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, 3 July 2025 at 2.00 pm

Room 2&3 - County Hall, New Road, Oxford OX1 1ND

If you wish to view proceedings online, please click on this Live Stream Link.

Martin Reeves
Chief Executive

Contact Officer: ***Taybe Clarke-Earnscliffe***
email: Taybe.Clarke-Earnscliffe@Oxfordshire.gov.uk

Membership

Chair – Councillor Helen Pighills
Vice Chair - District Councillor Joy Aitman

Board Members:

Cllr Helen Pighills	Vale of White Horse District Council
Cllr Georgina Heritage	South Oxfordshire District Council
Cllr Rachel Crouch	West Oxfordshire District Council
Cllr Nathan Ley	Cabinet Member for Public Health & Equalities, Oxfordshire County Council
Cllr Chewe Munkonge	Oxford City Council
Cllr Rob Pattenden	Cherwell District Council
Ansaf Azhar	Director of Public Health, Oxfordshire County Council
Kate Holburn	Consultant in Public Health/Deputy Director, Oxfordshire County Council
Mish Tullar	District Partnership Liaison
Daniel Leveson	ICB Place Director
Robert Majilton	Healthwatch Oxfordshire Ambassador

Notes: Date of next meeting: 18 September 2025

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 Chair

2. Apologies for Absence and Temporary Appointments

3. Declaration of Interest - see guidance note opposite

4. Petitions and Public Address

5. Notice of Any Other Business

14:03 to 14:05

To enable members of the Board to give notice of any urgent matters to be raised at the end of the meeting

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

To approve the Note of Decisions of the meeting held on (**HIB5**) and to receive information arising from them.

7. Performance Report (Pages 9 - 16)

14:10 to 14:20
10 minutes

Presented by Panagiota Birmpili, Public Health Registrar, Oxfordshire County Council

8. Report from Healthwatch Ambassador (Pages 17 - 20)

14:20 – 14:30
10 minutes

Presented by Robert Majilton, Healthwatch Oxfordshire Ambassador

9. Mental health hubs in providing interfaces in highstreets (Keystone programme) (Pages 21 - 44)

14:30 – 14:50

Presented by Tasmin Irving, Oxford Health

10. Break - 14:50 - 14:55

11. Community Health and Wellbeing Model CHDOs (Pages 45 - 58)

14:55 – 15:20

Presented by Kate Austin, Public Health Principal, Public Health and Community OCC, Fiona Ruck, Health Improvement Practitioner, Oxfordshire County Council, Community Health Development Officers (CHDO's)

12. Local area coordination, Community link workers and the prevention strategy (Pages 59 - 66)

15:20 – 15:45

Presented by Ian Bottomley, Commissioning Manager Age Well, OCC

13. AOB

15:50 – 16:00
10 Minutes

HEALTH IMPROVEMENT PARTNERSHIP BOARD

OUTCOMES of the meeting held on 6 February at 14:00

Present:	Cllr Chewe Munkonge, Oxford City Council
Board members	Ansaf Azhar, Director of Public Health
	David Munday, Consultant in Public Health, Oxfordshire County Council (Lead Officer)
	Dan Leveson, Place Director for Oxfordshire, BOB ICB
	Cllr Chewe Munkonge, Oxford City Council
	Cllr Rob Pattenden, Cherwell District Council
	Cllr Rachel Crouch, West Oxfordshire District Council
	Cllr Georgina Heritage, South Oxfordshire District Council
In attendance	Bethan McDonald, Public Health, Consultant in Public Health in Data and research. Oxfordshire County Council
	Katherine Howell, Healthwatch Oxfordshire
	Josh Lenthall, Chief Executive, Active Oxfordshire
	Derys Pragnell, Consultant in Public Health,
	Yasmin Illsley, Public Health Principal
	Clare Grey, Health Improvement Practitioner
	Sam Keyte, Senior Campaigns Manager Bite Back
	Poppy Gould – Young Person who took part in the Bite Back project
	Olivia Clymer, Director of Strategy and Partnerships at Oxford University Hospitals,
	Emma Hayes, Service development manager, Here for Health Oxford University,
	Nicole Satullo, Palliative Care Nurse
Officer:	
Apologies:	

Robert Majilton, Healthwatch. Taybe Clarke-Earnscliffe, Business Support Team Leader, Minute taker, Oxfordshire County Council

ITEM
1. **Welcome** Chair welcomed the participants to the Health Improvement Board meeting. Chair noted this was Dr Sam Harts last Health Improvement Board meeting and Dr Sam Hart was thanked for all his hard work and contributions over the years. It was also noted that this is David Munday's last meeting, Ansaf Azhar acknowledged David's contributions to public health in Oxfordshire, highlighting his journey from consultant to Director of Public Health at Buckinghamshire Council and expressing gratitude for his efforts in health improvement and partnership forums. **Health and Well-being Boards:** Changes in the health and well-being boards were discussed, including the need to fill the vice chair position. The integrated care boards have decided that one of the chiefs (nursing officer, delivery officer, medical officer, or dental officer) will take a place-based role. Matthew Tait, the Chief Place Officer for Oxfordshire ICB, will take this role. **GP Lead Role:** Michelle Brennan has taken the GP lead role in the Oxfordshire Health and Well-being Board. **Vice Chair Position:** There is still a gap in the vice chair position, which often takes the clinical lead role. Discussions are ongoing about who will fill this role. **Dan Leveton's Role:** Dan Leveton, who has done significant work in the partnership space, is taking on more of an ICB role while still leading for place. He will be less visible at the place partnership level but will still be involved as necessary.
2. **Declarations of Interest** There were no declarations of interest.
3. **Petitions and Public Address** There were no petitions and public address.
4. **Notice of any other business**

6. **Minutes of Last Meeting**

All signed off as correct.

