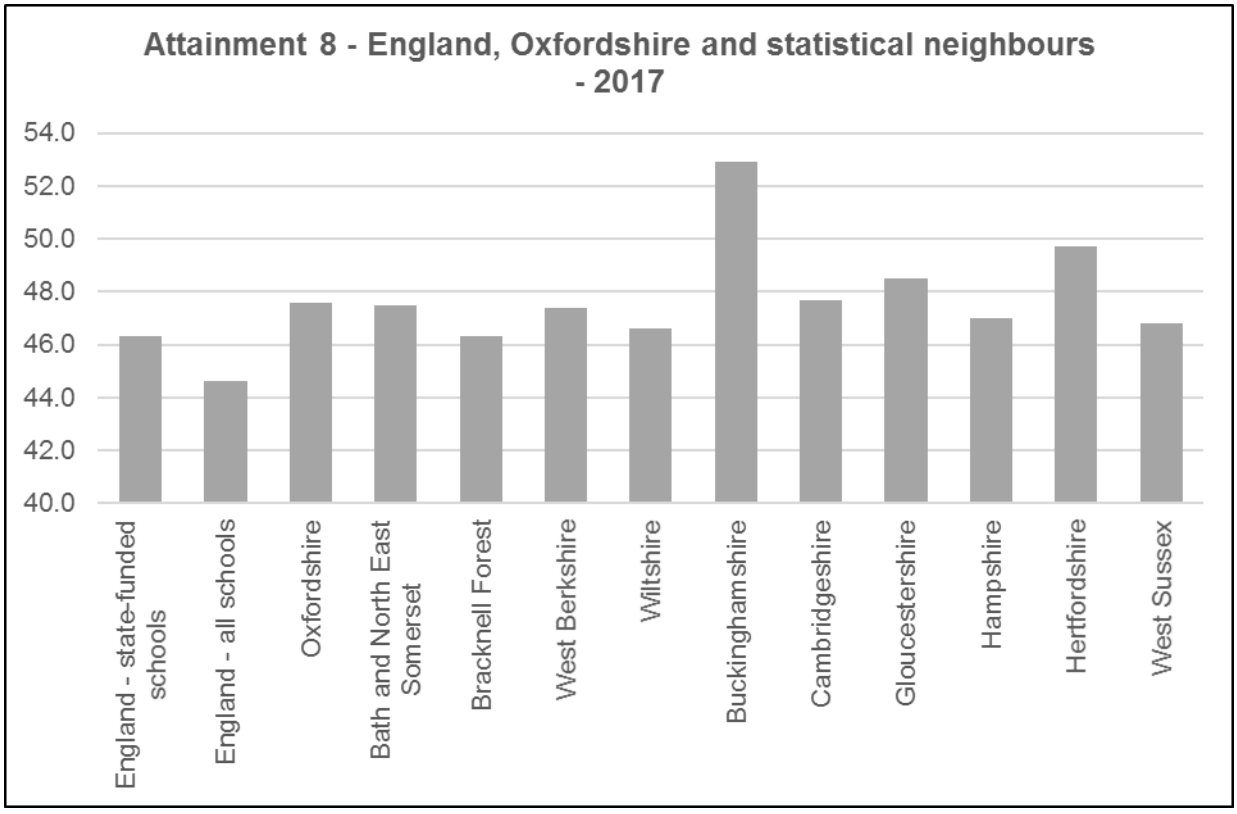
The chart shows that:

- Attainment at the end of key stage 2 varies between different ethnic groups. Chinese pupils are the highest achieving group in 2017 as in the last few years, although this cohort is only 13 pupils, and so the statistics are less reliable.
- Attainment of 'mixed', 'white' and all pupils is broadly similar to the national average.
- Pupils from Black and Asian background are lower in attainment than the England average and this is a source of inequality, although the numbers of students in Oxfordshire are small and so the statistics are less reliable.

Results at the end of secondary school

The new system aims to capture the progress a pupil makes from the end of primary school to the end of secondary school in measures called Attainment 8 and Progress 8. New GCSE qualifications will be added in 2018 and 2019 so measures may not be comparable over time.

Attainment 8 scores add up attainment in 8 subjects and average them. Results are shown below:



NB the axis does not start at zero so differences will appear visually to be magnified.

The chart shows that:

- Oxfordshire performs better than England and is comparable with similar Authorities, although some, such as Buckinghamshire score higher.

Progress 8 is a measure of improvement between key stage 2 and key stage 4 (i.e. during secondary schooling). Oxfordshire's children are compared with a similar national peer group to see if they do better or worse than the peer group. Oxfordshire scores 0 which means we do as well as the average. However, compared with similar authorities, five of our statistical neighbours have a below average score and three have an above average score.

Regarding free school meals, the attainment 8 gap in Oxfordshire is slightly wider in Oxfordshire than that recorded nationally and shows that this inequality persists throughout the 'school career'.

We need to keep a watching brief on these new scores as they develop and more data is added.

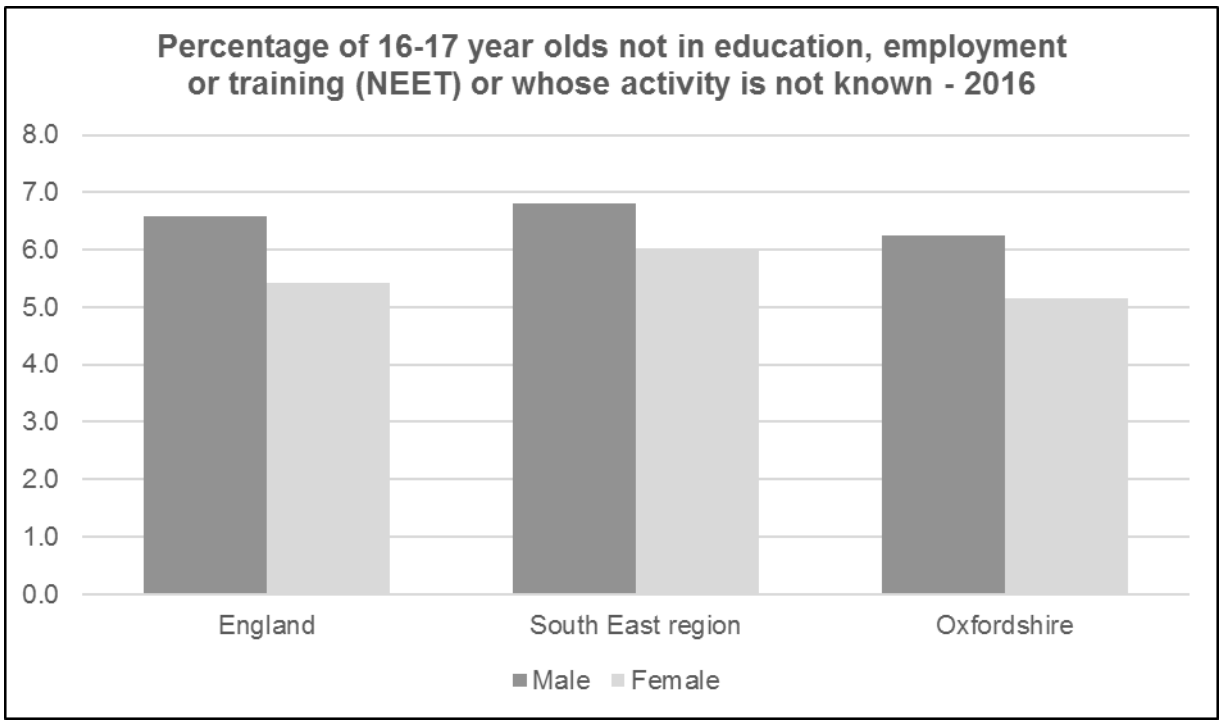
Overall for school attainment the themes are:

- Oxfordshire's scores are improving overall.
- However, inequalities are a cause for concern amongst children with free school meals and children from Asian and Black ethnic groups.

Indicator 8. 16-17 year olds not in education, employment or training.

From September 2016 the Department for Education changed the requirement on Authorities to track school age 18-year-olds. Local Authorities are now only required to track and submit information about young people up to the end of the academic year in which they have their 18th birthday i.e. academic age 16 and 17-year-olds. This means that accurate comparisons can't be made as before.

In the new system only one year of data is available, the results are shown below for males and females:

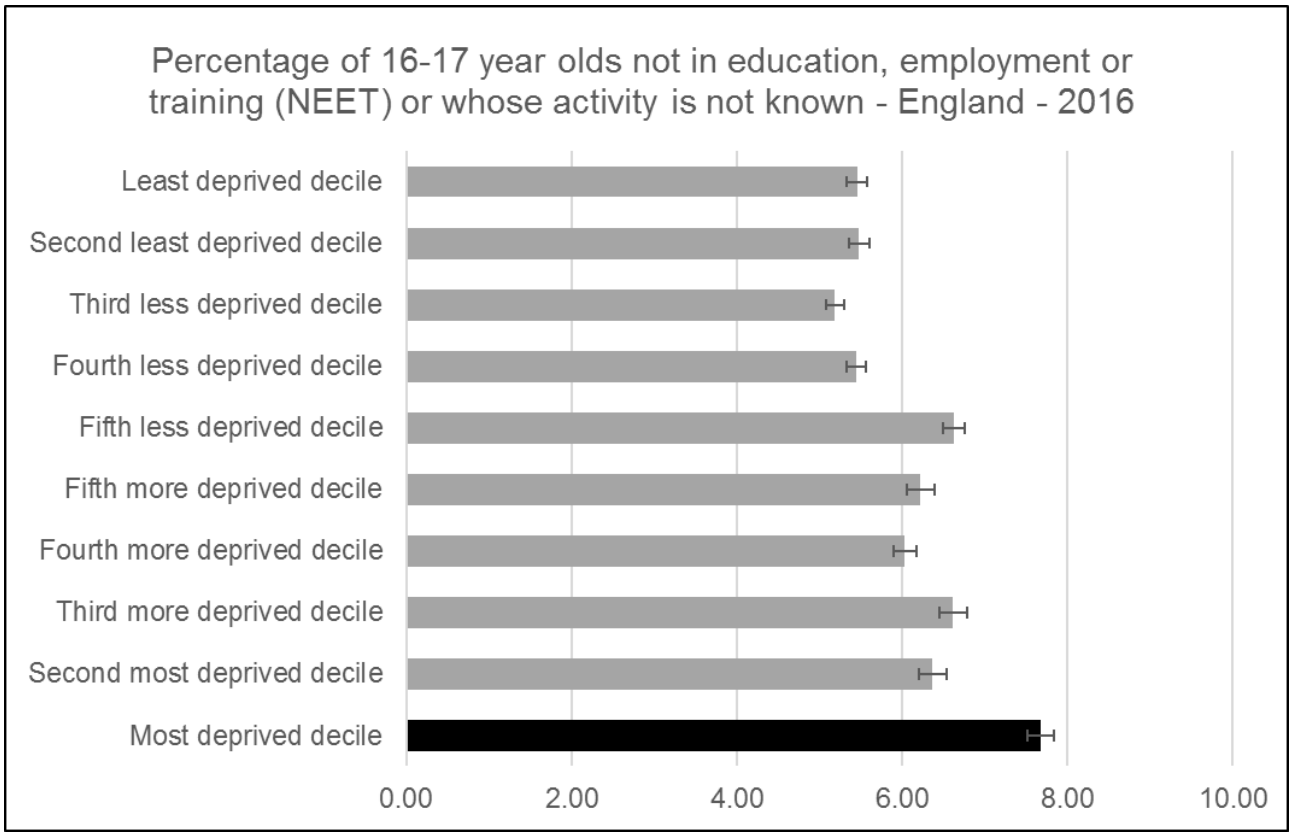


The chart shows that:

- Oxfordshire's figures for males and females are better (i.e. lower) than both the national and regional figures at just over 6% for males and just over 5% for females.
- This is a good result.

Improvement is possible however as some similar Local Authorities have lower figures – Hertfordshire for example is around 3% overall.

National figures show the following result:

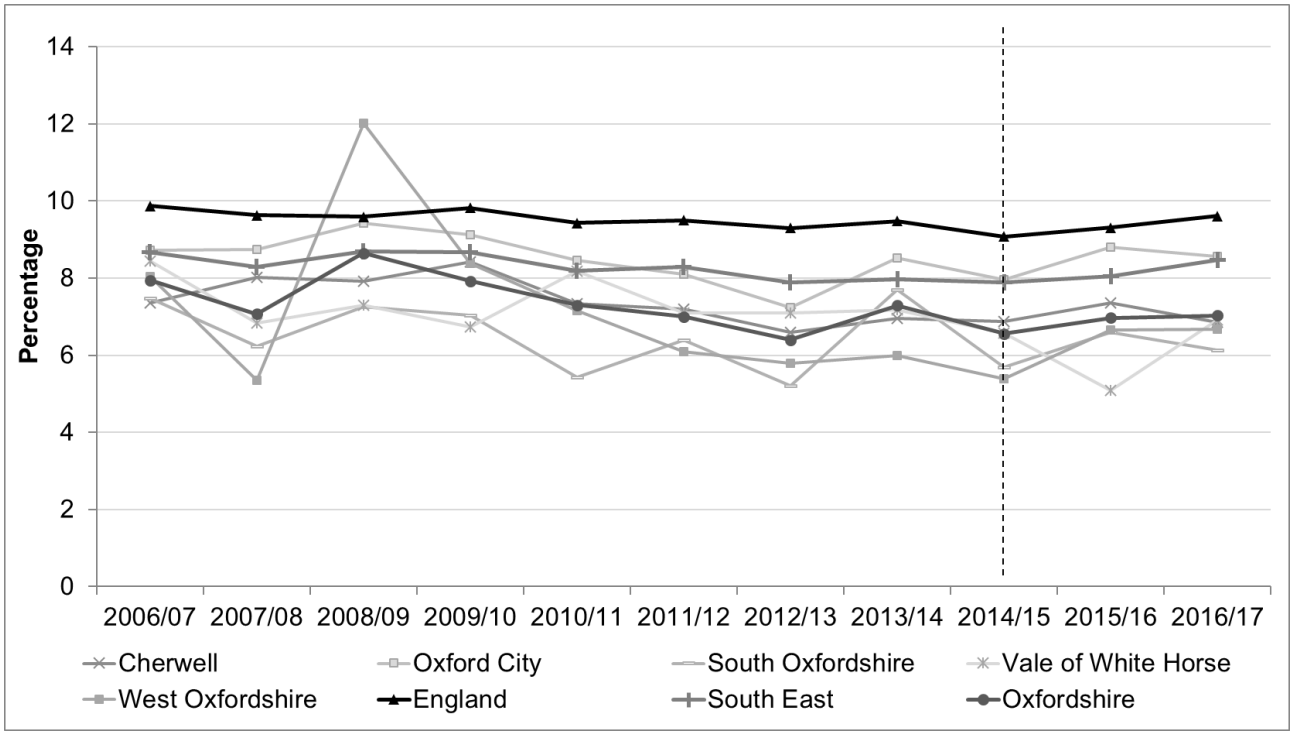


There is an 'inequalities gradient' at play here in the national data, with children in the most disadvantaged tenth of the population being about 2% more likely to be not in education, employment or training than those in the least disadvantaged tenth.

Indicator 9. Obesity in children in reception year.

Obesity is one of the biggest threats to health and wellbeing and it starts young. This indicator looks at children as they enter school. Obesity is more common in disadvantaged children.

Percentage of children in Reception Year who are obese



National Child Measurement Programme (NCMP)

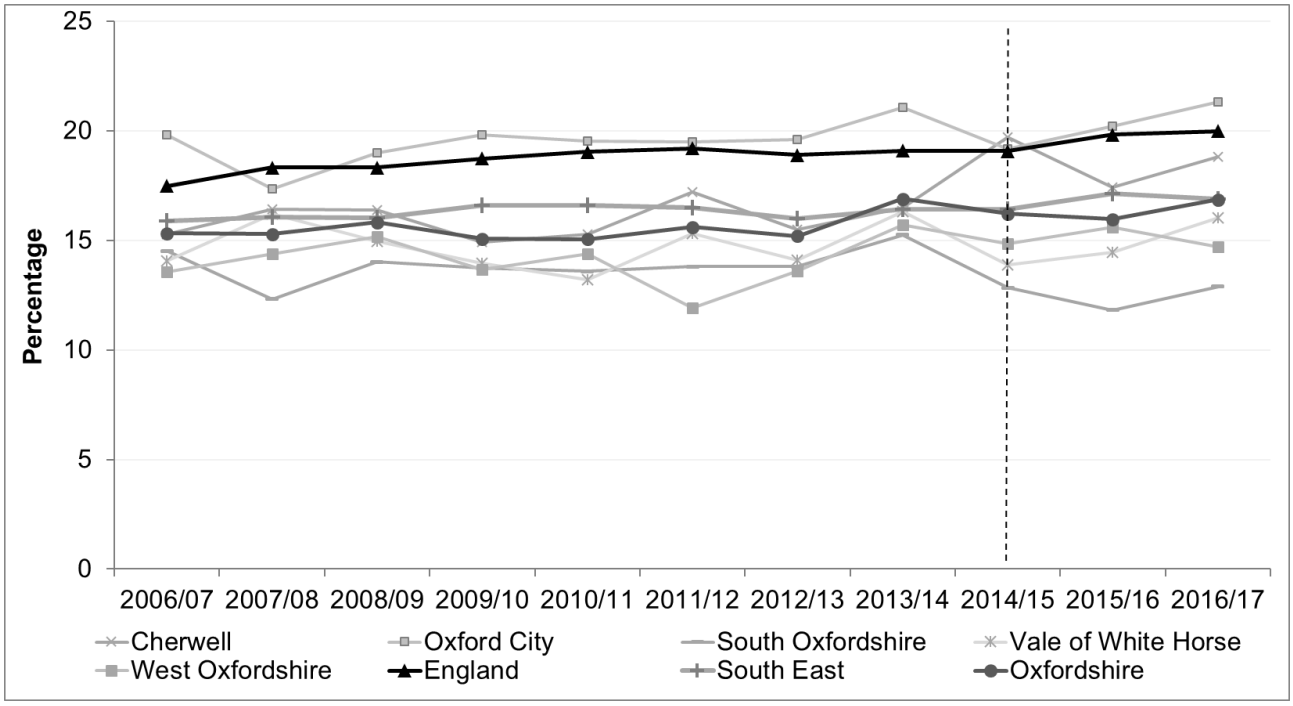
The chart shows that:

- Oxfordshire continues to buck the national trend, having obesity levels in reception year of around 7% compared with almost 10% nationally. Both these figures are too high – but it is a good result for Oxfordshire comparatively speaking.
- The trends are fairly static over time.
- Oxford City continues to have a higher rate – this will be due largely to higher levels of social disadvantage. The figure for more disadvantaged parts of the City will be higher still as the poor result is offset by very low levels in more affluent parts of the City.