7. **Performance Report**

Presented by Bethan Mcdonald, Consultant in Public Health in Data, intelligence and research, Oxfordshire County Council

Performance Report:

Childhood Obesity:

- Year 6: 32% of children measured in Year 6 are overweight or obese, a significant increase from pre-pandemic levels (30%). Inequalities exist within the county, with rates ranging from 17% in North Central Oxford to 43-45% in areas like Littlemore and Rose Hill.
- Reception: 19.3% of children in reception are overweight or obese, similar to pre-pandemic levels. Inequalities are also present, with rates less than 10% in North Central Oxford and more than 25% in Littlemore and Rose Hill.

Premature Mortality from Cardiovascular Disease:

- The rate is currently 53 per 100,000, showing no significant change over the last 10 years. Local activities include work around physical activity, healthy weight, and tobacco control.

Smoking in Pregnancy:

- The rate is 5.5%, above the target of 5.1%. There is a steadily declining trend over the last five years, supported by initiatives like the maternity tobacco dependency advisor service and local stop smoking service.

Alcohol Treatment:

- Completion and progress indicators remain above target and national averages, with 60% completions and 74% treatment progress. Programs take a holistic, person-centered approach.

Physical Activity:

- 20.6% of adults do less than 30 minutes of physical activity a week, stable over the last four years but above the target of 18%. Programs like Active Oxfordshire and Move Together support increased physical activity.

Depression Diagnosis:

- A new indicator for the percentage of patients aged 18 and over with newly diagnosed depression is being tracked, replacing the previous indicator on adult patients recorded with depression.

8. **Report from Healthwatch Ambassador**

Presented by Katherine Howell, Healthwatch Oxfordshire Ambassador

Healthwatch Report:

- **Urgent and Emergency Care Survey:**
  - A survey was launched to understand people's experiences navigating urgent and emergency care services, including 111, 999, emergency departments, and MIUs. Initial findings indicate that 111 is increasingly becoming the first port of call for many people.
- **Women's Health Services:**
  - Reports are being compiled based on feedback from 600 women, highlighting issues such as lack of support for menopause and pain management for gynaecological conditions like endometriosis.
- **Men's Health:**
  - Feedback from men, particularly working-age men, indicated barriers to seeking health care, including work pressures and difficulty getting GP appointments.
- **Community Insight Profile:**
  - A profile for Wood Farm and Town Furze was developed, revealing significant differences in people's experiences based on factors like housing tenure, income, mobility, and access to affordable, healthy food.
- **Enter and View Visits:**
  - Reports were published from visits to White Horse Medical Practice, Abingdon Hospital, and the discharge lounge at the JR, among others.
- **Outreach Activities:**
  - Healthwatch engaged with various groups, including refugee support groups and the lived experience advisory forum for people with homelessness experience.
- **Webinars:**
  - Recent webinars covered topics like men's mental health, GP surgery staff roles, and the NHS 10-year plan on digital transition. Upcoming webinars will focus on mental well-being support for children and young people.

9. Healthy Weight Environments

Presenters Derys Pragnell, Consultant in Public Health, Yasmin Illsley, Public Health Principal, and Clare Grey, Health Improvement Practitioner, Sam Keyte – Senior Campaigns Manager Bite Back, Poppy Gould – Young Person who took part in the Bite Back project

Healthy Weight Environments Minutes:

- **Introduction and Overview:**
  - Yasmin Illsley, a public health principal, provided an overview of the whole systems approach to the healthy weight agenda, focusing on support, prevention, healthy weight, and system leadership.
  - The all-age health weight management program commenced on October 1st, offering various services, including commercial and specialist groups.
- **Environmental Impact:**

- Emphasis on shaping and influencing the environment to make healthy options more accessible.
- Introduction of a healthier out-of-home food officer to engage with businesses and the public to promote healthy food options.
- Strategic school food and physical activity officer to enhance food and physical activity opportunities in schools and workplaces.

- **Advertisement and Planning:**
  - Discussion on the impact of unhealthy food advertisements in public spaces and the need for policy changes to limit such advertisements, especially near schools and youth congregating areas.
- **Biteback Project:**
  - Sam Kayte from Biteback introduced the project, which aims to change how food is made, marketed, and sold, involving young people in policy discussions.
  - Poppy Gould, a sixth form student, shared her experiences and the challenges young people face with junk food advertising and availability.
- **Key Points from Poppy Gould's Presentation:**
  - Highlighted the pervasive presence of junk food in schools and towns, making it difficult for young people to make healthy choices.
  - Emphasized the need for better control over junk food advertising and the importance of providing healthier options.
- **Discussion and Comments:**
  - Ansaf Azhar highlighted the urgency of addressing the food environment and leveraging planning and advertisement regulations to reduce the prevalence of unhealthy food options.
  - Cllr Rachel Crouch shared her observations about changes in fast food options and the importance of education in schools.
  - Claire Gray emphasized the need for easy policy changes to restrict junk food advertising and manage new hot food takeaways near schools.

10. Oxfordshire on the Move and Place Universal Offer

Presented by Josh Lenthall, Chief Executive, Active Oxfordshire

Active Oxfordshire Discussion Minutes:

- **Introduction:**
  - Josh from Active Oxfordshire presented an overview of their initiatives and the impact of their programs.
- **Whole System Approach:**
  - Focus on a whole system approach to physical activity, emphasizing collaboration with various partners and targeting inequality.
  - Key programs include U Move and Move Together, which cater to families with children on free school meals and individuals with long-term health conditions, respectively.
- **Impact and Successes:**

- Move Together program has shown significant impact, including a 50% reduction in GP appointments for participants.
- The program has saved approximately 8,000 GP appointments, freeing up capacity for other patients.
- Participants in the program have shown a reduction in falls and an increase in physical activity levels.

- **New Opportunity:**
  - Introduction of the Place Universal Offer, with Sport England investing £630,000 over three years to improve capacity and capability in Oxfordshire.
  - The focus will be on creating conditions for the system to work effectively, with an emphasis on trust, community involvement, and reducing inequality.
- **Discussion Points:**
  - Importance of involving the Health Improvement Board in the work and identifying any missed opportunities for collaboration.
  - Emphasis on the need for systemic change and the role of physical activity in addressing broader health and social issues.
- **Comments and Questions:**
  - Katherine Howell from Healthwatch highlighted the importance of addressing safety concerns in areas like Wood Farm to encourage physical activity.
  - Dr Sam Hart emphasized the need for self-referral and de-medicalization of physical activity interventions.
  - Ansaf Azhar discussed the importance of evaluating the long-term impact of the Move Together program and scaling successful initiatives.

11. Prevention Activity in the OUH

Presented by Olivia Clymer, Director of Strategy and Partnerships at Oxford University Hospitals, Emma Hayes, Service development manager, Here for Health Oxford University, Dion Surname?, ED Consultant, Nicole Satullo, Palliative Care Nurse

Prevention Activity in Oxford University Hospitals (OUH):

- **Here for Health Service:**
  - Provides personalized support to patients, staff, and visitors to improve health literacy and encourage lifestyle changes.
  - Conducted over 5,000 lifestyle conversations and made over 1,000 referrals to specific support services in 2024.
  - Delivered over 500 NHS health checks for staff in partnership with Health Checks Oxfordshire.
  - Involved in active travel projects to increase cycling confidence and accessibility for OUH staff.
- **High Intensity Service (HIS):**
  - Focuses on patients who frequently use healthcare services due to health anxiety, mental health issues, or long-term conditions.

- Aims to break the cycle of frequent healthcare use and improve patient outcomes.

- **Alcohol Care Team:**
  - Provides face-to-face interventions in the emergency department to educate staff and patients about alcohol-related issues.
  - Links with community partners to offer comprehensive support.
- **Homeless Improvement Team:**
  - Works with patients experiencing homelessness to provide social support and avoid unnecessary hospital admissions.
- **Hospital Navigator Program:**
  - Focuses on youth aged 15-25 to address issues related to exploitation, gang violence, and drug use.
  - Utilizes "reachable moments" in the emergency department to intervene and provide support.
- **Palliative Care Service:**
  - Aims to improve the quality of life for patients with life-limiting illnesses and their families.
  - Provides symptom management, psychosocial support, and maintains patient independence.
  - Offers bereavement support to families, which has been life-saving for many.

12 Any other Business

Next meeting July TBC

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Health Improvement Partnership Board

3rd July 2025

Performance Report

Background

1 The Health Improvement Partnership Board has agreed to have oversight of delivery of two priorities (priorities 3 and 4) within Oxfordshire's Joint Health and Wellbeing Strategy 2024-2030, and ensure appropriate action is taken by partner organisations to deliver the priorities and shared outcomes. An important part of this function is to monitor the relevant key outcomes and supporting indicators within the strategy's outcomes framework. This HIB performance report has therefore been edited to reflect the relevant measures and metrics from the outcomes framework.

2 The indicators are grouped into the overarching priorities of:

3 Healthy People, Healthy places

- 3.1 Healthy Weight
- 3.2 Smoke Free
- 3.3 Alcohol related harm

4 Physical activity and Active Travel

- 4.1 Physical Activity
- 4.2 Active Travel
- 4.3 Mental Wellbeing

Current Performance

3 The table report below show the agreed measures under each priority, the latest performance available and trend in performance over time. A short commentary is included to give insight into what is influencing the performance reported for each indicator.
Where data is available at sub-Oxfordshire level, this is indicated with * for District and ‡ for MSOA level.

4 All indicators show which period the data is being reported on and whether it is new data (*refs numbers are highlighted*), or the same as that presented to the last meeting.

Of the 25 indicators reported in this paper:
9 indicators have NEW DATA *(Reference Numbers are highlighted in the report)*
These are: ***3.11, 3.15, 3.16, 3.31, 3.32, 3.33, 3.34, 4.12, 4.34***
1 indicator(s) without rag rating.
17 green indicator(s).
6 amber indicator(s).
1 red indicator(s).