Indicator 10. Obesity in year 6 (10/11 year olds)

The last indicator showed an average of 7% obesity for Oxfordshire's children in reception year. By the time children become 10-11 years old the Oxfordshire figure rises to around 17%. This is better than England's figure of 20%, but it is still a concerning increase in such a short time. This trend continues into adulthood when over 50% of people are overweight or obese.

Percentage of Year 6 children who are obese



National Child Measurement Programme (NCMP)

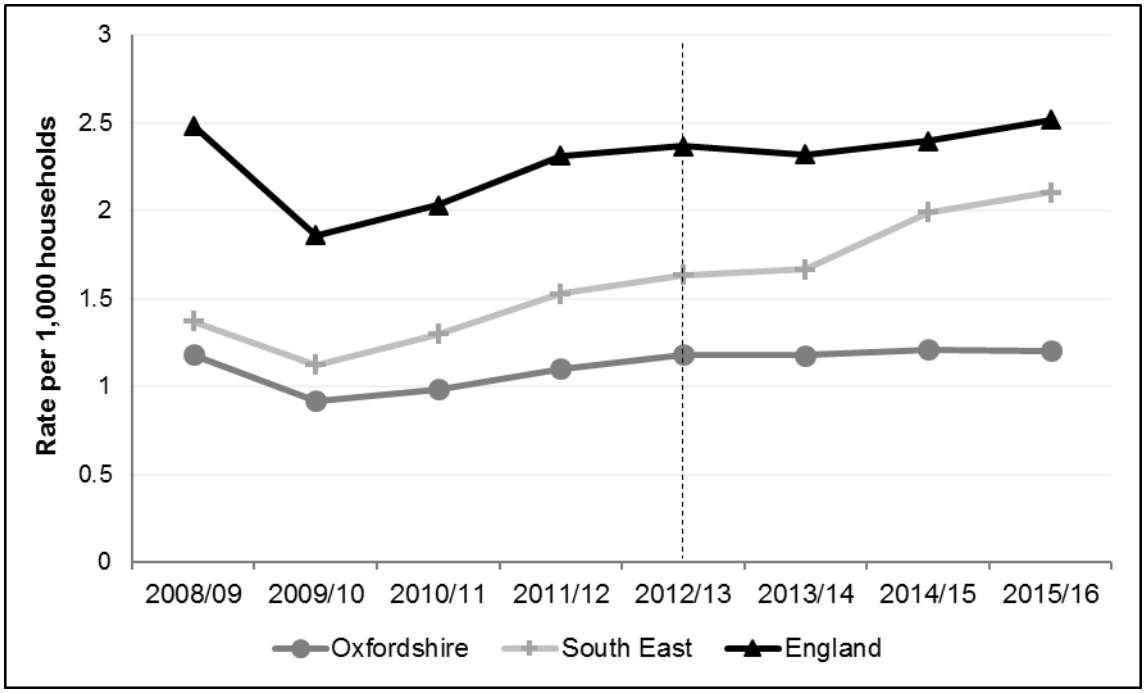
The chart shows that:

- Oxfordshire as a whole performs significantly better than the national average for prevalence of obesity in Year 6 children.
- Oxford City and Cherwell are the only districts which do not have significantly lower rates than England, and the City's figure is higher. This is a reflection of the fact that these areas have a greater number of disadvantaged children.
- Over time childhood obesity shows a slow gradual rise with some possible levelling off over recent years.

Indicator 11. Homeless Households

To be homeless is a direct measure of disadvantage and gives us a useful overall indicator.

Statutory homelessness: crude rate per 1,000 households, Oxfordshire, the South East and England.



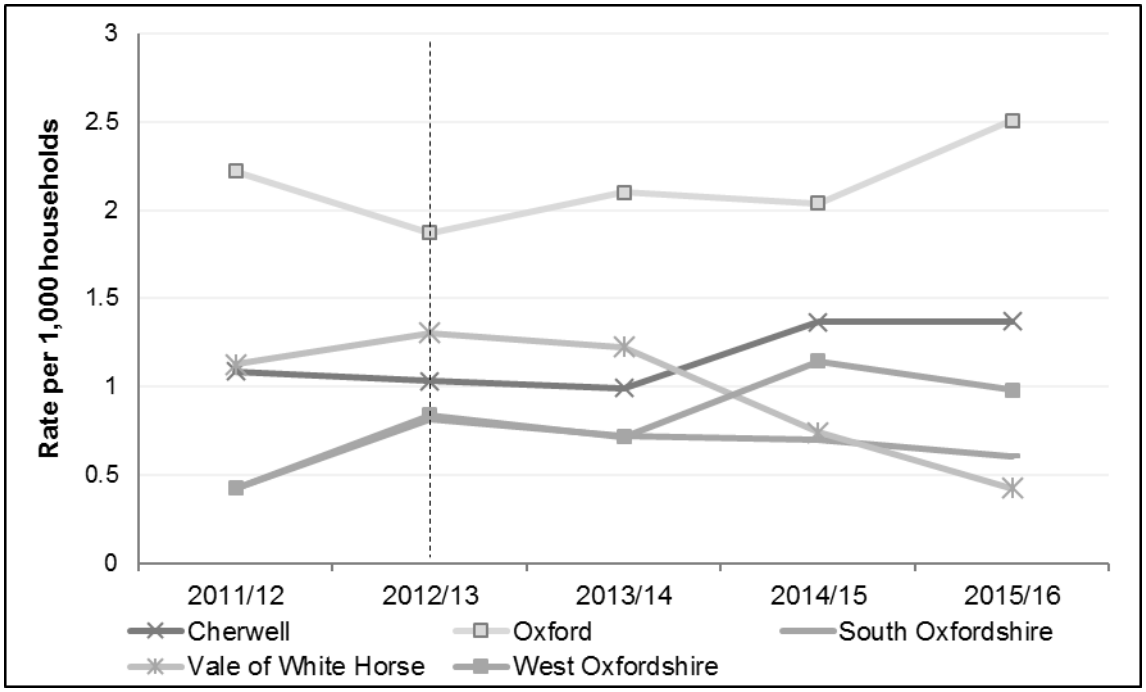
Department for Communities and Local Government

The chart shows that:

- The Oxfordshire figure is much lower than the regional and national average.
- The Oxfordshire rate is stable at just over 1% of households while national and regional rates are rising and more than double this figure.
- This is a good result which bucks the national trend.

If we drill down into the Oxfordshire data we get the following picture at District level:

Statutory homelessness: crude rate per 1,000 households, Districts in Oxfordshire.



Department for Communities and Local Government

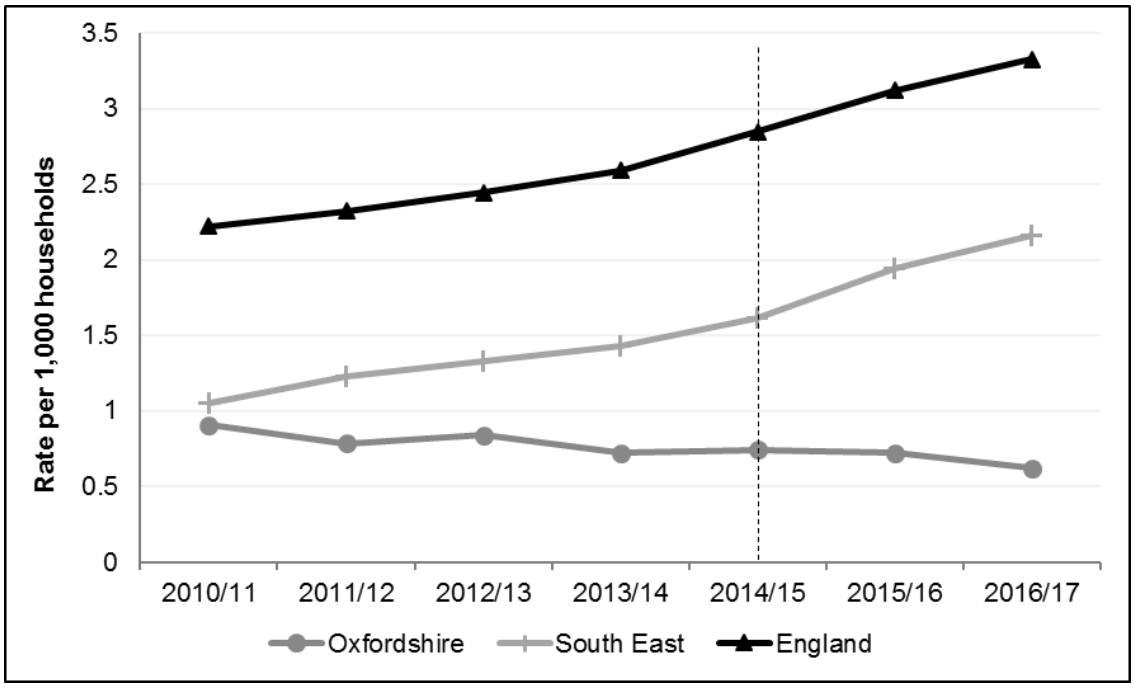
The chart shows that:

- Homelessness is most prevalent in Oxford City and is similar to the England rate.
- All other districts are significantly lower than England.

Indicator 12. Households in temporary accommodation

Placing homeless families in temporary accommodation is a means of preventing homelessness and provides a stop-gap. It is also an indicator of significant disadvantage. The first chart shows the big picture:

Households in temporary accommodation, Oxfordshire, the South East and England



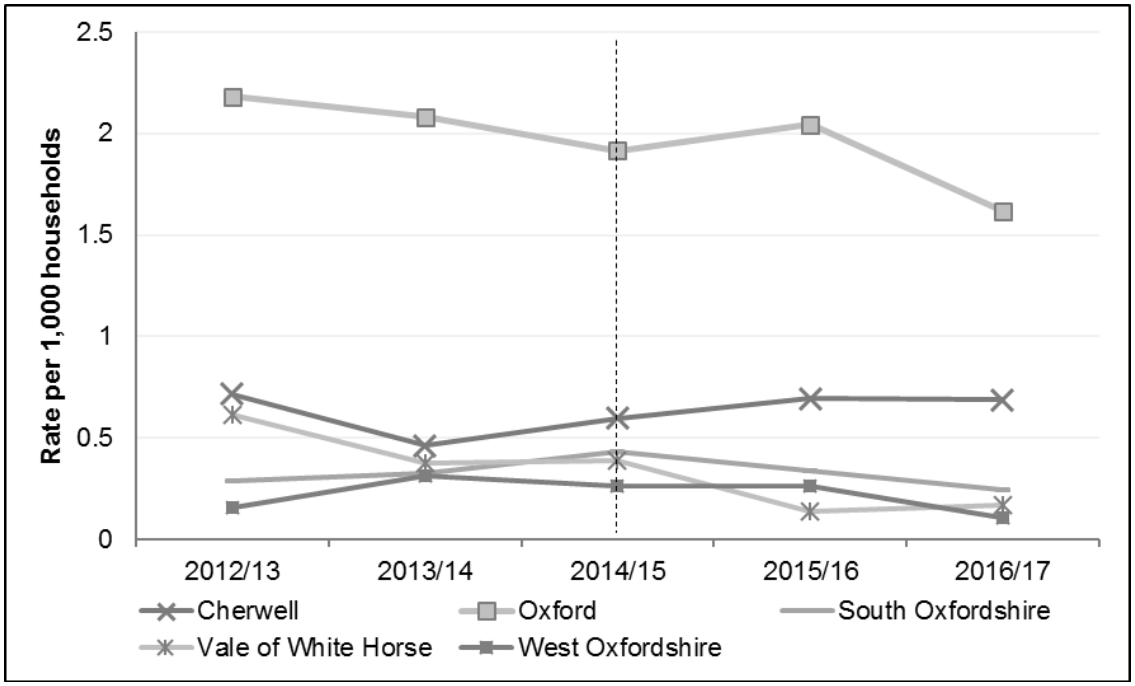
Department for Communities and Local Government

The chart shows that:

- Oxfordshire performs very well indeed on this measure. The rates are falling and are much lower than the national figures. In contrast the national figures are rising steeply.
- This is an excellent result.

The next chart shows the same data at District level:

Households in temporary accommodation, Districts in Oxfordshire



Department for Communities and Local Government

The chart shows:

- Another very good result over the last year's data overall.
- Rates in general are low.
- Rates in Oxford are higher but have fallen sharply and are lower than the national average.
- Rates in Cherwell are steady.
- Rates in Vale of White Horse, West Oxfordshire, and South Oxfordshire are among the lowest in the region.

Overall Assessment and Conclusion

Overall the indicators show a general reduction in these measures of disadvantage over the year which is a heartening result. However, inequalities are hard-wired into our society based on income, education, ethnicity and gender. We need to take a systematic and sustained approach to tackling disadvantage in Oxfordshire – we are on the right track at present, but vigilance is required.

Educational attainment among children with free school meals and from Asian and Black ethnic groups is a source of concern.

What did we say last year and what has happened since?

For convenience I have inserted last year's recommendations and have given an assessment of progress beneath each one.

Recommendations from last year

1. The Health and Wellbeing Board should ensure that the work of the Health Inequalities Commission continues to be taken forward.
   This is being achieved.

2. The Basket of indicators of inequalities in childhood should be reported in the DPH annual report next year. The Health Improvement board should monitor homeless acceptances closely during the year.
   This has been achieved.

3. The next phase of the Oxfordshire Sustainability and Transformation Plan should target disadvantaged groups and seek to level up inequalities. The service 'offer' should not be 'one size fits all' and the needs of different parts of the county should be recognised.
   This has been superseded by the intervening review of the Health and Wellbeing Board outlined in Chapter 1. This recommendation is now being taken on actively by the Health and Wellbeing Board.

Recommendations

1. The Health and Wellbeing Board should ensure that dealing with inequalities features prominently in the new Joint Health and Wellbeing Strategy and that all health and social care and public health strategies plan for such reductions.

2. The basket of indicators of inequalities in childhood should be reported in the DPH annual report next year.

Chapter 4: Lifestyles and Preventing Disease Before It Starts

If you want to boost your odds of a long and disease-free life, your lifestyle really matters. I've said it before and I'll say it again.

We are what we eat, drink, breathe, think and do.

These things shape our whole lives.

In this chapter we're going to look at some lifestyle choices and their consequences, and we're going to start with the most important issue of the last decade or two: diet, exercise and obesity.

Obesity – why it matters.

Everything in our current culture pushes us towards obesity. We enjoy:

- Less physical labour
- A cornucopia of foods from across the world on tap
- Cars and public transport
- Relatively more cash to spend
- Every shape and size of restaurant
- A vivid advertising industry – now messaging us 24/7
- Many, many fast food options – delivered from armchair to front door if we want it – as close as the nearest app
- Cheap alcohol and relaxed licensing laws
- Electronic communication so we don't even have to go out to have company

The snag is that these things are a cocktail that tends to end up in one place – Under-exercised. Overweight. Obese.

It's been creeping up on us for years, just like it has already in a more extreme form in the USA.

And as a result, more than half of all adults are overweight or obese. And once it becomes the new norm, who notices?

People in the UK are around 20% less active now than in the 1960s. If current trends continue, we will be 35% less active by 2030.

'We are the first generation to need to make a conscious decision to build physical activity into our daily lives.'

So what's the catch? What's the problem?

Well, ***unfortunately obesity leads to more of all the long-term things we don't want.*** It increases our chances of heart disease, stroke, diabetes, cancer, dementia and makes any disability worse and it costs the national economy an estimated £27bn, the NHS £6bn and social care £350m each year.

Of course, it's also a big inequalities issue and affects women more than men, unskilled workers more than skilled and Black and Asian ethnic groups more than White.

The UK Millennium Cohort Study showed in 2017, for example, that the higher a woman's educational level the less likely is it was her children will be overweight.

Definitions of Physical Activity and Obesity

Physically active*: Percentage of adults (aged 19+) who meet Chief Medical Officer recommendations for physical activity (150+ 'moderate intensity equivalent minutes' – which means doing enough to make you breathe a little harder - per week).*

Physically inactive: *Percentage of adults (aged 19+) that are physically inactive (less than 30 'moderate intensity equivalent minutes' per week).*

Excess weight: *Percentage of adults (aged 18+) classified as overweight or obese, based on Body Mass Index (BMI) which is your weight in Kgs divided by your height in metres squared. For most adults, a BMI of:*

- *18.5 to 24.9 means you're a healthy weight*
- *25 to 29.9 means you're overweight*
- *30 to 39.9 means you're obese*
- *40 or above means you're severely obese*

So why do we keep going in this direction?

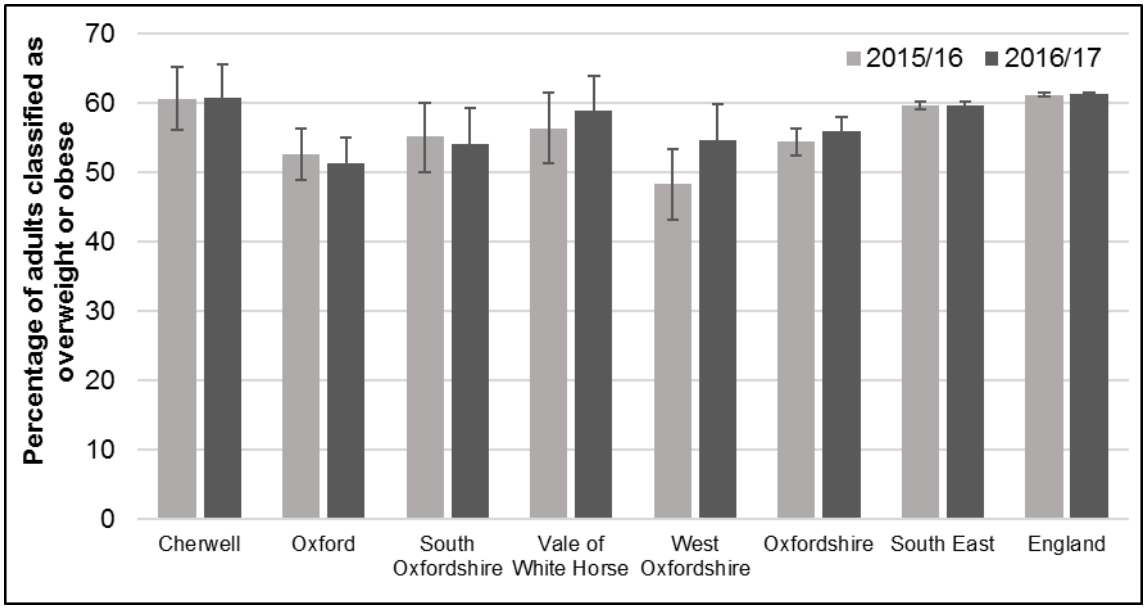
Well, lifestyles are hard to turn around. They are the warp and weft of what we are day to day and changing is difficult – we are programmed for short term pleasure rather than long term wisdom - and changing and sticking to a change in lifestyle is even more difficult…… ask anyone who has lost weight on a diet how easy it is to keep the pounds off long term – it isn't easy, is it?