4.12 Percentage of physically inactive children - (less than average of 30 minutes a day)

There are data quality concerns with this indicator and therefore viewed with caution. Public health will lead a Physical activity Health Needs Assessment in 2025/26 to better understand the data, gaps in provision and local .

Live Well Priorities

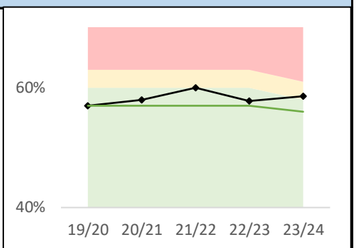
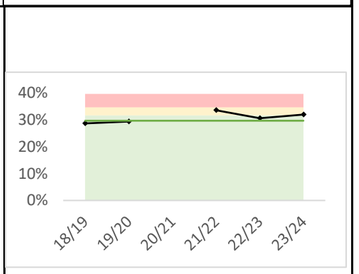
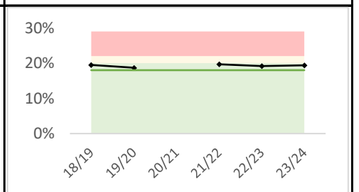
New data is indicated by highlighted references number.

Targets set by local Public Health

All metrics are reported at county level. Available at District * and MSOA ‡ level

Key

Supporting

		Frequency	Target	Reporting Period	Value	RAG	Commentary	Trend Chart
3	**Healthy People, Healthy places**							
3.1	**Healthy Weight**							
3.11	Adults (aged 18 plus) prevalence of overweight (including obesity) *	Annual	56.0%	23/24	58.6%	A	As part of the whole systems Approach to Healthy weight, a detailed action plan focuses on the following pillars: Prevention, environment, support and wider strategy. A New All age healthy lifestyles came into effect in September 2024. The number of adults people benefiting from this service is now increasing following a slow start. This includes targeted work to support Global Ethnic Majorities, those with low to moderate mental health condition and men – all of whom may otherwise not traditionally benefit from such services. Work continues across the system to improve the food environment in priority neighbourhoods through working with planning, advertising at city and district level and established food businesses is building moment	
3.12	Year 6 prevalence of overweight (including obesity) * ‡	Annual	28.0%	23/24	32.0%	A	In Oxfordshire, latest data (23/24) shows for year 6 there has been a very slight (not statistically significant) increase in excess weight over the last year though trend is fairly level. For this age group excess weight fell from 34% to (21/22) to 31% (22/23) then to 32% 23/24 Oxfordshire performs well against the England average generally, but there are some areas in Oxfordshire where children have experienced excess weight over a long period. A new all age healthy weight service launched in September with a focus on addressing inequalities associated with weight. For children, there is the option of both group sessions within the community and remote programmes to support them and their family to create healthy habits. Work to support more healthy environments continues.	
3.13	Reception prevalence of overweight (including obesity) * ‡	Annual	16.6%	23/24	19.3%	A	There has been a very small increase in Reception overweight and obesity which is similar to pre- pandemic levels in 2018/2019. Work is continuing to address this through the whole systems approach to healthy weight action plan and specific programmes such as You Move and the brand new, all age weight management service Beezee, which came into effect on 1st September 2024.	
3.14	Achievement of county wide Gold Sustainable Food Award	Annual	Gold	2023	Silver	G	**Application delayed until next year, 2026.** Working towards Gold award by continuing to develop and grow activities across all the key issues and gather evidence; showing exceptional achievement in two areas. This will involve: launching a campaign to signal our goal of achieving Gold , promoting a county-wide effort, engaging with high profile ambassadors and creating ways people can engage e.g. pledge.	Not applicable

Live Well Priorities

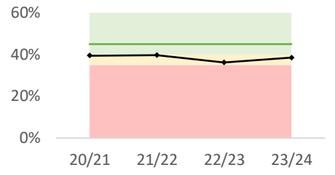
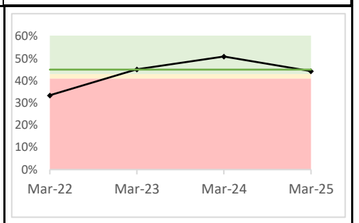
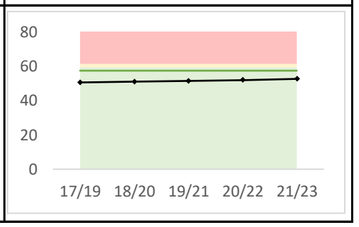
New data is indicated by highlighted references number.

Targets set by local Public Health

All metrics are reported at county level. Available at District * and MSOA ‡ level

Key

Supporting

		Frequency	Target	Reporting Period	Value	RAG	Commentary	Trend Chart
3.15	Percentage of adults aged 16 and over meeting the '5-a-day' fruit and vegetable consumption recommendations *	Annual	45.0%	23/24	38.6%	A	A range of initiatives to support access to good food as part of the healthy weight agenda continues. From working with food retailers directly, to action plans lead by the districts and most recently a food Summit, Lead by Good Food Oxfordshire in June 2025 in which our director of Public Health is chair, to ensure continued and new commitment across the system. Programmes of support for children and young people also continue, with the view that healthy habits – such as eating 5-a-day can start early and continue into adulthood.	
3.16	Of those residents invited for a NHS Health check, the percentage who accept and complete the offer.	Annual	45.0%	24/25	44.2%	G	Activity by Primary Care to deliver NHS Health Checks has been consistent throughout the year and an improvement on 2022/23. Alongside this, the Supplementary NHS Health Check Service provider has been offering community health checks showing a high take up from the priority groups identified by the Council	
3.17	Healthy Start Voucher uptake	Monthly	63.0%	Mar-24	61.0%	G	**NB: NHS have reported an issues with source data -Therefore no new update for this report.** Launch of new messaging, marketing resources and campaign in May 2024 working with City/District Councils, Good Food Oxfordshire, Home Start and NHS. Based on insight from families and co-produced with local organisations working with ethnic minority groups (African Families in the UK, Sunrise Multicultural Centre). Raising uptake is more than just awareness; families need help applying, missed opportunities to get families signed up and a need for strong leadership and accountability.	No data available
3.18	Under 75 mortality rate from cardiovascular disease (Rate / 100k) (New name) *	Annual	57.6	2021-23	52.8	G	This outcome has worsened slightly in the current reporting period (21-23) to the previous (20-22) which is a trend seen across UK and is related to wider impacts of COVID-19 pandemic. However, the Oxfordshire data remains better than regional, national and similar authority comparators. Local activity to address this outcome sits within theme specific work on tobacco control, or whole systems approach to obesity, or physical inactivity or alcohol harm. Specific updates will be provided as per HIB annual work plan	

Live Well Priorities

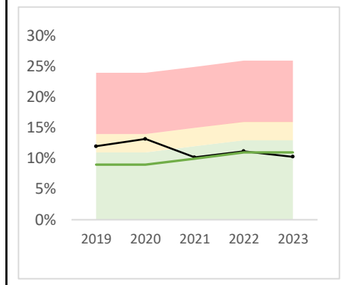
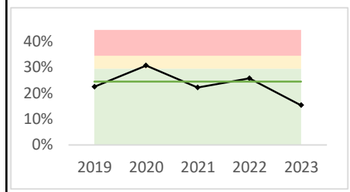
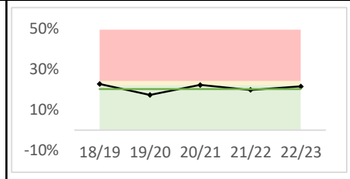
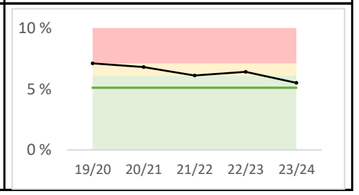
New data is indicated by highlighted references number.

Targets set by local Public Health

All metrics are reported at county level. Available at District * and MSOA ‡ level

Key

Supporting

		Frequency	Target	Reporting Period	Value	RAG	Commentary	Trend Chart
3.2	**Smoke Free**							
3.21	Smoking Prevalence in adults (18+) - current smokers *	Annual	9.9%	2023	10.3%	G	The Oxfordshire Tobacco Control Alliance oversees work to reduce smoking prevalence in Oxfordshire. Work is within four pillars: prevention, support, environment and enforcement. The local stop smoking service (LSSS) continues to support smokers to quit, with specific focus on priority groups and . NHSE funded tobacco dependency services are in place within acute, mental health and maternity settings. Additional grant funding to boost smoking cessation efforts across England was received in April 2024 and is further supporting these programmes and expansion of the LSSS through a recommission ready for summer 2025. The new stop smoking campaign, 'It's Well Worth It' was launched on 30th September and is planned to direct residents to local stop smoking provision.	
3.22	Smoking prevalence in adults in routine and manual occupations (18-64) - current smokers *	Annual	23.3%	2023	15.3%	G	The local stop smoking service targets work with routine manual through a variety of initiatives. Including the national Swap to Stop initiative for provision of free vapes. The new stop smoking campaign, 'It's Well Worth It' was launched on 30th September and plans to appeal to a range of residents including this priority group.	
3.23	Smoking prevalence in adults with a long term mental health condition (18+) - current smokers (GPPS) *	Annual	20.0%	22/23	21.1%	G	The Tobacco Dependency Service (TDS) funded by NHSE/ICB specifically supports adult inpatients with mental health conditions to quit smoking. In addition the local stop smoking service supports individuals with low level mental health challenges. The newly commissioned Local Stop Smoking Service (LSSS) will include enhanced work in this area.	
3.24	Smoking prevalence in pregnancy	Annual	5.1%	23/24	5.5%	G	Most pregnant women who smoke are now being supported via the new maternity in-house tobacco dependency advisor service (via NHS Long Term Plan funding). The local stop smoking service continues to support pregnant women to quit smoking, but numbers are fewer. A national incentive quit scheme for pregnant women is due to be rolled out across the Country. Oxfordshire has submitted an expression of interest to be part of the scheme – outcome awaited.	