What is the situation in Oxfordshire?

We have already looked at obesity in children in detail in Chapter 3 on inequalities. To recap, by the time they reach school, 7% of children are obese. More are overweight. By the time they are in Year 6, the figure is more like 17% and so it goes on increasing into adulthood.

The Active Lives Survey tells us that the picture for adults from who have 'excess weight' in our Districts and county looks like this:

Excess weight in adults (18+)



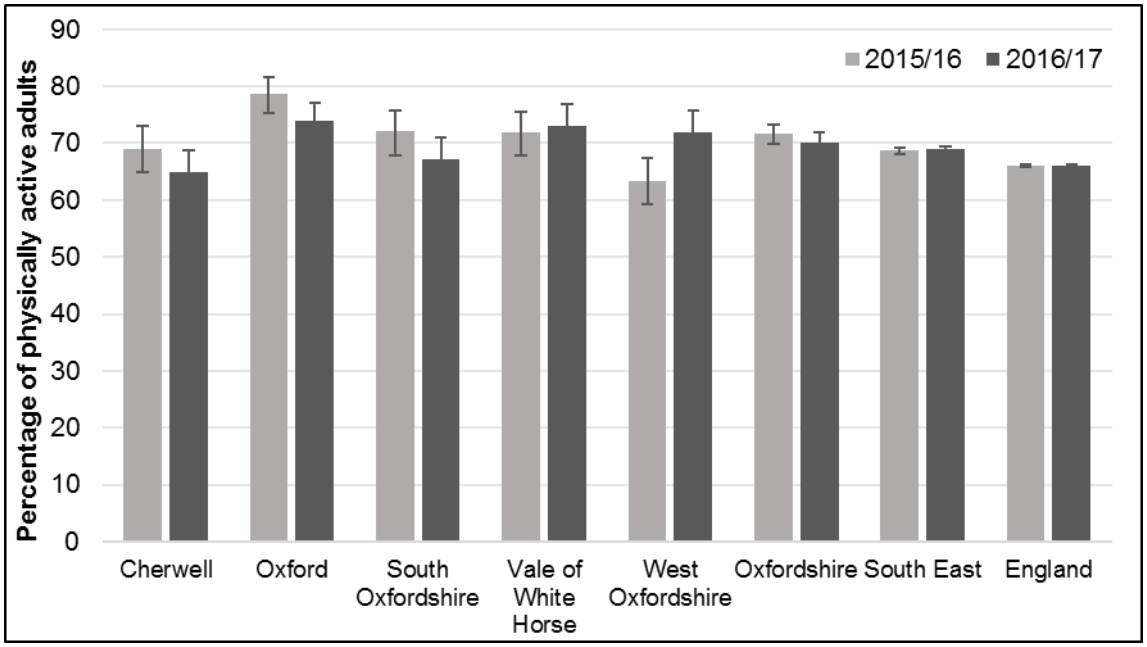
Active Lives Survey

The chart shows that:

- In Oxfordshire, over 5 in every 10 adults are either overweight or obese.
- Oxfordshire has had a significantly lower proportion of adults overweight or obese than in England overall. This is relatively good news.
- The chart reflects the different age-structures of the different Districts, the younger structure of the City keeping its figure lower.

Let's take a look at some of the factors underpinning obesity. Physical activity is very important as it burns calories and thus burns fat…… and any physical activity is OK, even standing instead of sitting, or taking one flight of stairs, or getting off the bus a stop early – it doesn't need to come clad in lycra!

Physical activity in adults (19+)



Active Lives Survey

The chart shows that:

- Oxfordshire has had a higher proportion of physically active adults than England in both survey years. This is good news.
- Again, the differences between Districts will mostly be due to different age structures – younger adults being more active than older ones.

Inequalities are at work in the realm of physical activity too:

- Those who are working are more likely to be active than those unemployed or economically inactive
- Those less disadvantaged are more likely to be active than those more disadvantaged
- Those of White or Mixed ethnicity are more likely to be active than those from Asian, Black, Chinese, or Other ethnicities
- Males are more likely to be active than females
- Participation in physical activity decreases with age. Nationally, 76% of 19-24 year olds were physically active in 2016/17 compared to 26% aged 85+

So what do we do about it?

The answer set out in last year's report holds good:

'the answer has to come through teamwork between the individual, family, government, employers, planners and organisations. It's about 1000 adjustments to 1000 tillers to turn the flotilla we all sail in.'

To be more specific, I think the answer comes at 3 levels:

1. Government/ National

2. County/District

3. Personal

Government/ National level

Government can help to create an overall climate in which exercise and healthy eating become easier.

This has begun with initiatives such as the sugar tax, food labelling and starting a debate on protecting children from advertising. **This is gradual work.** It begins with voluntary agreements and ends in legislation. **It is for the long haul and Public Health England have done a good job in championing the debate**….. but…… ***we*** are the electorate and the consumer, and ***we*** have to want these changes too… which means that ***we*** have to understand the issues and want change. Once they become ballot-box issues we should see the pace of change increase. The ever-increasing demand on the NHS due in part to obesity-generated diseases may in time provide the fillip policy makers need.

Government can make changes in many other helpful ways too e.g. emphasising exercise in the curriculum and onto Ofsted's agenda; also through rewarding transport schemes which reward active travel and so reduce traffic congestion. These things are happening, but the pace is gradual.

The national campaigns on nutrition such as '5 a day' have been very effective in raising public awareness. You can tell when campaigns are effective as the message enters the vernacular.

At County and District level there is much we can do too - especially if Government supplies the framework and the incentives.

This is the level at which we plan the road schemes, put in the cycle paths, design the communities, and work with the schools and local organisations and assemble the Growth Deals.

This is where 'getting health into planning' comes in. Initiatives such as the Healthy New Towns initiative and all the other measures detailed in chapter 2 are excellent examples of how we can work together to reduce the threat of obesity, as well as reducing heart disease, cancer and

reducing the impact of dementia (and thus demand on our hospitals). It is also the level at which we work with schools on travel plans not involving cars, social prescribing by our GPs and enticing people into using parks and green spaces.

On a personal level.

If you cast your eyes back to the list of modern lifestyles that heads up this chapter, the changes we all need to make are pretty obvious and you don't need a Director of Public Health to tell you what to do. The point is,

This isn't nannying, it is enlightened self-interest. It is backing your own team in the game of life – and it's up to you.

We can all do a little more activity and we can all eat a little healthier, and it's those small daily changes that add up to make the difference…….

How are we doing overall in Oxfordshire?

There are three main points to make in summary:

- We are still better than the national averages on exercise and obesity measures – this is good progress.

- The Health Improvement board is taking a sound approach to coordinating effort – this needs to continue and the recent interest in prescribing activity for people is a great boost.

- The addition of a stronger 'getting health into planning' aspect of this work has tremendous potential if it can be tapped – this would be a major step forward. Chapter 2 is all about this.

On the strength of this assessment I would make the following recommendations.

Reviewing what I said last year, the recommendations have the same thrust but good progress on the Healthy New Towns and spreading their message more widely means that I am repeating these recommendations more emphatically this year.

Recommendations

1. The Health Improvement Board should continue to coordinate this work and ensure that the Health and Wellbeing Board retains an overview. The current emphasis on prevention within the NHS is very promising.

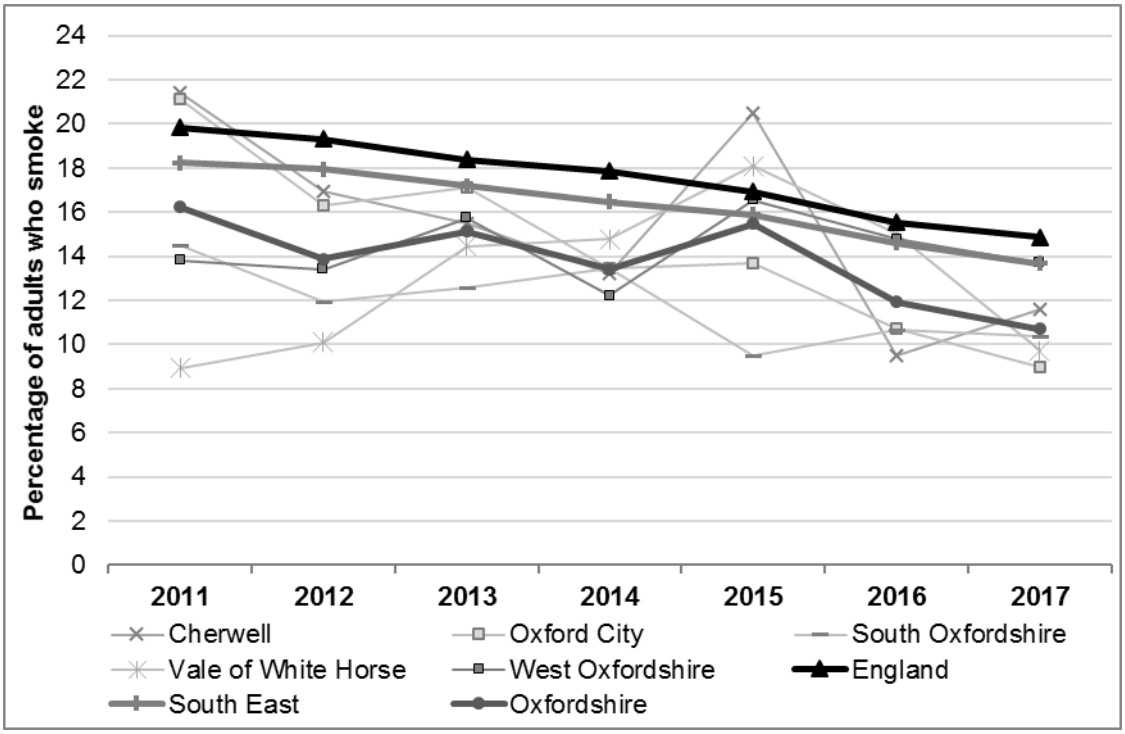
2. All organisations should work together to generalise the benefits of initiatives such as the Healthy New Towns and find a way to build health issues squarely into the planning process.

Smoking and Tobacco Control

Smoking tobacco continues to be the single most harmful thing you can do to damage your health. Smoking causes conditions ranging from cancers, heart attacks, strokes, rheumatoid arthritis and dementia.

In Oxfordshire, the prevalence of adult smokers has seen a continued decline in the past few years. This is excellent news. The decline is shown in the chart below. The prevalence of adults who smoke in Oxfordshire is currently estimated to be around 11% which is lower than the national prevalence of around 15%. **This is very good for the health of Oxfordshire.** The estimated rates in Districts will vary from year to year because the numbers are small.

Smoking prevalence in individuals aged 18+ by District in Oxfordshire



Active People Survey

The chart shows:

- The general decrease in the number of smokers at all levels. This bodes well for the future.
- The fact that Oxfordshire performs better than national and regional levels.
- The variation between Districts – caused mainly by the modest sample size of the survey.

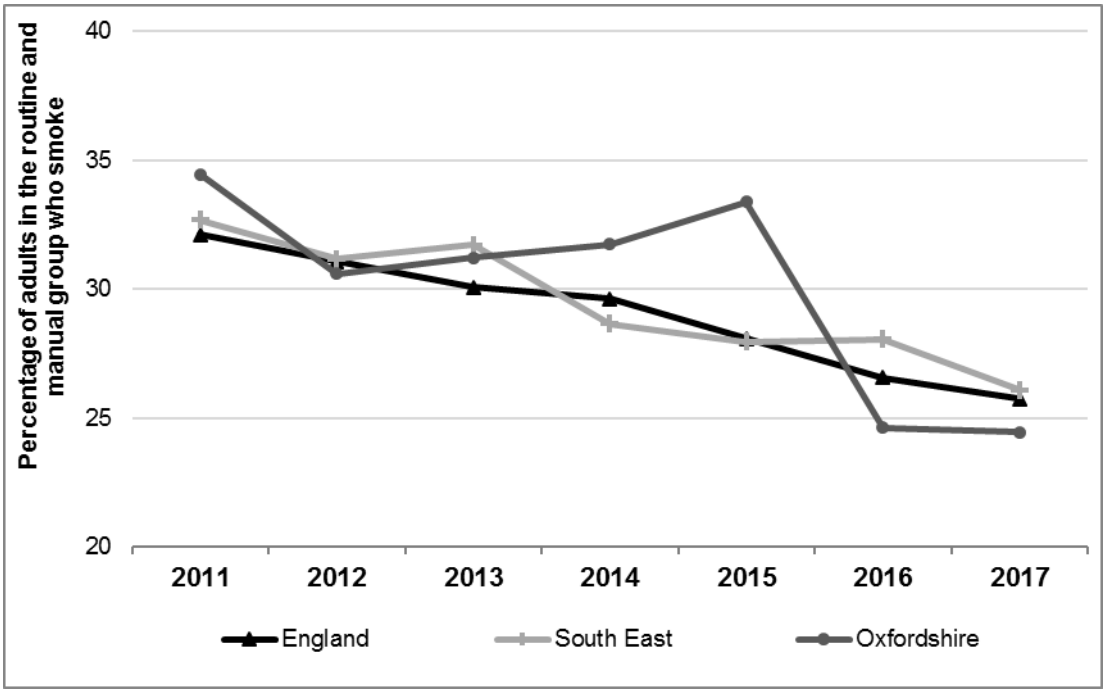
While falling smoking rates in the County are what we want to see, there is no room to be complacent. ***There is still a large inequality in who smokes, with much higher levels of smoking found in more disadvantaged communities.*** **The level of smoking in routine and**

manual workers in the County is 24.4%, more than double the average. To meet the need, services are being targeted at the groups who need it most.

The chart below shows the higher figures for smokers in manual groups across the County.

Adults smoking: 18+ in Routine and Manual groups

Active People Survey



Active People Survey

The chart shows:

- The higher levels of smoking in manual workers at all geographical levels.
- The same downward trend as for all smokers.
- Oxfordshire's figure showing variation year on year but currently lower than regional and national averages.

Tobacco Control

Tobacco control is an umbrella term used to describe a broad range of activities aiming to reduce smoking and the problems it causes. In 2017, the Government published a new Tobacco Control Plan, to pave the way for what they dubbed a 'smoke free generation'. Since the introduction of the last Tobacco Control Plan, smoking prevalence among adults in England has dropped from 20.2% to just 15.5%—the lowest level since records began.

The National Plan prioritises working with NHS organisations in reducing smoking in pregnancy, the harm to disadvantaged communities and the harm to people with mental health conditions.

Locally the County Council and other local stakeholders have a responsibility alongside central Government to help reduce smoking rates. To achieve this the Oxfordshire Tobacco Alliance has been established as a partnership between organisations to monitor the situation, advocate stopping use of tobacco, and coordinate activities across the County. This will help us to act as a single unit in the fight against tobacco.

Last year I recommended that a new stop-smoking service should be commissioned that targets stop-smoking effort at the groups with the highest smoking rates. This has been achieved. I also recommended that the Health Improvement Board should monitor the situation which has also been done.

Recommendations

- The Health Improvement Board should continue to monitor activities of local stop-smoking services and wider agencies to help people quit smoking and also not to start in the first place.

- The Oxfordshire Tobacco Alliance should develop coordinated plans to reduce the use of tobacco in Oxfordshire.

NHS Health Checks

NHS Health Checks (commissioned from GPs by the County Council's Public Health team since 2013) specifically target the top seven causes of preventable death: High blood pressure, smoking, high cholesterol, obesity, poor diet, physical inactivity and alcohol consumption.

Eligible individuals aged 40-74 years are invited for a check every 5 years (191,000 people). The 40- 74 years age range of the programme was set nationally because this is the group in which detection and prevention of heart and circulatory disease is most cost effective.

Since 2013 in the first five years of the programme in Oxfordshire, 190,000 invitations (98.7% of eligible population) were sent to residents. **There were 95,485 health checks given to residents -** 50.4% of those invited - which is a good result compared to other areas. The programme has achieved the following impressive results:

- **26,422 people were given advice about their weight**

- **21,173 people were informed they had high blood pressure**

- **9,072 people were given smoking cessation advice**

- **8,426 people were advised to increase physical activity**

- **4,522 people were given advice on lowering alcohol consumption**

- **3,494 people were told they were on the threshold of developing Type 2 diabetes**
- **1,357 people were informed they were Type 2 diabetic**
- **900 people were diagnosed with Chronic Kidney Disease**

What we said before and what we are doing about it

Last year I recommended that we should continue to market the NHS Health Check programme in new and innovative ways to increase its uptake. *This is being done and a comprehensive programme is in place.*

I recommended that we should continue to work with GPs to improve on the uptake of Health checks and investigate new ways to improve the way people are invited. *Currently plans are being developed to advertise Health Checks on-line, targeting the catchment areas of the local practices as invitations go out.*

I recommended that we should better identify and engage with high risk groups to take up the offer of a free NHS Health Check. *A health equity audit has identified groups in the community who are not taking up the offer of the free health check. We are working with minority groups to learn why they do not have a health check and what can be done to their take-up.*

I recommended that we should continue to work with partners to improve on the quality of the programme locally and to the knowledge base supporting the programme nationally. All the GPs have signed up to continue delivering the health check programme. *We are continuing to work with the practices on auditing services to deliver continued quality improvements.*

Recommendations for NHS Health Checks

The first five years of the NHS Health Check programme have been a success locally and is well embedded in the health system. While it is well received by the public, we cannot be complacent. 50.4% of people offered had their free health check which is commendable, but 49.6% of people didn't. We need to reach out to these people and do more to encourage them to have a free health check. The concerted efforts to raise the profile of this programme with the public and improve on the programme must be maintained. In order to achieve this the public health team should:

1. Continue to market the NHS Health Check programme in new and innovative ways which take advantage of emerging technologies.

2. Continue to work with GPs to improve on the uptake of the offer of a free NHS Health Check.

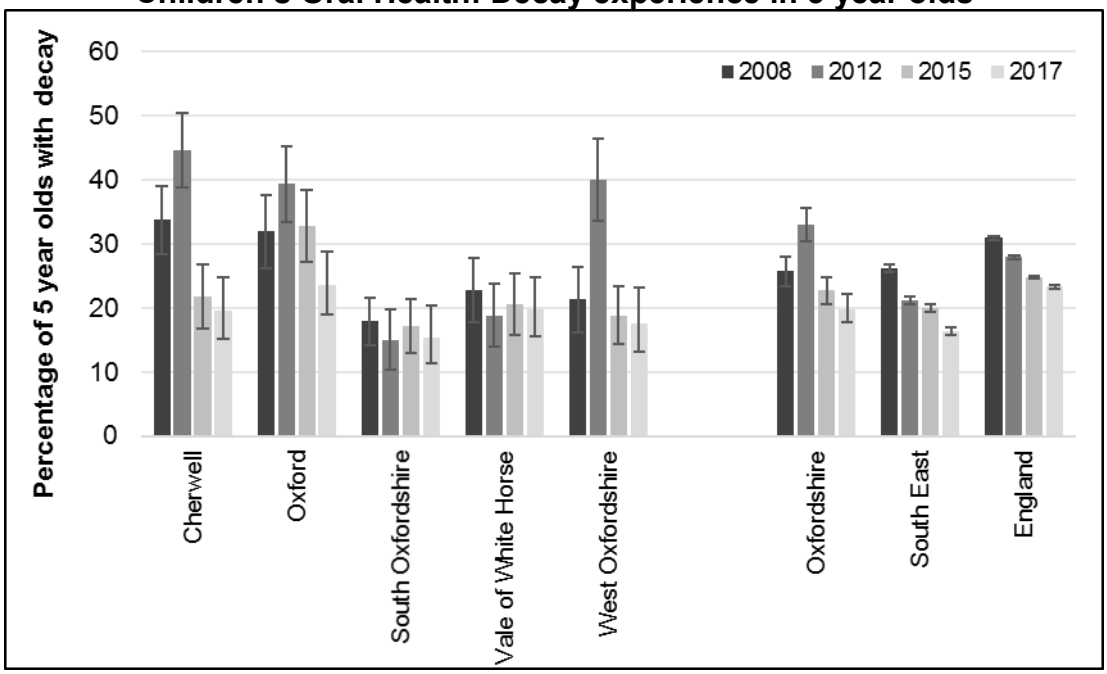
3. Better identify and engage with high risk groups to take up the offer of a free NHS Health Check.

Oral Health The marked improvement in oral health and the number of adults keeping their teeth is a result of better brushing with fluoride toothpaste and more awareness of oral health. This is welcome. Tooth decay is one of the most easily preventable diseases.

The picture in children

Local data is based on national surveys whose sample size is really too small to draw firm conclusions beyond a County basis. Looking at the national data we can see that tooth decay is linked with other measures of general social disadvantage and so is a further source of inequality in the County. Latest data from the 2016/17 oral health survey of five-year-old children shows that in Oxfordshire 80% of 5 year old children were free from any decay which is significantly better than the national average of 77%. This is a good improvement locally from 67% who were free of decay in the 2012 survey. The range of decay is still unequal in the county, 76% of children in Oxford are decay free whereas in South Oxfordshire this number is 84%.

Children's Oral Health: Decay experience in 5 year olds



National Dental Epidemiology Programme for England, Oral Health Survey of five-year-old children

The chart shows that:

- These are estimated figures, making it hard to draw firm conclusions. The small bars at the top of the columns on the graph indicate the amount of uncertainty about the figures – they are best estimates. The taller the thin line, the bigger the uncertainty.

- There is an improving trend over time in Oxfordshire which mirrors improvement in the South East and in England.

- Oxfordshire performs better than England but not as well as the South East as a whole.

Last year I recommended that the oral health promotion service should continue its policy of training staff in oral health so that a small 'army' of professional can reach out to educate people about oral health in setting such as maternity, schools and care homes. *This has been achieved and these principles will inform the re-commissioning of the service.*

Recommendations re oral health

1. The Director of Public Health should continue to monitor trends in tooth decay.

2. A new oral health service should be commissioned which aims to train front line workers in oral health promotion

A word about alcohol

Alcohol consumption continues to fall nationally and locally. This is part of a secular trend. In its wake, indicators such as alcohol related deaths are also improving. At the same time, our partnership group working on reducing harm from alcohol has continued to make good progress, and so, apart from this update I am not going to report further on this topic this year.

Last year I recommended that opportunities should be taken to give people brief advice about drinking and alcohol related harm*. This is now also part of the 'Making Every Contact Count' programme. The work is progressing at a steady pace and is being led at Buckinghamshire-Oxfordshire-West Berkshire level.*

Chapter 5: Promoting Mental Wellbeing and Positive Mental Health

For the past 2 years I have looked in detail at the mental health of young people.

This year I want to devote a major part of this report to mental wellbeing, positive mental health and promoting mental wellbeing for all age groups.

It isn't an easy topic to capture for a number of reasons that are worth stating up-front:

- Mental wellbeing and mental health problems are less easy to define than physical health problems. The two often occur together and it is better to treat the whole person.

- The statistics reflect this – there is a notorious dearth of good hard data on mental health and wellbeing – it is quite different from physical health.

- We tend to know when we don't experience good mental health e.g. when we are anxious or depressed, but we tend to overlook it when we do have it.

- Talking about mental health problems can be stigmatising. Coming forward to seek help can be difficult leading to many problems staying undetected. This is less of an issue than 20 years ago, and our young people of school age are coming forward with problems much sooner than they used to.

So, let's look at some definitions.

The World Health Organisation defines positive mental health as:

'... a state of wellbeing in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community.'

This is an interesting definition. It includes the concept of stresses of life as a cause of problems and has contributing to the community as a yardstick of positive mental health.

It's worth unpacking stress as something that makes us lose our sense of mental wellbeing. This seems to operate in 3 ways:

1. Stress early in life can predispose us to mental health problems in later life

2. Stress in the day to day sense can veil our sense of mental wellbeing leading to discontent or dissatisfaction…..something many people feel much of the time. This can be as simple as coping with the daily round – exams – young children – work.

3. Stress can also act as a trigger in those predisposed to serious mental illnesses such as schizophrenia and bipolar disorder.

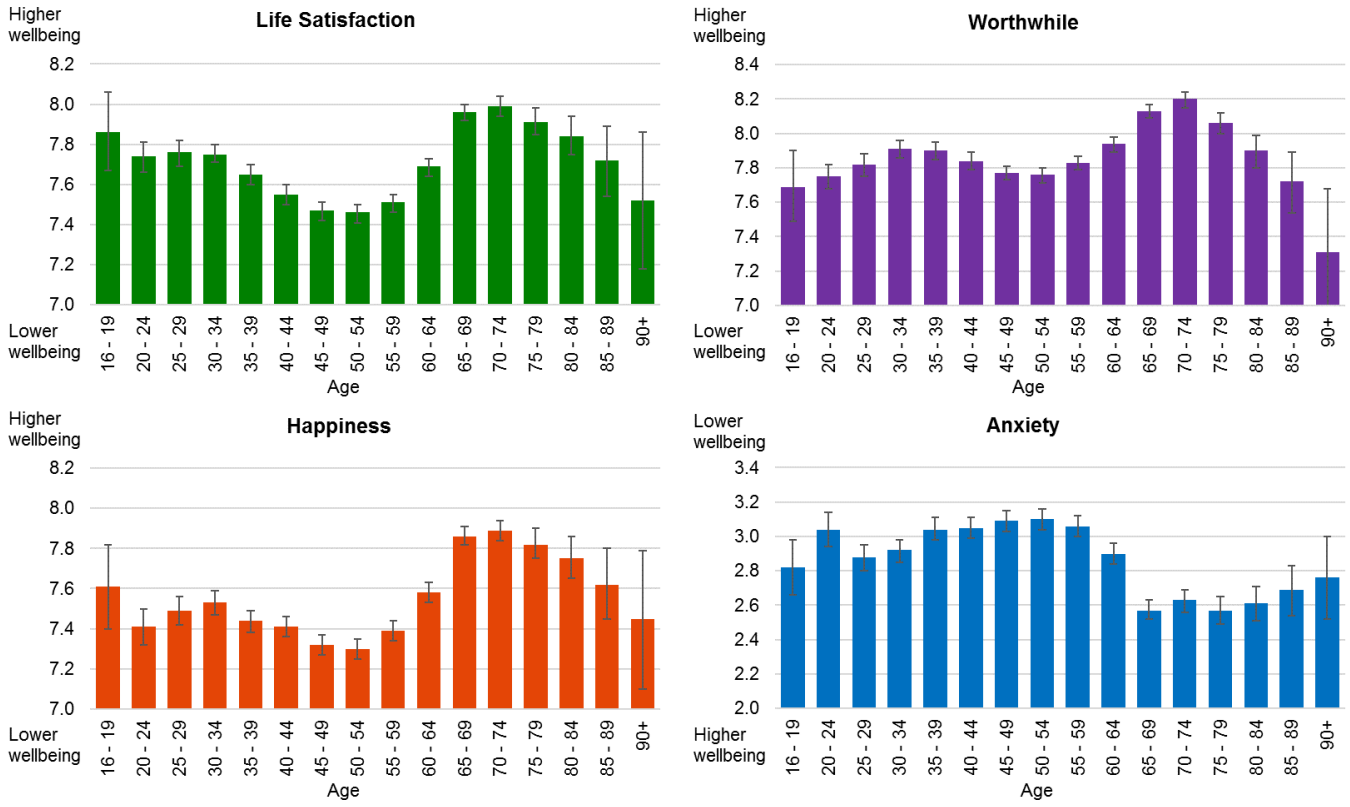
Looking at stress more closely in younger people led the Chief Medical Officer to evidence the following list of factors which build resilience in young people and so helps them withstand the stresses and strains of modern life. These are:

- Positive relationships with caring adults
- Effective caregiving and parenting
- Intelligence and problem-solving skills
- Self-regulation skills
- Perceived efficacy and control
- Achievement / motivation
- Positive friends or romantic partners
- Faith, hope, spirituality
- Beliefs that life has meaning
- Effective teachers and schools

The reverse of this list leads to decreased resilience and vulnerability to stress.

We can get a handle on mental wellbeing in over 16s from a UK survey which asked about people's levels of satisfaction with life, happiness and anxiety. It shows some surprising results. The results are shown below in 5-year age bands from age 16 onwards below

Average personal wellbeing ratings in the UK by age, 2016-17



Source: Office for National Statistics

The results show:

- All measures of happiness and wellbeing tend to start well in one's teens and early twenties, dip rather steeply and progressively in the 30s, 40s and 50s and then improve dramatically around retirement age.

- Anxiety levels do the opposite – they are lower in the teens and early twenties, rise in adults of working age and then fall dramatically.

- As older age increases, life satisfaction and happiness do fall, and anxiety increases a little.

It is tempting to see this as evidence of the stresses of life mounting as jobs, families and mortgages add to responsibilities leading to increasing measures of mental unrest. This leads to a general period of wellbeing in the retirement years with some decline as the stresses of old age take effect.

Just how common are mental health problems across the age groups?

The following facts from Public Health England and Government sources tell the story – and the numbers are surprisingly high.

Children and Young People

- 1 in 5 children have a mental health problem of some kind. In Oxfordshire this equates to 28,700 children in the 0-17 age group

- In those suffering lifelong mental health problems, 50% have begun by age 14 and 75% by age 25.

- Children from the poorest 20% of households have a 3-fold greater risk of mental health problems than children from the wealthiest 20%

Mental health of all Adults

- 1 in 4 adults suffer from a mental health disorder at some point.

- 15 million working days were lost in England due to stress, depression and anxiety in 2014 – up 24% from 2009.

- 1 in 6 people of working age have a mental health disorder

- Mental health problems are the biggest single reported form of disability.

- Of people with long term conditions, 1 in 3 have a mental health disorder, usually anxiety or depression.

- People with mental health problems in England and Wales have a reduced life expectancy of about 10 years compared with those who do not.

Impact of work and impact on the economy

- 19% of long term sickness is due to mental health problems.
- Each year mental ill health is estimated to cost the economy £70bn in lost productivity, NHS costs and care benefits.

Women and Maternity

- Postnatal depression affects 1 in 10 women within a year of giving birth. In Oxfordshire this equates to around 700 women per year.

Learning Disability

- People with learning disabilities have six times the risk of developing mental health problems.

Older People

- Depression in over 65s affects around 22% of men and 28% of women. In Oxfordshire this equates to around 12,400 men and 18,700 women.
- 850,000 people are living with dementia in the UK – by 2020 the figure will top 1 million. In 2016-17 there were almost 5,500 GP-registered patients in the Oxfordshire Clinical Commissioning Group with a diagnosis of Dementia and Alzheimer's disease, up from 5,200 in 2015-16. The estimated total number of people living with dementia in Oxfordshire (diagnosed and undiagnosed) is thought to be around 8,000.

These facts give an eloquent picture of just how common mental disorders are and just what a prize mental wellbeing really is.

The facts and figures above refer to the general population. The figures are even higher in specific groups. This is set out in the section below.

Vulnerable groups and inequalities in those at risk of mental health problems

The Local Government Association reports that the risk of mental health problems is higher in the following groups of people experiencing:

- Poverty
- Homelessness
- Disability
- Long term illness
- Violence or abuse

The risks are also higher in the following groups:

- Veterans
- Lesbian, gay, bisexual and transgender communities
- Looked after children
- Refugees and asylum seekers
- Some Asian, black and minority ethnic groups.

Here we see the all too familiar impact of social disadvantage and inequalities. The take-home message has to be that,

'Tackling inequalities also reduces the burden of mental health problems and promotes positive mental health'

I would also add carers to the list of people particularly at risk – 57% of carers in the latest Oxfordshire survey reported general feelings of stress. Just under half reported feeling depressed.

Protecting ourselves and promoting good mental health

There seem to be several factors that nurture mental wellbeing and promote good mental health. Together these could be seen as a programme of 'mental health self-defence'. They are easy to list but rather more difficult to achieve in practice.

Protective factors are:

- A nurturing childhood.
- Good community design which fosters safety, communication, access to greenspaces, makes exercise easy and is 'dementia friendly'.
- Being more active in everyday life.
- Investing in one's 'life assets' i.e. maintaining a network of friends, maintaining hobbies and interests, contributing to the local community.
- Practising Mindfulness and the '5 ways to wellbeing' (see below)
- Achieving a healthy work-life balance.
- Being in steady work.
- Catching problems early.
- Reducing social inequalities.
- Proactive and early help for vulnerable groups.

So, reviewing these factors, how well are we doing in Oxfordshire?

This is a massive topic and there is only space to give a high-level overview in this report. My view would be:

A nurturing childhood

We are doing a lot to support families to achieve this through our Community Midwifery and Health Visiting Services, through our school health nurse service, through partnership work in the Children's Trust and through the Children's Safeguarding Board.

For example we can look more closely at the County Council's **Health Visiting** service provided by Oxford Health NHS Foundation Trust. It is rated by the Care Quality Commission as 'outstanding'. **Health Visitors assessed 7,253 new mothers for maternal mood last year by the time baby was 8 weeks old, this is 97.1% of the eligible population and is a very good result.**

Mental wellbeing is promoted at every Health Visiting contact and women with existing mental health problems receive additional support.

If there is a mild to moderate risk of mental health problems then the service uses the 'Knowing Me Knowing You' model which helps mothers to help themselves to find long term solutions and strengthen the all-important bond with their baby. There is also a focus on building a good social network through meeting other mothers and community groups.

The low figures for **teenage conceptions** in Oxfordshire mentioned elsewhere in this report are also a positive indicator of future mental wellbeing. Oxfordshire's high figures for **breastfeeding** are also helpful to the bonding process between mother and child.

Although still concerning, levels of **childhood poverty** are relatively low**,** providing another useful positive indicator.

Referral to children's social care gives us another side-light on children who are in difficulties. In 2016-17, 6,429 children were referred to **children's social care**. This number is increasing but is in line with similar Local Authorities and is part of a national trend.

Overall our Children's social care service is rated by Ofsted as 'good' which is an excellent result. Services are working with partners to offer **'early help'** to intervene before situations reach a crisis. This has been successful and early help assessments have risen steadily throughout the year. It is expected that over 1,300 of these assessments will be carried out in Oxfordshire this year. This is a good development aimed at solving problems early.

There is also a welcome emphasis on **children leaving local authority care**, aiming to build their resilience and maximise their life chances. This is a good development. By March 2017 there were 230 known care leavers in Oxfordshire. The County Council stays in touch with 94% of care leavers and takes an active interest in their lives. This compares with the England average of 90% - a good result.

Schools of course have a vital part to play in young people's mental wellbeing. The County Council's **school health nurse service** (run by Oxford Health NHS Foundation Trust and rated by the Care Quality Commission as 'outstanding') shows just how important this is. **In 2017/2018 school health nurses saw children for emotional wellbeing or psychological support on 7,665 occasions from a total of 33,276 interventions (22%).** This was a rise from 7,224 occasions the previous year. Emotional and psychological problems were the most common reason young people saw a school health nurse. Our school health nurse service is more comprehensive than in neighbouring areas and this is a major weapon in our fight to detect and treat problems early. Our nurses are trained in common childhood mental health and wellbeing issues including self-harm, low mood, eating disorders and building resilience. They may help the child directly or signpost them on to other services.

Good Community Design

This is the subject of Chapter 2 of this report and it is of vital importance. If we can design communities to strengthen social interaction, make exercise easy, make access to good food easy and help people with conditions such as dementia, we are hard-wiring mental wellbeing into the fabric of our villages and towns.

The Healthy Towns initiative really does point the way forward. Please see Chapter 2 for more detail.

Exercising and increased physical activity

Exercising makes people feel good both mentally and physically and makes us more resilient to the stresses and strains of life. It also protects against anxiety, depression, heart disease, stroke, cancer and dementia - it is a real all-round winner!

We have high levels of exercise in Oxfordshire, but we still need to make it easier to stay active. A number of useful initiatives have been strengthened over the last year:

- Building in cycleways and walkways has become standard in transport planning – this is good news.

- Our Healthy New Towns have had success with their planned parks and 'blue lines' which map out 5 kilometre and 2 kilometre walks.

- Our County Sports Partnership which aims to promote sport and physical activity across the County has been re-branded and re-launched as Active Oxfordshire. Their mission is to Get Oxfordshire Active - Every person in Oxfordshire including sport & physical activity as an essential part of their daily routine.

- 21 Oxfordshire primary schools are participating in an initiative called 'WOW'. WOW is run by Living Streets, the UK charity for everyday walking, as part of their Walk to School Campaign and it has been proven to make pupils healthier and happier, as well as reducing congestion around school gates. The County Council's Public Health team have contributed funding towards this programme. The baseline rate of active travel amongst the 21 participating schools in September 2017 was 65%. In July 2018 this had risen to 86%.

- Oxfordshire School Sport Games, during the 2016-17 academic year, 95% of primary schools and 100% of secondary schools took part, involving nearly 30,000 participants.

- School Health / College Health Improvement Plans also focus on mental health and wellbeing and physical activity within the education community

- See chapter 2 for involvement of schools in Bicester in getting more exercise through the Healthy New Towns initiative.

Overall this is a positive story for Oxfordshire.

Social Prescribing

Social prescribing means prescribing exercise or participation in clubs and hobby groups instead of traditional prescribing. It is designed to support people with a wide range of social, emotional or practical needs, and many schemes are focused on improving mental health and physical well-being.