Live Well Priorities

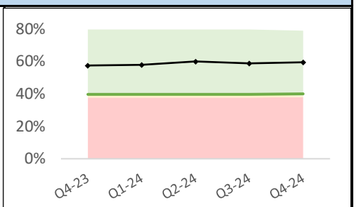
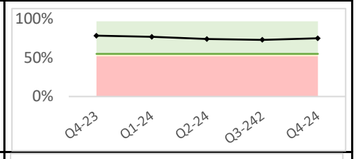
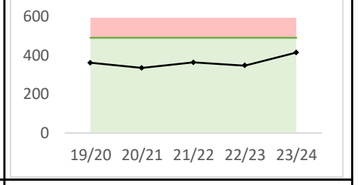
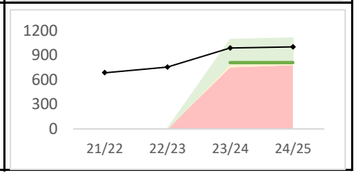
New data is indicated by highlighted references number.

Targets set by local Public Health

All metrics are reported at county level. Available at District * and MSOA ‡ level

Key

Supporting

		Frequency	Target	Reporting Period	Value	RAG	Commentary	Trend Chart
3.3	**Alcohol related harm**							
3.31	Alcohol only successful treatment completion and not requiring treatment again within 6 months	Quarterly	40.0%	Q4-24	59.4%	G	The latest performance remains significantly above the national average of 34.6%, and has increased again on last quarter. This is achieved through strong partnership and multi-agency working, extensive community-based engagement and outreach, providing holistic person-centred care, individualised goals, and supported by access to residential treatment where necessary.	
3.32	Alcohol treatment progress	Quarterly	55.0%	Q4-24	75.0%	G	The latest performance remains significantly above the national average of 51% and demonstrates delivery of the national and local strategic aims, which are ensuring people are supported through effective support, engagement and treatment.	
3.33	Admission episodes for alcohol-related conditions (Narrow) Rate / 100K *	Annual	490	23/24	414	G	Oxfordshire rates are below the south east average. There is significant ongoing partnership and multi-agency work to prevent the number of people drinking to hazardous levels, and significant investment and activity in community services to ensure people receive the support they require to prevent escalation of need. Other indicators demonstrate the positive impact of these services.	
3.34	Alcohol only numbers in structured treatment	Annual	810	24/25	1002	G	In line with national strategic aims, extensive partnership work and outreach with those with health inequalities has supported the partnership to continue to increase the number of people in treatment over the last year, and rates of increase are above the England average. This demonstrates the impact of additional investment from central government linked to the national strategy.	

Live Well Priorities

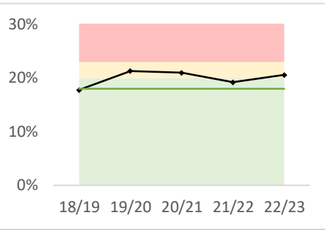
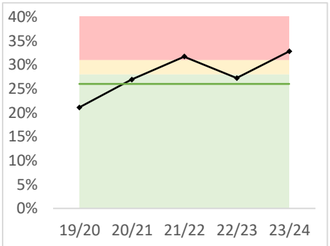
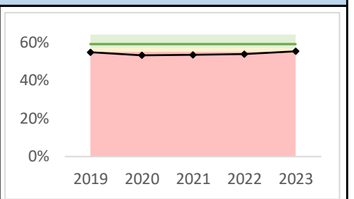
New data is indicated by highlighted references number.

Targets set by local Public Health

All metrics are reported at county level. Available at District * and MSOA ‡ level

Key

Supporting

		Frequency	Target	Reporting Period	Value	RAG	Commentary	Trend Chart
4	**Physical activity and Active Travel**							
4.1	**Physical Activity**							
4.11	Percentage of physically inactive adults (Less than 30 minutes a week)	Annual	18.0%	Nov22-Nov23	20.6%	A	Efforts to increase physical activity across Oxfordshire adults are coordinated by Active Oxfordshire and supported across District, County and ICB, utilising a whole systems approach to physical activity. This takes an inequalities lens as per their Oxfordshire on the Move strategic approach. Programmes include upskilling professionals working with people who are least likely to be active, one to one and group support for individuals.	
4.12	Percentage of physically inactive children (less than average of 30 minutes a day)	Annual	26.0%	Academic Yr 23-24	32.8%	R	We note for this indicator there are some challenges with the data sample and therefore some caution to be applied to interpreting these results. Active Oxfordshire continue to work towards their Oxfordshire on the Move Physical Activity strategy. We've seen an expansion of the children's You Move programme into Early Years in September 2024. Enabling opportunity to create healthy habits in children early. We've commission Healthy Movers also to support early years, delivered across several schools and community settings. Increased strategic support within school setting with the development of Active Framework. Public health will lead a Physical activity Health Needs Assessment in 2025/26 to better understand the data, gaps in provision and local assets/opportunities.	
4.13	Uptake of Move together	6 monthly	1000	Apr-Sep_24	2042	G	Move Together is jointly funded by public health and BOB ICB to support people with long term conditions (LTC). The target of an increase in 1000 steps per day, was surpassed, an average of 2042 steps per day being achieved across all participants meeting who engaged with the programme.	Reported for the first time. Chart not yet available
4.14	You move programmes	6 monthly	45.1%	Apr-Sep_24	52.0%	G	You Move, a physical activity programme delivered by Active Oxfordshire, jointly commissioned by public health and ICB, supports children and their Families meeting eligibility for free school meals, children in care, or some other vulnerable groups such as young carers. The programme delivers heavily subsidised or free physical activity. 52% of participants self-report an increase in physical activity via questionnaire.	Reported for the first time. Chart not yet available
4.2	**Active Travel**							
4.21	Active travel - percentage of adults walking/cycling for travel at least three days per week (age 16+)	Annual	59.0%	22/23 Nov	55.2%	A	Oxfordshire County Council's cycling and walking activation programme comprises a range of measures to enable people to cycle and walk more such as school streets, travel planning, led walks and bike libraries. These activities in conjunction to improvements to cycling and walking infrastructure seek to deliver an increase in active travel.	