Social prescribing schemes can involve a variety of activities which are typically provided by voluntary and community sector organisations. Examples include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports.

The City GP Locality of the Clinical Commissioning Group have an established programme and have ‘care navigators’ who link to GP practices and signpost people to activities.

North & West GP localities have won a national bid for funding of a social prescribing scheme and are working with Cherwell and West District Councils and Citizens Advice locally from September 2018. This is a good development.

Details of social prescribing as part of the Healthy New Towns initiative are detailed in Chapter 2

Mental health self-defence – 5 Ways to wellbeing

The excellent programme of what I call 'mental health self-defence' - the 5 ways to wellbeing - is becoming better known. This is something everyone can practise and I recommend it. Researchers have set out 5 practical and simple things anyone can do to improve mental wellbeing. They are:

According to the 'NHS Choices Moodzone' webpages they are:

- **Connect** – connect with the people around you: your family, friends, colleagues and neighbours. Spend time developing these relationships.

- **Be active** – you don't have to go to the gym. Take a walk, go cycling or play a game of football. Find an activity that you enjoy and make it a part of your life.

- **Keep learning** – learning new skills can give you a sense of achievement and new confidence. So why not sign up for that cooking course, start learning to play a musical instrument, or figure out how to fix your bike?

- **Give to others** – even the smallest act can count, whether it's a smile, a thank you or a kind word. Larger acts, such as volunteering at your local community centre, can improve your mental wellbeing and help you build new social networks.

- **Be mindful** – be more aware of the present moment, including your thoughts and feelings, your body and the world around you. Some people call this awareness "mindfulness". It can positively change the way you feel about life and how you approach challenges.

I've also seen this set out as 7 things you can do via the Mental Health Foundation and the Civil Servants' Charity website:

1. **Keep active** Physical activity does wonders for your mental health

2. **Talk about it** Get together with friends, family or colleagues and have a good old natter!

3. **Eat well** Good food is another great way to support your mental health. Vitamins and other nutrients can protect your mental wellbeing.

4. **Drink sensibly** Why not pass on the alcohol and have a mocktail party? By replacing alcohol with your favorite juices, you might discover a new favorite whilst having a healthy evening in.

5. **Keep in touch** Spending time with friends and loved ones, whether it's a BBQ or full on dinner party is a great way to open up and share your story with the people that matter most.

6. **Be mindful** Learn a technique called mindfulness to help yourself cope during stressful times.

7. **Be you** We're all different. Do what you're comfortable with. By talking about mental health locally, you will be helping to break down some of the stigma surrounding mental health issues.

The point I want to make here is that there is a growing awareness of these common things that improve people's sense of wellbeing in the broadest sense. It's something you do for yourself. For example, there is a thriving workplace 'mindfulness' group which County Council staff run for themselves, and this sort of initiative is expanding rapidly…… try it!

Earlier this year the County Council's Public Health Team worked with MIND to run a 5 Ways to Wellbeing campaign which used social media, posters and Tea and Talk events in libraries all around the county to highlight mental health and wellbeing. MIND also used the launch event at event at County Library in Oxford to display their World Mental Health Day book – a collection of stories and contributions from their clients and supporters.

The campaign gained good coverage on social media and in the press. Overall more than 9000 people saw the campaign via Facebook and 8000 on Twitter, while others attended the library sessions to join in small group discussions.

Work-life balance

This is a difficult issue given the pace of modern life and the nature of working patterns. Duncan Selbie, Public Health England Chief Executive has said,

'Having a job is good for our health, but the quality of our jobs makes the difference. Ensuring people have a safe, encouraging and supportive working environment will help keep them well and in work for longer. This is something that all employers should take steps to achieve'

Good quality work is important for good mental wellbeing: The Health Foundation report that over 1 in 4 employees feel depressed when they work long hours. They also report that 61% of workers in insecure employment have worked when unwell for fear of losing their job or pay. The TUC report that in-work training and further education makes people happier and more effective at work.

This is a matter for individual employers but it begins close to home. In the County Council for example there has been a real emphasis placed on training and development of staff over the last year. It's good for the employee and good for the employer, and it promotes good mental health. We also have a long-standing programme of Health in the Workplace events led by our Human Resources team which promotes physical activity, health checks and mental health self-defence.

Being in steady work

Being out of work is decidedly bad for mental wellbeing. Chapter 3 reports on our very low levels of employment which is a boon, but, as Duncan Selbie points out above, the quality of the job also matters a great deal.

Domestic abuse

This topic covers a wide range of issues from domestic violence to controlling and coercive behaviour covering physical, psychological and sexual aspects. This is a major stress and puts

mental health seriously at risk. An estimated 28,000 residents aged 15 + are thought to be affected altogether, around 1000 people access specialist services and around 300 individuals are classed as 'high risk'.

A major review of services for domestic abuse was carried out in 2016 and a new service was launched on the 4th of June 2018. This pulls together all services, County and District, into a single 'pathway' under a new service provider A2 Dominion. This is a major step forward. It is too early to evaluate the service yet and it requires a watching brief.

Armed Forces and Veterans

There are more than 8,500 military personnel and almost 5,000 family members living and working in the county. The nature of their work means that they are vulnerable to emotional pressures both in active service and as veterans. Partnership work is strong and Oxfordshire's close relationship with the military is cemented in the Community Covenant, which is a statement of mutual support between the civilian community and the local armed forces. An updated Covenant was signed by a wide range of partners in June 2018, signifying their willingness to continue to work together for the good of armed forces, families and local communities.

The County Council Armed Forces Champion co-chairs the Veterans' Forum which meets annually and oversees a wide range of work to ensure that veterans are able to get the services they need locally. Although a huge network of organisations supports the armed forces community, the Veterans Forum highlighted that finding the right service or assistance is not always easy. In response the 'Veterans' Gateway' was launched last year (June 2017) as a single point of contact for veterans and their families to enable them to get the right advice and support from local organisations both within and outside the armed forces sector: https://www.veteransgateway.org.uk/

Special consideration has been given to ensuring access to mental health services over the last few years not only for veterans but for families of serving personnel too. Local NHS providers have been able to fast-track individuals who need treatment for Post-Traumatic Stress Disorder, for example. Oxfordshire MIND have also delivered training and support services to families of serving personnel on the Oxfordshire military bases, helping them through times when members of their families were on active service in war zones and returning home. Grants from the Community Covenant Fund have enabled this work to expand. In addition, the Armed Forces Primary Care Services personnel regularly attend training set up by the Public Health team to help them identify and give treatments such as brief advice on alcohol use, which may be linked to mental health concerns.

Reducing inequalities

Any action to reduce health inequalities and reduce social disadvantage is highly likely to improve mental wellbeing and protect against mental health problems. Chapter 3 deals with this issue in more detail, but it is very clear that any programme of mental health improvement will also be a programme which reduces inequalities.

Preventing dementia

Dementia is estimated to cost the UK £11.6 Bn in unpaid care, £4.5 Bn on state funded social care and £4.3 Bn on health care. It is a massive issue with the number of cases set to top the 1 million mark in the UK by 2025.

The good news is that it can be prevented or delayed to some extent – how? Public Health England point to the following factors:

At societal level:

- By helping people to give up smoking or never start – some cases of dementia are linked to disease of the blood vessels.
- By improving environments where people can be more active – another boost for the healthy New Towns initiative.
- By promoting healthy eating
- By addressing loneliness and creating better community spaces

At an individual level (reminiscent of the 5 ways to wellbeing mentioned above):

- By volunteering and socialising
- By reading, doing puzzles and crosswords
- By learning new things such as a second language

The great work of the Voluntary and Community Sector and Faith Groups

The work of many charities is key to keeping people mentally healthy. Charites such as MIND, RESTORE and Age UK do a great deal to improve the quality of people's lives and to improve their social networks. It doesn't stop with the big specific charities though – carers groups and the different condition-based support groups for sufferers and families have a major role to play too. Any organisation which promotes better connections, more activity and a sense of purpose is contributing to mental wellbeing.

Faith groups have a tremendous part to play too as does the scouting movement and groups like the WI.

All of these endeavours promote a really crucial sense of focus, purpose, creativity and belonging which is highly effective in promoting mental wellbeing. It protects the mental health of the users of these services and is also protective for those who organise them and take part.

The examples are too numerous to cover here – I would simply like to pay a heartfelt tribute to the work done by 1000s of (largely unsung) heroes and heroines across the County who carry out this work.

Mental Wellbeing: Conclusion

This a major public health issue now and increasingly in the future. Everyone has a role to play from individuals, to community groups, to organisations, to employers, to schools, to Government. We have many useful initiatives in place. We now need to take this work to the next level as organisations and coordinate our activities better. The recommendations below drive at this, but first I want to review what I said last year.

What the report said last year and what's been done about it.

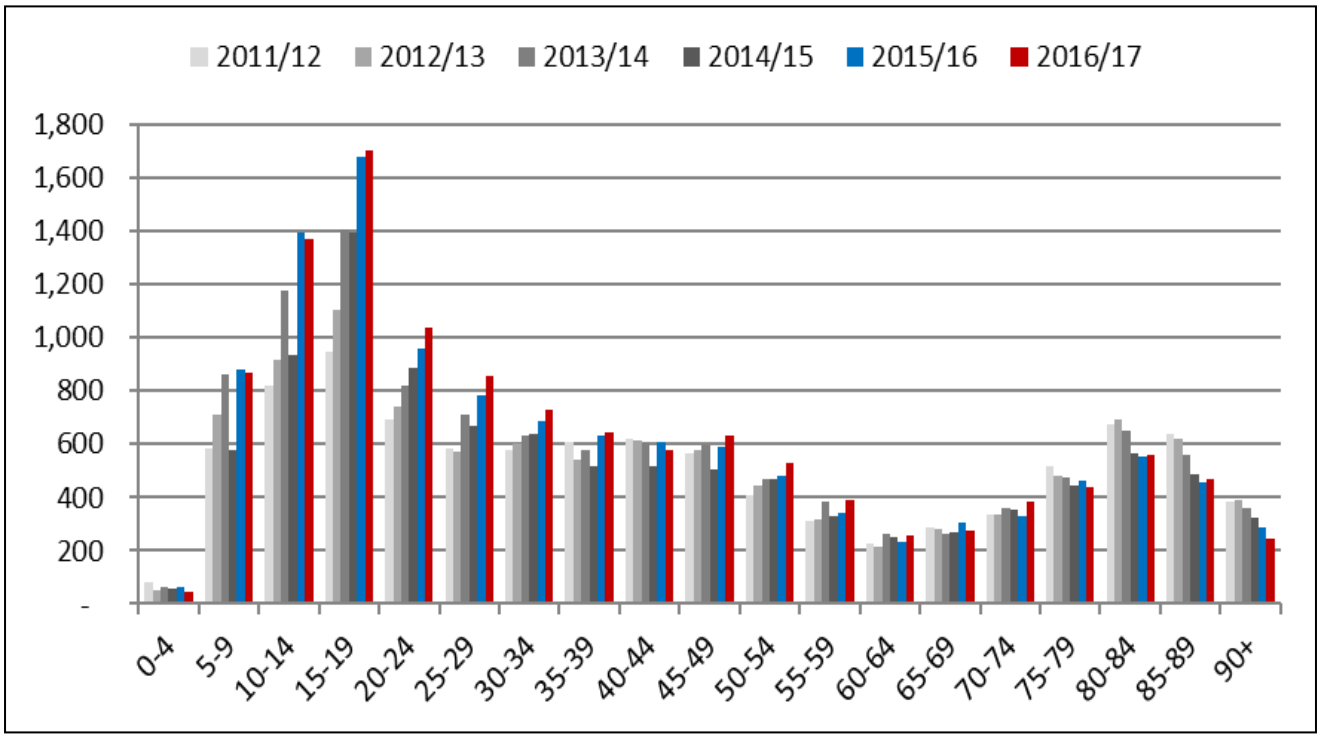
Last year I reported on children's mental health problems and self-harm. There was particular concern as the number of referrals to children and young people's mental health services were increasing and that services were under pressure to cope – this is part of a national issue.

The reality is that we are dealing with a new phenomenon – children and young people coming forward in increasing numbers seeking help with emotional distress. This is a good development. The question is, how should services cope?

The significant contribution our School Health Nurses are making has been highlighted earlier in the chapter.

The latest data on referrals looks like this:

Number of Oxfordshire residents referred to Oxford Health mental health services 2011-12 to 2016/17



This shows that:

- Referrals for 0-4s, 5-9s, 10-14s all fell slightly in latest data, and referrals for 15-19 rose slightly.

- Referrals in the 10–19 year age group are by far the highest in any age group and this is mirrored nationally.

In terms of action taken:

Waiting times for Children's mental health services remain a huge challenge locally and nationally as services try to cope with the ever-increasing number of referrals and the increasing number of children waiting for a first appointment.

The local service model implemented over the last year is sound, but it has taken longer to settle in than expected. Crucially, the overall service is supported as the model of choice by children and parents as well as by the professionals.

The aim now is to be more ambitious in trying to increase self-referral by young people rather than waiting for a professional referral. This is likely to increase demand further but is felt to be the right thing to do. This will allow assessment to be done 'live' and immediately on the phone and treatment begun immediately rather than waiting for cumbersome referral processes. This also helps to not medicalise and stigmatise these common emotional problems.

Oxford Health NHS Foundation Trust (which runs the service) is also putting together an improvement plan to reduce the number waiting by seeing if additional support can be brought in to help with initial assessments.

Time will tell if these initiatives are effective.

Regarding hospital admissions for self-harm, the figures remained broadly similar to last year and are broadly in line with national and regional trends. The specific numbers of admissions fluctuate year on year in the different age groups. In 15-19 year olds in Oxfordshire the rate has risen for the past three years, and is just above the England average. The rate is lower for 10-14 year olds. This fluctuation is to be expected as the numbers are statistically fairly small overall. The key fact is that this is a national trend.

In terms of specific action:

The County Council Public Health team commissioned the play 'Under My Skin' for the third year in a row. It is a play performed in schools by Pegasus Theatre to raise awareness of self-harm for Oxfordshire's young people, and access to support services. It was developed via the multi-agency self-harm network in collaboration with Pegasus Theatre. This was a response to an increase in self-harm rates in the north of the County.

Headline Outcomes for the play

- Year on year outcomes continue to be excellent
- 26 schools in Oxfordshire received the play with a total of 28 performances
- 5078 young people in Years 8 and 9 saw the play
- The cost was £3.94 per pupil
- 95% of young people said their awareness of self-harm had increased since seeing the play
- 90% know where to get support since seeing the play
- 87% felt using theatre was a good way of learning about difficult topics
- 69 young people saw their School Health Nurse on the topic of self-harm in the immediate two weeks post performance

The play will be commissioned again for 2018/2019 school year.

Recommendations regarding mental wellbeing and mental health promotion

1. There is good activity across the County. This now needs to be taken to the next level.

2. The Health Improvement Board should receive a specific Joint Needs Assessment on mental health issues alongside this annual report and should use these to direct planning by the end on 2018/19

3. The Health Improvement Board should coordinate this effort and should create a new framework for mental health promotion activity by the statutory sector and beyond.

Chapter 6: Fighting Killer diseases

Part 1. Epidemics, Flu and Antimicrobial Stewardship

The improvement in the quality of our living conditions and the advances in modern medicine have meant that threat of major illness and large numbers of deaths due to communicable disease are considered as a problem from the past or a problem for poor and developing countries.

Most people don't see or know about the efforts made to keep them safe from infectious diseases. There are still stark reminders of the continuing threat that can arise at any time and present a very real risk to us all irrespective of countries and borders, as seen with Ebola and Zika in recent years. The concerns about flu last winter is a reminder of the continued vigilance that is still needed to safeguard our population's health from communicable disease.

A lot of the work that goes on to protect the community from communicable diseases is relatively unseen and out of the public eye. This work must still be a priority and continue to be delivered every day of the year to make sure that suitable preparations are in place for the worst scenarios. Directors of Public Health and their teams have worked closely with Public Health England and the NHS across the Thames Valley to make sure we can respond when the need arises. **This cooperation and 'behind the scenes' effort is vital.**

The right response continues to be systemic and calm planning. We need to ensure that we are organised so we can respond when the need arises without fear or panic. The need to remain vigilant continues to hold true.

Last winter saw an increase in the level of flu compared to the previous few years of low activity. This put pressure on the health system and caused the cancellation of planned procedures nationally. This increased flu activity was expected and world-wide surveillance helped us in planning how to limit the effect of flu during the winter season. This included a concerted effort to encourage people who work as carers of vulnerable people in our community to take up a free flu vaccine.

The threat of **antibiotic resistance** and the rise of "superbugs" remains a cause for concern. Antibiotics are important drugs in the fight against bacterial infections which were once life threatening in animals and humans. Bacteria are highly adaptable and the widespread misuse of antibiotics and inappropriate prescribing of antibiotics continues to lead to increasing numbers of bacteria which have developed resistance to antibiotics which once were effective.

Failure for us all to act responsibly now could see antibiotics becoming ineffective and the return of people dying of once curable infections and returning us to the situation before the discovery of penicillin.

How do we keep this work going?

Success depends on several key elements:

- Maintaining a well-qualified and well-trained cadre of Public Health specialists in Local Government.
- Continuing to build and maintain long standing relationships with colleagues in Public Health England and the NHS.
- Mainstreaming our plans by working with the Police, Military and many of the other organisations under the auspices of the Thames Valley Local Resilience Forum (LRF).
- Educating and advising the public of their role as individuals in limiting antibiotic resistance.

Our work on this in Oxfordshire has been strong. It is vital to keep the specialist workforce we have now to continue with this important work.

Part 2. Infectious and Communicable Diseases

Health Care Associated Infections (HCAIs)

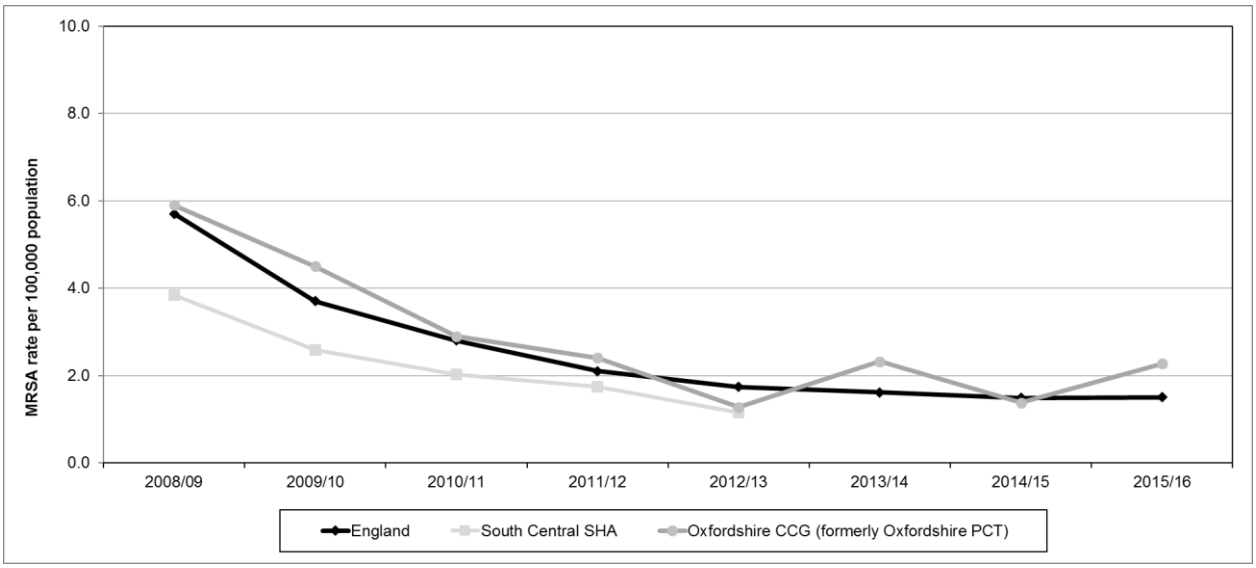
Infections caused by superbugs like Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C. diff.) continue to be an important cause of avoidable sickness and death, both in hospitals and in the community. These infections do not grab headlines as they have in the past but they still need everyone to remain vigilant to limit an increase in the incidence of infection.

Methicillin Resistant Staphylococcus Aureus (MRSA)

MRSA is a bacterium found commonly on the skin. If it gains entry into the blood stream (e.g. through an invasive procedure or a chronic wound) it can cause blood poisoning (bacteraemia). It can be difficult to treat people who are already very unwell so it is important to continue to look for causes of the infection and identify measures to further reduce our numbers of new cases of infection. MRSA has fallen gradually in Oxfordshire in response to the direct measures taken by hospital and community services to combat it. The local situation is shown below.

Infections can be limited by using traditional hygiene methods. Nationally there is a zero-tolerance policy and the rate of MRSA is still higher than we would like to see. The improvements over the past years in Oxfordshire have reflected the efforts to reduce MRSA and continued vigilance is still required by all hospital and community services to combat MRSA infections.

Methicillin Resistant Staphylococcus aureus (MRSA) - crude rate per 100,000 population (2008/09 – 2016/17)



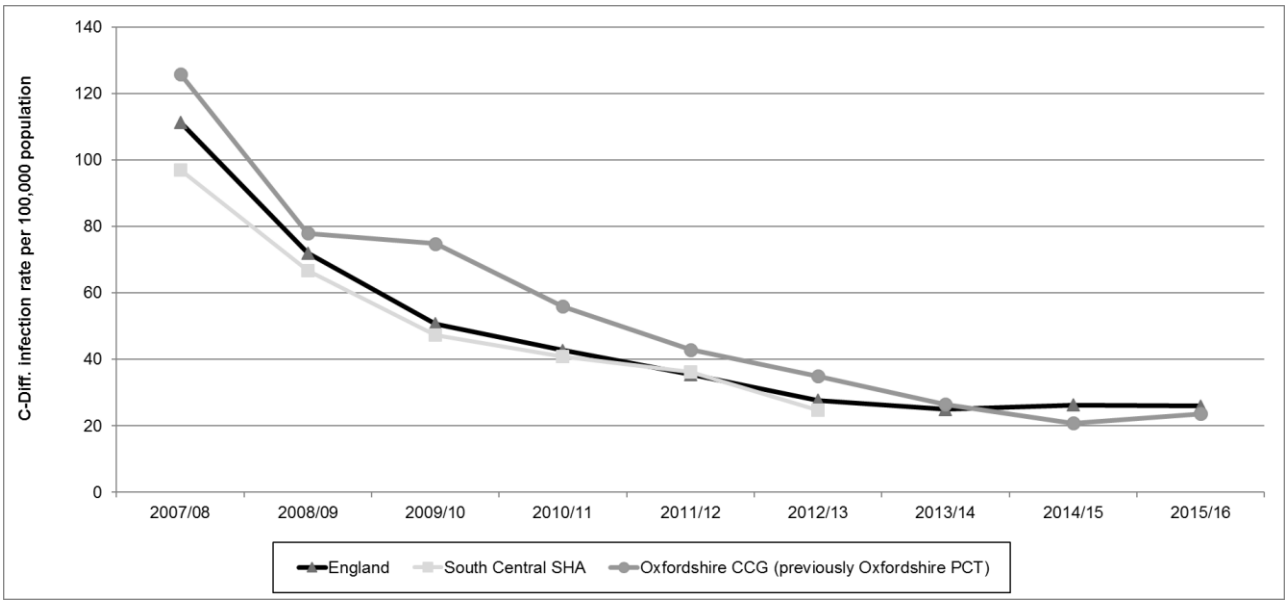
Public Health England (PHE), Health Protection Agency (HPA)

Clostridium difficile (C.diff)

Clostridium difficile is a bacterium that causes mild to severe diarrhoea which is potentially life-threatening especially in the old and infirm. This bacterium commonly lives harmlessly in some people's intestines but commonly used broad spectrum antibiotics can disturb the balance of bacteria in the gut which results in the C.diff bacteria producing illness.

The focussed approach on the prevention of this infection has resulted in the steady reduction of cases in Oxfordshire since 2007/08 as shown in the chart below which is in line with the national trend. This reduction in C. diff involved coordinated efforts of healthcare organisations to identify and treat individuals infected and careful use of the prescribing of certain antibiotics in the wider community.

Clostridium Difficile Infection (CDI) - crude rate per 100,000 population (2007/08 to 2016/17)



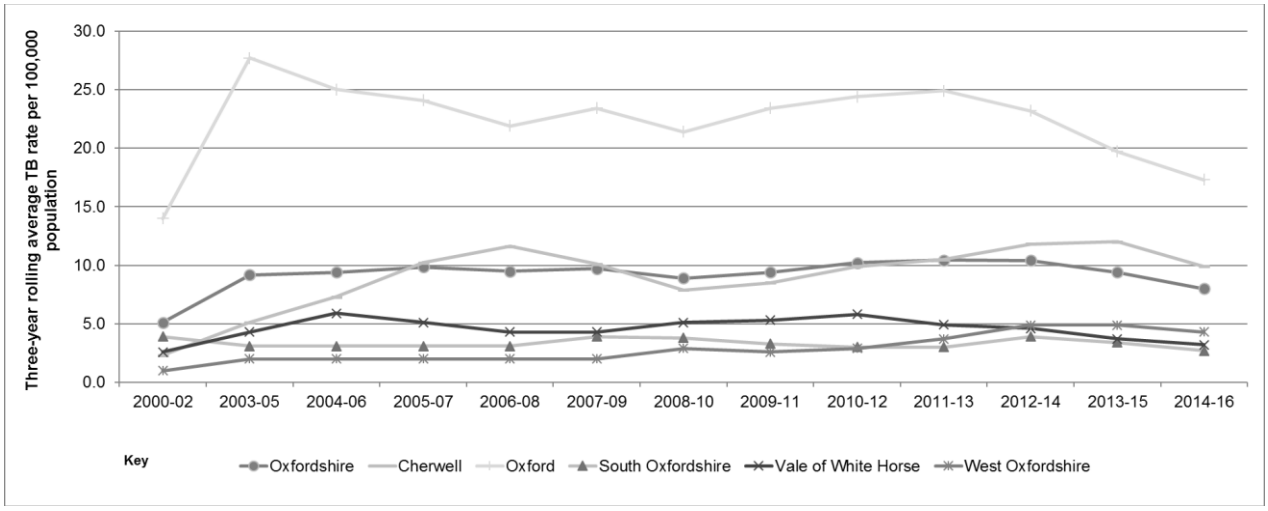
Public Health England (Health Protection Agency)

Tuberculosis (TB) in Oxfordshire

TB is a bacterial infection caused by Mycobacterium Tuberculosis which mainly affects the lungs but which can spread to many other parts of the body including the bones and nervous system. If TB is not treated, active TB can be fatal.

In Oxfordshire, the numbers of cases of TB at local authority level per year are very low. The local figures are shown below.

Tuberculosis (TB) – Incidence rate per 100,000 population (2000-2 to 2014-16)



Public Health England, Health Protection Agency (HPA) Enhanced Tuberculosis Surveillance

The levels of TB in the UK are continuing to show a reduction due to the ongoing coordinated efforts by TB control boards across England to improve TB prevention, treatment and control.

The rate of TB in Oxfordshire remains lower than the national average and is similar to average levels in Thames Valley. In the UK, the majority of cases occur in urban areas amongst young adults, those moving into the area from countries with high TB levels and those with a social risk of TB (e.g. homeless). This is reflected in the higher rate of TB in Oxford compared to other districts in the County.

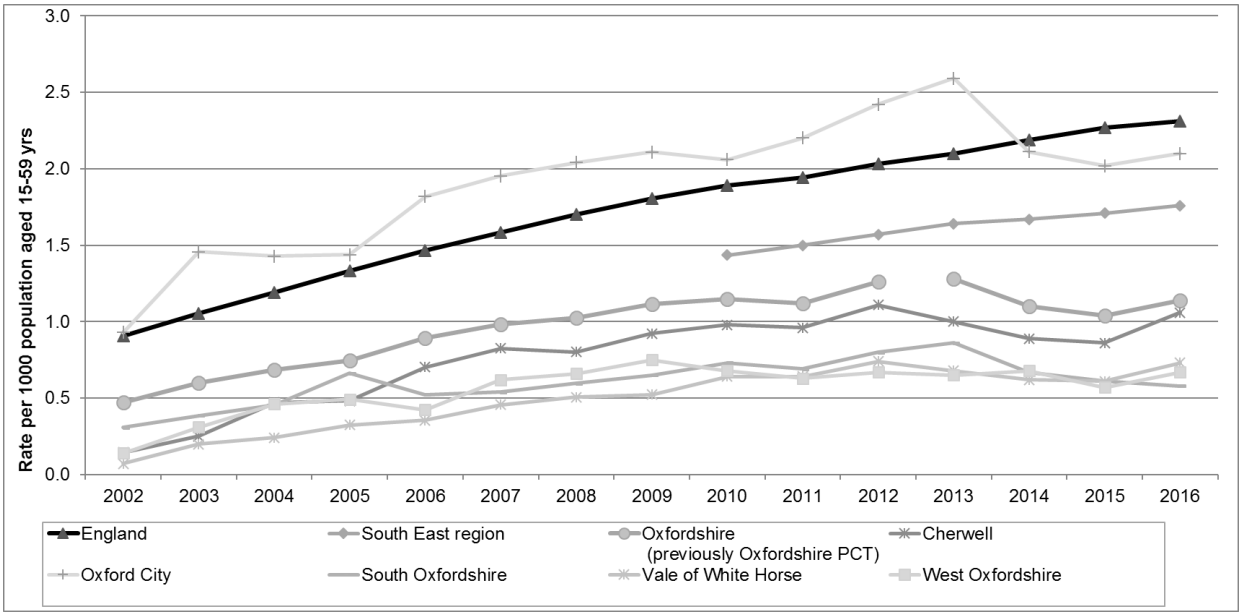
The National TB strategy which has been developed by Public Health England is beginning to realise a reduction in the levels of TB in England.

Sexually transmitted infections

HIV & AIDS

HIV does not raise public alarm like it did in the 1980s, but it remains a significant disease both nationally and locally. Due to the advances in treatment, HIV is now considered a long-term condition and those who have HIV infection can now expect to have a longer lifespan in health than previously expected by HIV carriers. As such we expect to have more people living with HIV long term. 2016 data shows that there were 463 people diagnosed with HIV living in Oxfordshire, 233 out of these 463 were living in Oxford City. This trend is shown in the chart below and shows another decrease this year across the County.

Percentage of diagnosed HIV per 1000 population (i.e. people living with a diagnosis of HIV) aged 15-59 years. England, South East region, Oxfordshire and districts



Public Health England Sexual and Reproductive Health Profiles

Finding people with HIV infection is important because HIV often has few symptoms and a person can be infected for years, passing on the virus before they are aware of the illness. The sooner an infected individual begins their treatment the more effective treatment is with a better

prognosis for the individual concerned. Trying to identify people with undiagnosed HIV is vital. We do this in three ways:

- Providing accessible testing for the local population. In 2017 the sexual health service provided 15,495 HIV tests.

- Through community testing. Local residents who are at high risk of HIV can now access a testing kit online which is part of a national service led by Public Health England. This increases convenience and accessibility of testing.

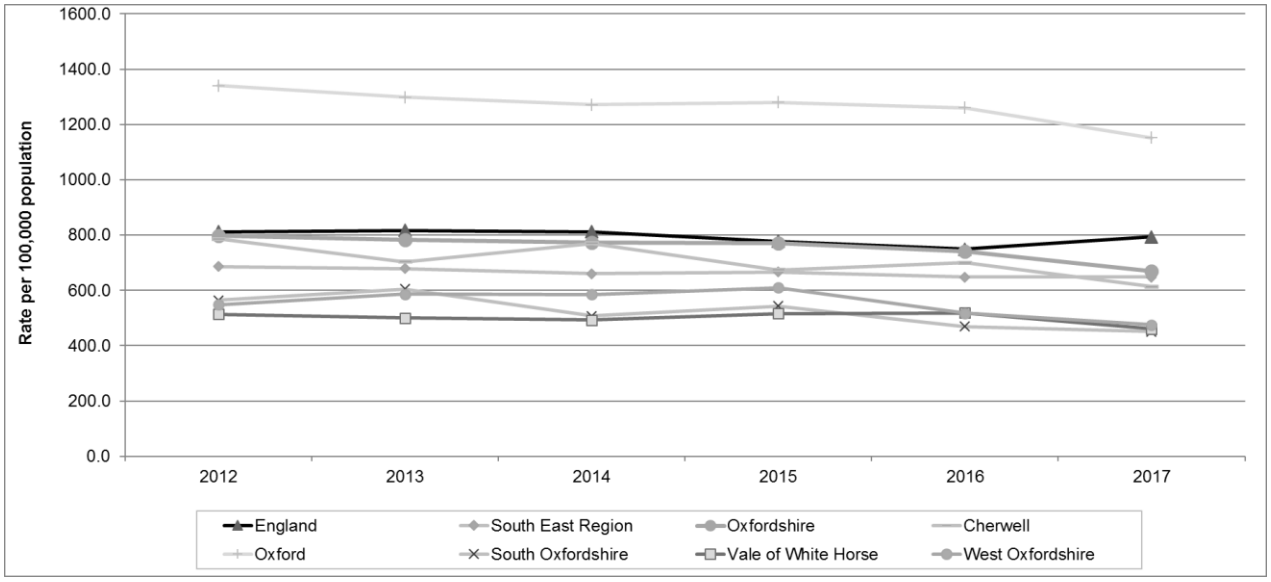
- Prevention and awareness. Educating the local population about safe sexual practices and the benefit of regular testing in high risk groups. The eligibility for accessing our condom scheme is available to men who have sex with men (MSM) and commercial sex workers, both groups being higher risk of contracting HIV.

Once diagnosed, the prognosis for HIV sufferers is now good, with effective treatments available. HIV still cannot be fully cured but the progression of the disease can be slowed down considerably, symptoms suppressed and the chances of passing the disease on greatly decreased. The trial of using drugs to halt transmission in high risk groups (PrEP) is currently being conducted nationally by NHS England. Local services are part of this trial and residents who meet the criteria can take part. The outcome of this trial is expected in a couple of years.

Sexual Health

Sexually Transmitted Infections (STIs) are still fairly common in England with the greatest number of cases in young heterosexual adults, and men who have sex with men (MSM). STIs are preventable through practicing ‘safe sex’. Total rates of STIs in Oxfordshire are still below the national average except in the City which has improved since 2013. The local picture is shown in the chart below.

All new sexually transmitted infections (STIs) rate per 100,000 population aged 15-64 years - 2012 to 2017



Public Health England / Health Protection Agency - Sexual and Reproductive Health Profiles

The different types of STI each show a mixed picture which is generally still good. Looking at each disease in turn gives the following picture.

- Gonorrhoea - Is below the national average for Oxfordshire overall and all districts except in Oxford City. The systems of testing which were introduced to reduce the number of false positive diagnoses has produced the expected decrease in the number of diagnosed cases.

- Syphilis - there was a slight increase which is in line with national activity. However, the rates are still below the national average in all Districts.

- Chlamydia - levels are lower than the National average in all Districts.

- Genital Warts – rates are still below national average and have seen a decline in line with the National trend. Oxford City still has significantly higher number of cases (reflecting the significantly younger age group) but the trend is still declining rates. With Human Papilloma Virus vaccination programmes in place nationally we anticipate a decline in rates over the coming years.

- Genital Herpes – rates are similar to national average except in the City which has higher levels. Again, this reflects the predominantly younger population of the City.

The County Council's integrated sexual health service which began in 2014 continues to see good levels of activity and this is welcomed.

In addition to the integrated service our GP surgeries have provide contraception services and pharmacies have provide access to emergency hormonal contraception.

The established partnership of local organisations continues to work together to identify and address priorities locally to further meet the sexual health needs of Oxfordshire.

Recommendation

The Director of Public Health should report on progress of killer diseases in the next annual report and should comment on any developments.

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A Report to the Health Improvement Partnership Board 22nd November 2017

Public Health Protection Forum business 2017/18

Purpose
This document will report on the activity of the Health Protection Forum for 2017/18.

1. **Introduction**
   1.1. Oxfordshire County Council (and the Director of Public Health (DPH) who acts on behalf of the local authority) has a critical role in protecting the health of its population. This role is to act as a watchdog, ensuring that all organisations working within Oxfordshire coordinate their activities and provide high quality services to protect the population.
   1.2. If organisations fall short of the required standards, the DPH has a duty to help them ameliorate the situation. It is therefore a leadership role rather than a managerial role.
   1.3. In order to carry out this role the DPH works in partnership with the relevant organisations via the Health Protection Forum which reports to the Health Improvement Board and hence the Health and Wellbeing Board.
   1.4. Most problems are dealt with directly by the Health Protection Forum, but should persistent difficulties arise these will be escalated to the Health Improvement Board and Health and Wellbeing Board as required.
   1.5. The Health Protection Forum therefore facilitates the DPH in fulfilling the statutory function of protecting the health of the population of Oxfordshire.