Live Well Priorities

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Targets set by local Public Health

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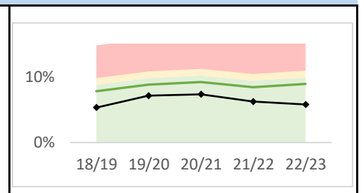
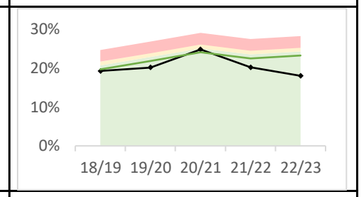
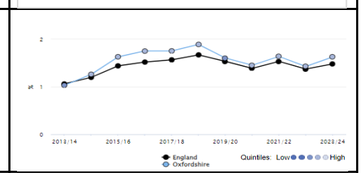
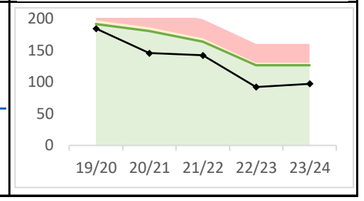
Key

Supporting

		Frequency	Target	Reporting Period	Value	RAG	Commentary	Trend Chart
4.3	**Mental Wellbeing**							
4.31	Self reported wellbeing: people with a low happiness score (16+) *	Annual	9.0%	22/23	5.8%	G	The Prevention Concordat for Better Mental Health Group have a shared action plan to support good mental wellbeing. Activities during this period include sharing key data and good practice to inform local initiatives, mental health awareness training for staff and volunteers and joint mental health campaigns. The group have recently developed a new shared action plan for 2024-27 with a focus on supporting resilience in communities	
4.32	Self reported wellbeing: people with a high anxiety score (16+) *	Annual	23.3%	22/23	18.1%	G	The Prevention Concordat for Better Mental Health Group have a shared action plan to support good mental wellbeing. Activities during this period include sharing key data and good practice to inform local initiatives, mental health awareness training for staff and volunteers and joint mental health campaigns. The group have recently developed a new shared action plan for 2024-27 with a focus on supporting resilience in communities	
4.33	The percentage of patients aged 18 and over with depression recorded on practice disease registers for the first time in the financial year. (NEW)	Annual	-	23/24	1.6%		The percentage of patients aged 18 and over with depression recorded on practice disease registers for the first time in the financial year has remained relatively stable over the past five years. The incidence in 2023/24 is 1.6% which is within the 2nd highest quintile in England. This indicator replaces the Adult patients recorded with a diagnosis of depression which has been retired.	
4.34	Emergency hospital admissions for intentional self-harm in all ages (Rate / 100k) *	Annual	126.3	23/24	97.3	G	For further insight, see the paper on Adult and Older Adult Mental Health in Oxfordshire which was presented at the Oxfordshire Joint Health Overview & Scrutiny Committee on the 12th September 2024	

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Your voice on health and care services

Healthwatch Oxfordshire (HWO) report to Health Improvement Board (HIB)
3rd July 2025
Presented by Healthwatch Oxfordshire ambassador, Robert Majilton

Purpose / Recommendation

- For questions and responses to be taken in relation to Healthwatch Oxfordshire insights.

Background

Healthwatch Oxfordshire continues to listen to the views and experiences of people in Oxfordshire about health and social care. We use a variety of methods to hear from people including surveys, outreach, community research, and work with groups including Patient Participation Groups (PPGs), voluntary and community groups and those who are seldom heard. We build on our social media presence and output to raise the awareness of Healthwatch Oxfordshire and to support signposting and encourage feedback. We ensure our communications, reports and website are accessible with provision of Easy Read and translated options.

Key Issues

Since the last meeting in February 2025:

- We published reports on:
  - **Listening to men in Oxfordshire** – what we heard from 167 men through proactive outreach across the county, including focused work in Didcot and Witney and at Banbury Mosque. Men told us about challenges including a lack of time, work and family pressure and the cost of living, as well as stigma and stereotypes about seeking help. https://healthwatchoxfordshire.co.uk/report/hearing-from-men/
  - **What we heard about pharmacy** - a summary of what we heard over the last year about pharmacy from 100 members of the public. Feedback included appreciation for good support and care and clear communication, as well as challenges and concerns around staffing pressures, pharmacy closures and increasing demand. https://healthwatchoxfordshire.co.uk/report/what-we-heard-about-pharmacy-april-2024-march-2025/
  - **What you told us about GP services** - a summary of what we heard over the last year about GP practices from 354 people. In particular, we heard about the barriers that people experience in accessing care, including difficulty

making appointments, navigating online services and a lack of support for people with additional communication needs. We heard about the difference it makes when practice staff and systems support people to overcome these barriers. https://healthwatchoxfordshire.co.uk/report/what-you-told-us-about-gps-april-2024-march-2025/

- **Urgent and emergency care services** - we heard from 322 people about experiences of trying to find out where to get urgent or emergency care. Many people were able to navigate the urgent and emergency care system and were positive about the care they received, but some people found the system complex and confusing to navigate, which could result in poor experiences or delayed care.