2. **Role of the Health Protection Forum**
The group report on the following issues
- Prevention
- Planning and preparedness
- Relationships and accountabilities
- Monitoring of local data
- Reporting of local issues which may affect the health of the local population

3. **Membership of the forum**
Membership of the forum includes;
- Director of Public Health, Oxfordshire County Council (Chair)
- Oxfordshire County Council Portfolio Holder for Public Health
- Consultant in Public Health/Public Health Medicine with responsibility for Public Health Protection/emergency planning – Oxfordshire (Deputy Chair)
- Director of Public Health England Centre – Thames Valley (or nominated deputy)
- District representation of Environmental Health colleagues
- Associate Director Medicines Management, Quality and Innovation, Oxfordshire Clinical Commissioning Group
- Head of Public Health Commissioning, NHS England Thames Valley
- Consultant in Public Health Screening and Immunisation, NHS England Thames Valley
- Consultant in Health Protection/CCDC with responsibility for Health Protection in Oxfordshire – Public Health England

Specialist advisors will be invited as necessary.

4. **Meetings**
The forum met three times in the financial year 2017/18. There were no extraordinary meeting held in this time.

5. **Activity Reporting**
The following activity was discussed and reported at the group meetings in 2017/18.

6. **Topical Infections (Lead role Public Health England)**
6.1 An outbreak of mumps in Oxfordshire, predominantly in the student aged population in Oxford city, aged 17-23, was identified in May 2017. There were 107 notifications in May compared to 7 the previous year. This increase was also observed nationally although not on the same scale. The number of notifications have declined to more expected levels since then. The reason for this increase is not known but mumps appears to be a cyclical disease with numbers peaking every three years, which is supported by local figures. It is spread by respiratory droplets and transmission is usually fuelled by close contact for example in in halls/colleges or parties. It is also not uncommon for mumps to occur in vaccinated individuals as the efficacy of the mumps component of the MMR vaccine declines with age and secondary infection is common. However, mumps in vaccinated individuals is less likely to lead to complications (including hospitalisation, orchitis and meningitis). In response to the outbreak information went to schools, colleges and the two universities on the signs and symptoms of mumps, actions to take if unwell and exclusion advice, as well as promotion of having two MMR vaccinations as the best way to avoid serious mumps infection as well as protecting the individual from measles and rubella. The public health message was also disseminated through some local media outlets.

6.2 During the winter season 2017/8 there were 20 flu outbreaks reported in Oxfordshire. Thirteen were confirmed positive for flu A or B or a combination of strains, 13 involved other respiratory outbreaks. Eighteen of the 20 outbreaks were reported in care homes. For influenza like illness outbreaks, public health advice is still to provide Tamiflu to care home residents prophylactically, as a preventive measure for those without symptoms, and for those with symptoms as treatment, if it can be delivered in a timely manner and is not contraindicated for the individual. Oxfordshire CCG are currently working with local providers to ensure that there is continued local support to respond to outbreaks in care homes.

6.3 Nationally there were elevated levels of notifications of scarlet fever in 2017/18 compared to previous years. Oxfordshire showed a similar pattern with over double the number of cases from October to April compared to the previous year (504 compared to 234 notifications). It is a cyclical disease so we would expect peaks every four years. However, from 2014 we have seen elevated numbers. It is not clear why this year is so high. It may be a combination of factors such as climate, behavioural patterns (increased awareness and attendance at GP practices), and incidence of predisposing viral factors such as chicken pox and influenza.

7**. Healthcare Acquired Infections (Lead Role Oxfordshire CCG)**
Clostridium Difficile (C.Diff.)
7.1 In 2017/8 there were 160 cases of C.Diff. reported. This was higher than the target threshold of 145 for the county. This was an increase on the previous year (135). The CCG are continuing to work with providers to improve the management of C.Diff.

Methicillin Resistant Staphylococcus Aureus (MRSA)
7.2 In 2017/18 there were 6 reported cases of MRSA which is an improvement on 2016/7 (8 cases).

7.3 Oxfordshire CCG continue to work with providers to continue the improvement on limiting and managing healthcare acquired infections.

8. **Environmental Health Issues (Lead Role District Councils)**
Air pollution continues to be a concern at both local and national level and gained more prominence. This has been discussed the health protection forum.

9. **Immunisation Programmes (Lead Role NHS England)**
Influenza Programmes
9.1 There were increased levels of flu locally and Nationally in the 2017/18 season. This was anticipated and did create pressures on the health system at local and national levels.

9.1.1 Child flu vaccinations 2016/17 Season
This year saw an increase in uptake of vaccinations in all children and extending the programme to year 4 children. The uptake in all ages of the programme was:

2-year-old children in Oxfordshire vaccinated 52.6% (last year 47.5%)
3-year-old children in Oxfordshire vaccinated 54.6% (last year 51.5%)
Reception year children in Oxfordshire vaccinated 73.7% (last year 41.2%)
Year 1 children in Oxfordshire vaccinated 71.2% (last year 68.3%)
Year 2 children in Oxfordshire vaccinated 72% (last year 64.2%)
Year 3 children in Oxfordshire vaccinated 67.9% (last year 63.5)
Year 4 children in Oxfordshire vaccinated 65.3% (new in 2016/17)

The ambition for 2018/9 is to extend the programme to offer vaccinations to year 5 children.

9.1.2 Adult flu vaccinations
There was improved performance in the adult programme on the previous year.

Adults aged over 65 in Oxfordshire vaccinated 75.5% (last year 73.8%)
Adults aged under 65 at risk in Oxfordshire vaccinated 52.4% (last year 52.4%)
Pregnant women in Oxfordshire vaccinated 58% (last year 52.8%)

9.1.3 Health and Social care workers
In the annual flu plan NHS England published a two-year Commissioning for Quality and Innovation (CQUIN) covering 2017/18 and 2018/19 which includes an indicator to improve the uptake of flu vaccinations for frontline healthcare staff within

providers. As in previous years, the national ambition is that a minimum of 75% of staff in trusts are vaccinated against flu. In 2016/17 the uptake amongst healthcare workers overall was 71.2%.

In November 2017 NHS England announced the inclusion of social care staff for the 2017/18 seasonal flu programme. The evaluation of this programme is being done by the National team. At time of writing the report, no data for the uptake in social care staff in Oxfordshire is available.

The inclusion of social care staff in the vaccination programme has been continued for the 2018/19 season.

10. Other Childhood vaccination programmes (Lead Role NHS England)

10.1 The performance of other childhood vaccinations is still generally performing similar to previous years of activity and is better that most areas in Thames Valley. The DPH and forum continue to monitor activity and ensure that the performance is maintained at an acceptable level. Vaccinations of note:

Measles

10.2 The number of children receiving the MMR vaccine aged 2 years was 95.0% which meets target uptake. However, the rate for MMR vaccination at 5 years was 90.4% (previous year 92.4%). The catch-up cohort of 5-year-old children continues to present challenges to improve on the uptake. The commissioning team have invested in staff to target this group and follow up on those who have not had a second MMR vaccination.

Rotavirus

10.3 The uptake of this vaccination in 2017/8 was 93.8% which was a continued improvement on the previous year's uptake of 93.6%.

11. Adult Vaccinations (Lead Role NHS England)

Shingles

11.1 The cohort for vaccination in 2016/17 was 70 & 78-year-old adults. The coverage of 70-year olds was 54.2% (58.0% in 2016/17). Coverage for 78-year olds was 57.6% (61.1% in 2016/17). The performance in Oxfordshire has seen a slight decrease on the previous year which has also been seen across Thames Valley and Nationally.

12. Screening Programmes (Lead Role NHS England)

Antenatal Screening Programmes

12.1 Programme activity continues to perform satisfactorily. Commissioners continue to work with the provider to improve on the avoidable repeat of blood spot tests. This has produced a reduction on the repeat tests from 4.8% to 2.8%. This is welcome but still above the target or 2%.

Bowel Screening

12.2 Screening is offered to people aged 60-74 years of age. The most recent annual data was in 2017 when 60.1% of the eligible population took up the offer of screening. This is an improvement on 2016 (58.3%) and is the same as regional levels of 60.1% it is better than national averages of 57.9%.

Breast Screening

12.3 This programme is available to women aged 50-70 every three years. Latest data showed that in 2017 78.6% of eligible women had a breast screen, slightly down from the previous year (79.3%). This is better than regional (76.9%) and National (75.4%) levels.

Cervical Screening

12.4 This programme is available to women aged 25-64. The percentage of those that took up the offer of screening in 2017 was 71.4 (72.5% in 2016). This is lower than regional (73.2%) and National (72.0%) levels. The uptake of screening in this programme still continues to struggle throughout the country.

Aortic Abdominal Aneurism Screening

12.5 This programme is available to men aged 65 to 74 over 10 years. Locally the programme screened in 80.1% 2016/17 (77.2% in previous year) of eligible individuals which exceeds the national target of 75%. However, this is below regional (81.3%) and National (80.9%) levels.

13. HIV and Sexually Transmitted Infections NHSE (Lead Role NHS England & Oxfordshire County Council)

HIV

13.1 Due to the advances in treatment, HIV is now considered a long-term condition and those who have HIV infection can now expect to have a longer lifespan than previously expected by HIV carriers. As such we expect to have more people living with HIV long term. 2016 data shows that there were 463 people diagnosed with HIV living in Oxfordshire, 233 out of these 463 live in Oxford City.

13.2 Early diagnosis of HIV is important as it improves the prognosis of treatment, reduces the cost of treatment and lowers the risk of transmission. Latest data for 2014-16 revealed that 25 cases of late diagnosis occurred in Oxfordshire.

13.3 The Sexual Health Services in Oxfordshire are now part of the National trial of Pre- Exposure Prophylaxis (PrEP) use being run by NHS England. The use of this PrEP in pilot programmes in London and other countries has been encouraging in seeing a reduction in new diagnoses of HIV in men who have sex with men.

Sexually Transmitted Infections (STIs)

13.3 Total rates of STIs in Oxfordshire are still below the national average except in the City which has remained at a similar rate since 2013.

Gonorrhoea

13.4 Gonorrhoea levels are below national average for Oxfordshire as a whole and all districts except in Oxford City. This is likely to be due to its younger age profile of the population in the city.

Chlamydia

13.5 Chlamydia levels continue to be lower than the national average in all Districts. The remodelling of Chlamydia testing to a more targeted programme to

better suit the local population has not seen any change to the local profile for chlamydia.

14. Blood Bourne Viruses

There were no major incidents locally to report.

15. Recommendations

The board are requested to consider the contents of this report on the health protection activity in the year 2017/18.

Annual Progress Report on Delivery of Domestic Abuse Strategic Recommendations

November 2018

Walking on egg shells. Hits the walls and doors. I'm not allowed to make decisions. I don't know what to do. Doesn't like me going out. The children are frightened. Calls me names. Shouts and swears at me. Pushes me. Threatens me. I'm so alone. Constantly texting me. Always checks how much I spend. I can't do anything right. Blames me for everything. It's all my fault. Lovely one minute, horrible the next. Turns my family against me. Tells me I'm a terrible mum. I'm scared. Accuses me of having affairs. Hurts our pet. Won't let me do what I want to do. Makes me feel like I'm crazy. Speaks for me. Silences me. Suffocates me. **Get help today. Call the Oxfordshire Domestic Abuse Service helpline: 0800 731 0055**

OXFORDSHIRE COUNTY COUNCIL

Annual Progress Report on Delivery of Domestic Abuse Strategic Recommendations

Purpose

This report is intended to provide the Health Improvement Board with an update on progress against the nine recommendations set out in Oxfordshire's Strategic Review of Domestic Abuse published late 2016 [link]. The report is intended to be an annual progress report but will also refer to elements of activity undertaken in 2017 to give a fuller picture on overall achievements. The final section of the report identifies our next steps in delivery.

Context

In 2016 a Strategic Review of Domestic Abuse was completed. This review took an in depth look at the occurrence of and services responding to domestic abuse in Oxfordshire. The review made a number of recommendations to be taken forward to ensure that the various agencies work together to deliver quality, consistent, safe and effective response for all those affected by domestic abuse. The recommendations focussed on working in partnership to provide the right services, taking steps to ensure robust measures are in place to protect and support victims and their families from the serious and significant harm and long-term impacts of abuse, and ensuring that this work is informed by actual experiences of people affected.

Both the Domestic Abuse Strategic and Operational Boards meet on a quarterly basis and both have sub groups which lead on certain aspects of their work. A regular reporting cycle to the Health Improvement Board is in place. Since the Strategic Review was published at the end of 2016, domestic abuse has become a key area of focus for partnership boards. In addition to the focus on domestic abuse by each of the Community Safety Partnerships in Oxford City and each of the Districts, domestic abuse has during the last year been one of 3 key priorities for the Joint Safeguarding Boards and it is also a priority for the Children's Trust.

The nine recommendations the Strategic Board has been focused on delivering are set out on page 65 of Oxfordshire Strategic Review of Domestic Abuse:

	Recommendations
1.	Endorse and implement a pathway of domestic abuse services based on the identified needs set out in this document (see page 58 - 60 for proposed pathway and service details)
2.	Implement the proposed new governance structure for domestic abuse (see pages 59 -60)
3.	Set up task & finish groups to consider (i) how to address "hidden" domestic abuse, (ii) improve prevention work, including work in schools and GP Practices (iii) multi-agency approaches and possible improvements to data capture in relation to domestic abuse including environmental scanning across the Thames Valley, (iv) the viability and effectiveness of a range of perpetrator interventions
4.	Adopt a co-commissioning approach that identifies resources, agrees a range of outcomes and measures success and implementation.
5.	Service user voice to be included in all service development and commissioning work considering the approaches highlighted in this Review and ensuring user voice reporting to both the domestic abuse operational group and to the domestic abuse strategic group.
6.	Strengthen connections both strategically and operationally between domestic abuse and sexual violence delivery.
7.	Training strategy for domestic abuse to be developed and co-funded to deliver multi-agency training
8.	Recommend that the Safer Oxfordshire Partnership develops a 5-year strategic plan for domestic abuse considering the funding for the sustainability of service provision and the longer-term outcomes for victims across Oxfordshire.
9.	Develop and implement an information strategy to ensure that appropriate and accessible information is accessible both to those affected and those responsible for responding to domestic abuse

Progress update

Progress on the delivery of each of the nine recommendations is set out under each recommendation heading written in bold.

No.	Recommendation
1.	**Endorse and implement a pathway of domestic abuse services based on the identified needs set out in Oxfordshire's Strategic Review of Domestic Abuse** • Pathway for adult victims and their families agreed and in place. • Domestic Abuse Pathway for Young people agreed and in place. Both pathways are available on the Oxfordshire Domestic Abuse Page. [link].
2.	**Implement a new governance structure for domestic abuse** • At the Domestic Abuse Summit in July 2017 a new governance structure was agreed and proposed to, and subsequently agreed by, the Health Improvement Board. In summary the governance is as follows: ➢ Domestic Abuse Operational Board, reporting to; ➢ Domestic Abuse Strategic Board, reporting to; ➢ Health improvement Board, reporting to; ➢ Health & Wellbeing Board ➢ Joint Safeguarding Boards hold Strategic Board to account taking the role of oversight and challenge • In addition to the above, over the past 12 months there have been reports (for information) to the Safer Oxfordshire Partnership, Housing Support Advisory Group and the Children's Trust. • OSCB/OSAB joint Boards have recently requested cross reporting with HIB: Interim proposal is that the DA Strategic Lead attends each of the next Local Community Safety Partnership meetings across the County to share progress on DA

	strategic delivery and respond to queries. • The Domestic Abuse Strategic Board has representation from key strategic stakeholders including children and adult social care, public health, Office of the Police and Crime Commissioner, Thames Valley Police, Chair of the Criminal Justice Board, health lead officers, Community Safety Partnership Leads and is chaired by the Lead for Children's commissioning. • The Operational Board benefits from a broad range of operational lead officers from of service delivery organisations and teams including both specialist domestic abuse providers and a wide range of public sector and voluntary and community sector agencies
3.	**Set up task & finish groups to consider key issues including "hidden" domestic abuse, prevention, improvements to data capture, the viability and effectiveness of a range of perpetrator interventions** • A "hidden abuse" task and finish group was established prior to the commissioning of new domestic abuse services and this work fed into the development of the new specification for services. • Black Asian Minority Ethnic and Refugee (BAMER) community development work funded from a central government grant is currently addressing "hidden abuse" within these communities in Oxfordshire and across the Thames Valley. • Thematic work of the Operational Board over the last 12 months includes: Programmes for victims and children, Perpetrator services and Prevention.
4.	**Adopt a co-commissioning approach that identifies resources, agrees a range of outcomes and measures success and implementation.** • At the Domestic Abuse Summit in July 2017 a co-commissioning approach was agreed *in principle.* • Resources from each of seven partners (Oxfordshire County Council, Oxford City Council, Cherwell District Council, West Oxfordshire District Council, Vale of White Horse District Council, South Oxfordshire District Council and the Office of the police and Crime Commissioner for the Thames Valley) was then identified and funding was committed by the end of August 2017 • Agreement was made by the commissioning partners to commission a range of domestic abuse services. • Procurement of new services took place between August and December 2017 with a preferred bidder being identified in the December.

	• Transition to new service model took place from January to May 2018 • Contract award to A2 Dominion following withdrawal by initial preferred bidder in May. • New contract delivering the new service model commenced 4 June 2018 • A partnership agreement was put in place with Oxfordshire County Council as lead commissioner. • Intensive support from OCC contract management team has been facilitating the service transition and monitoring services on how well they are delivering the outputs and outcomes agreed in the contract.
5.	**Service user voice to be included in all service development and commissioning work and ensure user voice included on both the domestic abuse Operational and Strategic Boards.** • Experts by Experience (people who have used domestic abuse services) have been involved in a range of commissioning and service development activities including: ➢ Attending visits to gather information on good practice elsewhere in the country ➢ Involvement in the tender by being part of the interview panel for prospective bidders. • Experts by Experience attend the Domestic Abuse Operational Board and take part in task and finish groups. • VOXY (the Voice of Oxfordshire Youth) held a domestic abuse consultation event on domestic abuse and young people in October this year and this was supported by the Strategic lead for domestic abuse and included a keynote speech from an expert by Experience.
6.	**Strengthen connections both strategically and operationally between domestic abuse and sexual violence delivery.** • The Operational Board is now regularly attended by representatives from sexual violence support agencies. • The Violence Against Women and Girls (VAWG) Co-ordinator links with a broad range of agencies on gender-based violence issues and delivers training to raise awareness with key professionals • The Strategic Board has just agreed to develop a broader strategy that aims to move in the direction of including all aspects of the Violence Against Women and Girls agenda including sexual violence and abuse within the next 5 years.

7.	**Training strategy for domestic abuse to be developed and co-funded to deliver multi-agency training** • Multi-agency training currently in place: Young People and Domestic Abuse, Designated MARAC (Multi-agency Risk Assessment Conference) Officer and Champions training • Single agency training in place e.g. Children's Social Care domestic abuse risk assessment training, police training • Currently in the process of co-designing (with our voluntary sector specialist training provider) modular multi-agency training which will include the following: ➢ Level 1 Domestic abuse awareness / appropriate referral ➢ Level 2 Responding to domestic abuse, understanding processes & procedures / roles and responsibilities ➢ Level 3 Risk assessment ➢ Level 4 Champions role • It will be based on a train the trainer approach to ensure efficient use of resource – existing Champions as trainers • Timeframes: Complete co-design December, Train the trainer early February, multi-agency mid Feb onwards
8.	**Recommend the development of a 5-year strategic plan for domestic abuse considering the funding for the sustainability of service provision and the longer-term outcomes for victims across Oxfordshire.** • The most recent meeting of the Domestic Abuse Strategic Board in November it was agreed that a working group would be established to meet in January 2019 to develop a 5-year strategy • The strategy will be developed with a view to extending the scope of the remit for the Strategic Board over the five-year period to include all elements of the Violence Against Women and Girls agenda.
9.	**Develop and implement an information strategy to ensure that appropriate and accessible information is accessible both to those affected and those responsible for responding to domestic abuse** • The recent Strategic Board meeting also agreed that a communications strategy should be developed in line with the priorities set out in the 5-year strategic plan referred to under actions set out under recommendation 8.

Next steps

The Strategic Board for Domestic Abuse has agreed to develop a five-year strategy that sets out a plan for each year with a view to broadening the remit from a purely domestic abuse focus to the broader focus of the Violence Against Women and Girls (VAWG) agenda as set out by central government in their VAWG Strategy. Building on the progress reported above, this document will set out the priorities for each year and ways of measuring whether these priorities have been achieved. It is proposed that this strategy forms the basis for future reporting to the Health Improvement Board with an annual report and quarterly updates on progress.

Sarah Carter
Strategic Lead for Domestic Abuse

9 November 2018

If you have any questions or comments you would like to raise in relation to any of the above or other domestic abuse related issues then please do not hesitate to contact me at Sarah.Carter@Oxfordshire.gov.uk

healthwatch Oxfordshire

Your voice on health and social care

1 Healthwatch England Healthwatch Network Awards 2018

Healthwatch Oxfordshire has won an award at the Healthwatch England national conference.

Celebrated every year, the Healthwatch Network Awards highlight the ways in which local Healthwatch organisations across the country have helped make people's views of health and social care services heard.

Healthwatch Oxfordshire was nominated for an award in the category 'Championing diversity and inclusion, Understanding the needs of a community that is seldom heard'. It won the 'Highly Commended'.

The nomination was for the video 'Patient Voices…Our Story', which Healthwatch Oxfordshire and local filmmaker Nicola Josse made with the Patient Participation Group of Luther Street Surgery, Oxford, and Oxford Health. This GP practice service the city's homeless population and the film highlighted how the patients themselves were getting involved to shape how services are run. Oli, Chair of the Luther Street PPG along with Rosalind Pearce, Executive Director of Healthwatch Oxfordshire presented the video at a workshop. The video was very well received and discussed widely at the workshop.

The film was made with a grant from NHS England's Celebrating Participation in Healthcare scheme.

Jane Mordue, Chair of Healthwatch England, said at the Awards Ceremony: "Last year, more than 341,000 people shared their views about where things could be improved in health and social care with the Healthwatch network.

"The Healthwatch Network Awards are a fantastic opportunity to celebrate this work, highlighting the difference local Healthwatch have made by using this wealth of intelligence to help decision makers target their efforts to make things better.

"This year we received some outstanding entries from the network with over 150 submissions. We were impressed by the quality and incredible range of work on show and they all highlight the real impact we can have when people's experiences are placed at the heart of the services they receive."

To watch the video view online at https://youtu.be/3ZLJ_G-3QMw or visit our web site www.healthwatchoxfordshire.co.uk

2 Reports published

Since we last reported to Health and Wellbeing Board in March 2018, Healthwatch Oxfordshire has published our annual report 2017/18 which can be found by following this link https://healthwatchoxfordshire.co.uk/our-reports/annual-

reports/ . A summarised version is available here: https://healthwatchoxfordshire.co.uk/our-reports/healthwatch-oxfordshire-reports/ together with a review of our activity between April and end June 2018. We have published two reports on Enter & Views of care homes in the county. The following sections give more detail on our research and listening activities in Wantage, and around access to dentists in care homes and to NHS dentists in the county.

2.1 Dentistry

Healthwatch Oxfordshire has published two reports about access to NHS dentistry:

a. 'Treatment only when needed: Dental services in Care Homes' was published in August 2018. The report details our findings of a survey carried out of all the care homes in Oxfordshire. One in five care homes responded and the main findings are that nearly half people living in the care homes did not access dentistry at all; there are significant gaps in provision; and that some care homes struggle to obtain dental services for their residents.
b. 'Filling the Gaps – Access to NHS dentistry' was published in September. This research was prompted by at we heard in Bicester in October 2017. We decided to look more deeply into the issue and ask ourselves further questions:

- What is the public's experience of using dentistry services?
- Is access to NHS dentistry a problem in other areas of Oxfordshire?
- What is working well?
- Are there barriers to people accessing NHS dentists?
- Are there areas for improvement that the dental surgeries and / or commissioners could address?

To find out the answers to these questions, between October 2017 and May 2018 we launched a county-wide project focusing on NHS dentistry. The main findings of the research fell into two categories – access to NHS dentists, and information about dentistry.

Both reports can be found here https://healthwatchoxfordshire.co.uk/our-reports/healthwatch-oxfordshire-reports/

Healthwatch Oxfordshire invited key stakeholders to a workshop on 17th September to discuss our findings and begin to identify how they can be addressed. The main outcome was agreement by the attendees to work together to develop an assessment tool for use by care homes to identify and put in place dental needs of individual residents.

It is worth noting that NHS England commissioners for dental services did not attend the workshop but have expressed interest in working in the future with Healthwatch Oxfordshire and other stakeholders.

2.2 Wantage

The report on our focussed activity in Wantage in May this year has now been published together with the responses from Oxfordshire County Council and jointly from Oxfordshire Clinical Commissioning Group and Oxford Health NHS Foundation Trust https://healthwatchoxfordshire.co.uk/our-reports/healthwatch-oxfordshire-reports/ The report highlighted What we heard in five themes and made four recommendations. The themes were:

1. There is concern about insufficient provision at the Wantage Health Centre on Mably Way;
2. There is concern about the new houses being built without the additional resources;
3. Public transport has been reduced and no longer meets some residents' needs;
4. Residents would like to see the Community Hospital be reopened;
5. GP's don't always refer to CAMHS quickly enough and the waiting lists are long when they do.

Recommendations

1. Improved communication between Oxfordshire Clinical Commissioning Group and the people of Wantage about the expansion of the Health Centre - what is the reality of the situation?
    a. Healthwatch has asked Oxfordshire Clinical Commissioning Group for the latest on the proposed developments and the response given on 3rd September 2018 was:
2. Open dialogue between Oxford Health NHS Foundation Trust and the community about the closure of the Community Hospital.
3. Increased mental health awareness training for GPs.
4. When planning local health, social care services, and additional housing, authorities should consider the travel and transport needs of the local community including access to public transport and supporting local community transport schemes.

3 Health Overview Scrutiny Committee

3.1 Oxfordshire Joint Health Overview and Scrutiny Committee MSK/Healthshare Task and Finish Group

Healthwatch Oxfordshire reported to the Task & Finish Group, presenting a report that collated patient stories and information gather from patients from our Feedback Centre and telephone calls. The stories we heard were so disturbing that we decided to publish our report without further delay.

In total we have heard from more than 50 patients, all often describing a dire patient experience, summarised as follows:

- confusing and poor communication between Healthshare and the patient;
- often long and complicated patient experience through from GP referrals, Healthshare, to GP referral, to Healthshare, to hospital, back to Healthshare, referrals…and so it goes on;
- people not being able to contact Healthshare by telephone despite frequent, and often over a long period of time, making calls; emails not being answered;
- patients not knowing where to go to make a complaint;
- long waiting times for appointments.

The report outlined our key concerns and recommendations as follows:

1. Constant problems with accessing Healthshare telephone number
    a. Increase capacity at Healthshare to answer calls within agreed time
    b. Do not let people hang on waiting for reply then cut them off!
    c. Offer a call back system
2. Patients not receiving written confirmation of appointment time and location
    a. Automated letter sent within 24 hours of when appointment made with contact number and email for cancellation / further information
    b. Use mobile telephone text for confirmation and reminder
3. Patients are being asked to travel substantial distances to appointments
    a. Review of locations of service considering where people live who are being referred
    b. First choice appointment offered at closest location – ask the patient as they will know travel / public transport needs
4. Information about Healthshare not given to patients on referral – confusion arises about whether this is an NHS service or not and how to contact them prior to receiving 'welcome' letter
    a. General Healthshare leaflet given to all patients referred by GP to include contact number, email, commitment to contact within set time
5. The Healthshare complaints procedure, including how to complain, should be accessible on the web site and in paper form. Patients who file a complaint should then be responded to stating whether Healthshare are treating this as a formal complaint.
    a. Healthshare must be required to report to OCCG on complaints received.
    b. Healthshare should place the Healthwatch Oxfordshire widget on their web site, thus giving patients a route to an independent voice.
6. 'How are we doing?' is **not** part of a complaints procedure.
    a. Healthshare should be required to report to OCCG analysis of 'How are we doing?' not just on the patient survey.
7. Patient satisfaction survey does not ask any questions about the referral process or administration.

a. Healthshare Patient satisfaction survey must include questions about the referral process, and communication between Healthshare and patient.

Prior to publication the report was sent to Oxfordshire Clinical Commissioning Committee and Healthshare Ltd for comment and response. All the recommendations were accepted or already being acted upon. Three recommendations are to be implemented by 19th October. These are:

- Formal complaints procedure and information to be clearly available on the Healthshare website
- Healthshare to include in its monitoring information what they have heard from their 'Tell us how we are doing' form
- The inclusion of questions about the referral process to be included in the Patient Satisfaction survey questionnaire.

Our report and the responses from Oxfordshire Clinical Commissioning Group and Healthshare Ltd can be found here https://healthwatchoxfordshire.co.uk/our-reports/

The promised improvements in the telephone service, and communications between the service and patients will be monitored closely by Healthwatch Oxfordshire.

4 Healthwatch Oxfordshire activities

4.1 Community Support Services and voluntary sector day centres review

One of Healthwatch Oxfordshire's main projects to date this year is a review of people's experiences of going through the service changes to community support services – day centre support – across the county. In October 2017 major changes were made to access and operational aspects of day centre provision, including eligibility, transport and a single service for elderly and people with learning disability.

Healthwatch Oxfordshire staff are visiting the eight County Council Community Support Service centres and six voluntary sector day centres talking to service users and staff to understand their experiences through this change. We have surveyed 800 people who used day centres prior to the changes in 2017. This project has taken over nine months to design – working with the County Council and Age UK Oxon – and is now in full flow.

A final report will be published in time to present to Joint Oxfordshire Health Overview & Scrutiny Committee (HOSC) in February 2019.

4.2 Abingdon pop-up shop

For the first time ever Healthwatch Oxfordshire opened a pop-up shop in a local town. Over four days at the end of August we located two members of staff and a volunteer in Abingdon town centre. Promoting Healthwatch Oxfordshire and encouraging members of the public to come and tell us their experiences of health and social care services. We contacted more than 100 people and learned some good lessons from this approach that will be applied when the team is next out and about in the community.

4.3 Patient Participation Group (PPG) support

July to end of September, we have supported 10 locality forum meetings and three events. With staff changes in mid-September the whole team at Healthwatch has continued to support the forum.

4.4 Project fund - voluntary

All five approved projects being led by community-based organisations are progressing well. Veronica Berry, the Healthwatch Oxfordshire Project lead is giving support, advice, and keeps regular contact to ensure that the projects are completed on time. The first two reports will be available from the end of October, with all reports planned to be published by the end of November.

4.5 Enter & View[1]

Enter & View reports on Beech Court Nursing Home and Ramping Cat Care Home are published on our website and available here.

4.6. Hospital Signage

After a lengthy campaign by Healthwatch, improved signage has been installed at the JR, providing designated parking spaces for hospital transport vehicles, and better publicinformation about the services available from the Patient Advice and Liaison Service (PALS).

5 External meetings attended since July 2018

The following list includes meeting attended by the Executive Director, Chair, Board members representing Healthwatch Oxfordshire, and members of the Healthwatch Oxfordshire staff team. The list does not include groups and organisations contacted as part of our listening / outreach activity.

[1] Enter & View - The Health and Social Care Act allows local Healthwatch authorised representatives to observe service delivery and talk to service users, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies.

- West Oxfordshire District Council – Cllr Baker, Cllr MacRae, Health and Wellbeing
- Locality Forum Chairs & Oxfordshire Clinical Commissioning Group (in attendance)
- Health Overview & Scrutiny Committee – 20th September
- Health Overview & Scrutiny Committee – Task and Finish Group – MSK/Healthshare
- Health & Wellbeing Board – workshop
- Health Improvement Board – Healthwatch Ambassador
- The Children's Trust – Healthwatch Ambassadors
- Oxfordshire Adults Safeguarding Board 26th September full Board meeting & joint meeting with Oxfordshire Children's Safe Guarding Board
- Oxfordshire Clinical Commissioning Group – Primary Care Commissioning Committee (non-voting member)
- Cherwell Partnership Network (member)
- Teleconference with Care Quality Commission managers
- Health Inequalities Commission – Implementation Group

6 Media

Since July 2018 Healthwatch Oxfordshire has received 32 requests for comments from the media; we have had 21 individual items of media coverage including radio, television and local newspapers. Stories that have received media coverage include:

- Dentistry in Care Homes
- Healthwatch Oxfordshire Board meeting in public in Wantage
- Potential closure of Cogges GP surgery in Witney
- A&E expansion at John Radcliffe Hospital
- Healthwatch Oxfordshire Annual Report
- Healthwatch Oxfordshire pop-up shop in Abingdon
- 10am-10pm hospital visiting hours.

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Health and Wellbeing Board

Draft letter from Oxfordshire Health and Wellbeing Board and Health Improvement Board to the Secretary of State for Health and Social Care, The Rt Hon Matt Hancock MP

Introduction
Following discussion at the Health Overview and Scrutiny Committee and Oxfordshire County Council, the Health and Wellbeing Board and Health Improvement Board are asked to consider writing to the Secretary of State for Health and Social Care to raise issues relating to prevention of ill health through alcohol consumption and increased levels of obesity.

A draft of the letter is set out below

Recommendation:

1. **Members of the HWB are asked to comment and approve the content of the letter**
2. **The Chairman of the Health Improvement Board is requested to take the draft to the next meeting of that board for comment and approval before it is sent.**

Draft letter:

Dear Secretary of State

The Oxfordshire Health and Wellbeing Board and its sub-partnership, the Health Improvement Board, would like to raise the issues of alcohol pricing and fast food advertising. We perceive that these issues are adversely affecting the health of our population and we would like to ask for your consideration of what can be done at national policy level to address this.

In Oxfordshire we have a systematic approach to reviewing population health through our Joint Strategic Needs Assessment. This has highlighted a range of priority issues which we are addressing though our Joint Health and Wellbeing Strategy. These priorities include alcohol related ill-health and increasing numbers of overweight and obese adults in the population. These topics have also been a subject of discussion at our Health Overview and Scrutiny Committee recently. We realise these are familiar national issues and welcome your recent announcements on the importance of prevention for improved population health.

However, in addition to preparation for the Green Paper, we would specifically like to ask you to consider further national policy options for alcohol harm reduction, including minimum unit pricing. This is likely to have an impact on the most complex and harmful drinkers in our population and would be a welcome national intervention to complement our well-regarded local outreach and treatment services.

In addition, we would welcome a national approach to curtailing advertising and promotion of “unhealthy” foods (containing high levels of fat and/or sugar, including

many fast foods). National measures to introduce an advertising ban through a range of media before 9pm would be a good development. The impact of advertising on children and families is well documented and a policy change would give a boost to our local efforts to establish a Whole System Approach to obesity.

I hope you will consider these suggestions for population health improvement.

Yours sincerely

Ian Hudspeth, Chairman, Oxfordshire Health and Wellbeing Board and Leader of Oxfordshire County Council.

Kiren Collison, Vice Chairman, Oxfordshire Health and Wellbeing Board and Clinical Chair, Oxfordshire Clinical Commissioning Group

Cllr Andrew McHugh, Chairman, Health Improvement Board and Cherwell District Council Executive Member for Health and Wellbeing.

Health Improvement Board
Forward Planning
Draft for discussion

Proposed Dates of meetings for 2019-20

1. 14th February 2019
2. 16th May 2019
3. 12th September 2019
4. 21st November 2019

All meetings will be from 1400-1600 and held at Oxford Town Hall

The following elements make up the forward plan

1. Standing items for each agenda
2. Regular reports from working groups
3. Specific items on relevant topics

1. Standing items	When to schedule	Note
Performance dashboard	Every meeting	
Performance report cards (on areas of concern e.g under performance)	As needed	
Minutes of the last meeting	Every meeting	
Forward plan	Every meeting	
Healthwatch Ambassador update	Every meeting	
Director of Public Health Annual Report	Annually - Autumn	
Joint Health and Wellbeing Strategy refresh	Annually - Spring	
Joint Strategic Needs Assessment	Annually - Spring	

2. Regular Reports from working groups (and frequency of reporting)	When to schedule	Note
Domestic Abuse Strategy Group (every meeting)	Update February 2019	Annual report Nov 2018
Active Oxfordshire (twice a year)	Feb 2019	Last report Sept 18
Mental Wellbeing Working group (once a year)	Feb 2019	New group to be convened.
Affordable Warmth Network (once a year	Feb 2019	Last reported Sept 2017
Housing Support Advisory Group (twice a year)	May 2019	Last reported Nov 2018
Healthy Weight – whole systems approach (once a year)	May 2019	New group to be convened
Social prescribing	Suggest May 2019?	CCG convene

(Tbc)		network meetings
Healthy Place making (Tbc)	National publication due April 2019. Report to HIB May 2019	Last report Sept 18 Working arrangements tbc
Making Every Contact Count (Tbc)	Sept 2019	Last report Sept 2018
Tobacco Control Alliance (Once a year tbc)	Nov 2019	Last reported Nov 2018
PH Health Protection Forum (once a year)	Nov 2019	Last reported Nov 2018

3. Specific topics / one off reports	**When to schedule**	**Note**
Alcohol – health related harm	May 2019	We have just agreed this as a new topic and will need a scoping / discussion document to agree the focus
Campaigns	tbc	Discussion and scoping Nov 2018
Intergenerational Concordat	February 2019	Following a conference in October 2018
Men's Health Report – to be presented by the Men's Health Group	February 2019	Research on take up of Health Checks by BAME men funded via Healthwatch voluntary sector grant