- Forthcoming report on:
  - **Women's health services** - what we heard about women's health services from 684 women and people who use women's health services. We heard about good experiences of care that was centred around people's needs and where they were listened to and provided with useful advice and treatment. We also heard about challenges around patients not feeling they were listened to or taken seriously, a lack of joined-up working between services, the impact of seeing health and care professionals who did not have enough understanding of women's health to support them, and waiting for care – sometimes over many years. We heard about examples of sexism and discrimination around race, age and disability.
- **Recent films** include:
  - **Patient Voices – making a difference together** – showcasing the brilliant work of patient groups in Oxfordshire, including Patient Participation Groups
  - **Understanding language support at your GP surgery** – together with Oxford Community Champions
  - **Role of GP receptionists** – together with Oxford Community Champions

  All films are available to watch via our website.

Enter and View reports and visits continue. Once complete, all reports and provider responses are available on our website including:

- Freeland House and Lodge, March 2025
- Hand and Plastic Injuries Clinic at the John Radcliffe, April 2025
- The Phoenix Ward at Littlemore Mental Health Centre, May 2025

Since the last meeting we also made Enter and View visits to:

- Connect Health at Hanborough House, Bicester Community Hospital and Townlands Hospital, Henley-on-Thames.

Other activity:

- We continue ongoing face to face **outreach** to groups and events across the county, including hospital stands (at the Churchill and Horton Hospitals), focusing on general and topical listening. Outreach since the last meeting includes SEND Together, Eid Extravaganza in Blackbird Leys, street outreach in Didcot, Wantage Health Day, and Ruscote Health Day in Banbury. In January-March we engaged with approximately 350 people.
- We support **My Life My Choice** to run a user-led Health Voices Group to ensure the voices and experiences of people with a learning disability are heard by commissioners and providers. A meeting on the theme of physical activity, with support from Active Oxfordshire, took place in March 2025.
- We held three public webinars:
    - **'Supporting mental health and wellbeing in our young people through their teenage years'**, 18th March – with speakers from Oxford Health NHS Foundation Trust's Mental Health Support Team
    - '**Living well in Oxfordshire'**, 13th May – with speakers from Oxfordshire County Council and support services, showcasing the support available to help people stay healthy and well
    - '**Let's talk about menopause'**, 10th June – with Lubna from Oxford Community Champions sharing her lived experience, and Dr Katie Barber, Clinical Lead of the Oxfordshire Community Gynaecology Service.

      Recordings of these webinars are available to watch on our website.

- Our next webinar will be on **Tuesday 16th September**, 1-2 pm – details and speakers to be confirmed.
- **Marmot Community event** - we supported a community-led event at Rose Hill Community Centre on 9th June, to enable over 100 people from a wide range of community groups to feed into the development of the Marmot approach to tackling health inequalities in Oxfordshire.
- Our most recent **Board Open Forum** was on **Wednesday 21st May** at Didcot Civil Hall.
- Our priorities and work plan for 2025-6 was published in March and include:
    - Looking at experiences of joint working across health and social care services, including by Integrated Neighbourhood Teams
    - Hearing people's views about using digital tools to access and enhance care
    - Hearing about mental health services, including dementia support
    - Hearing from young people about their experiences of health and social care
    - Community research with less heard communities, including working with Sunrise Multicultural Project in Banbury on cancer prevention and diagnosis.

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ITEM 9

Health Improvement Board

3rd July 2025

Oxfordshire Community Mental Health Framework

Purpose / Recommendation

1. **The Health Improvement Board is asked to note for information purposes and provide any feedback on progress**

Background

2. The Health Improvement Board has requested an update on the Mental health hubs in providing interfaces in highstreets (Keystone programme). The update is to understand where the hubs are currently located, and whether new hubs or locations are planned in the future. The briefing will also include how the hubs link with community providers and other services, such as community support and navigators like social prescribers and Community Health Development Officers.

Key Issues

3. Some of the challenges as described in the presentation are recruitment, seeking accommodation for a further two hubs, how the walk-ins are managed at the front door and not all PCNs have adopted (ARRs (Specialist Mental Health Workers), with some ending their contract with the workers.

Budgetary implications

4. None as this forms part of the Oxfordshire County Council and ICB Pooled Budget for the provision of Mental Health Services, which is a block contract.

Equalities implications

5. None as the Hubs are designed to be placed across Oxfordshire based on demographic need

Communications

6. This forms part of a regular update to Partners and part of the contractual delivery. The Hubs are promoted in the community and appropriate communications will be provided for the new Hubs when they launch.

Key Dates

7. None to note at present

Report by: Bhavna Taank (Oxfordshire County Council/BOB ICB) and Debbie Walton (Oxford Health)
June 2025

Contact
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and

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NHS
Oxford Health
NHS Foundation Trust

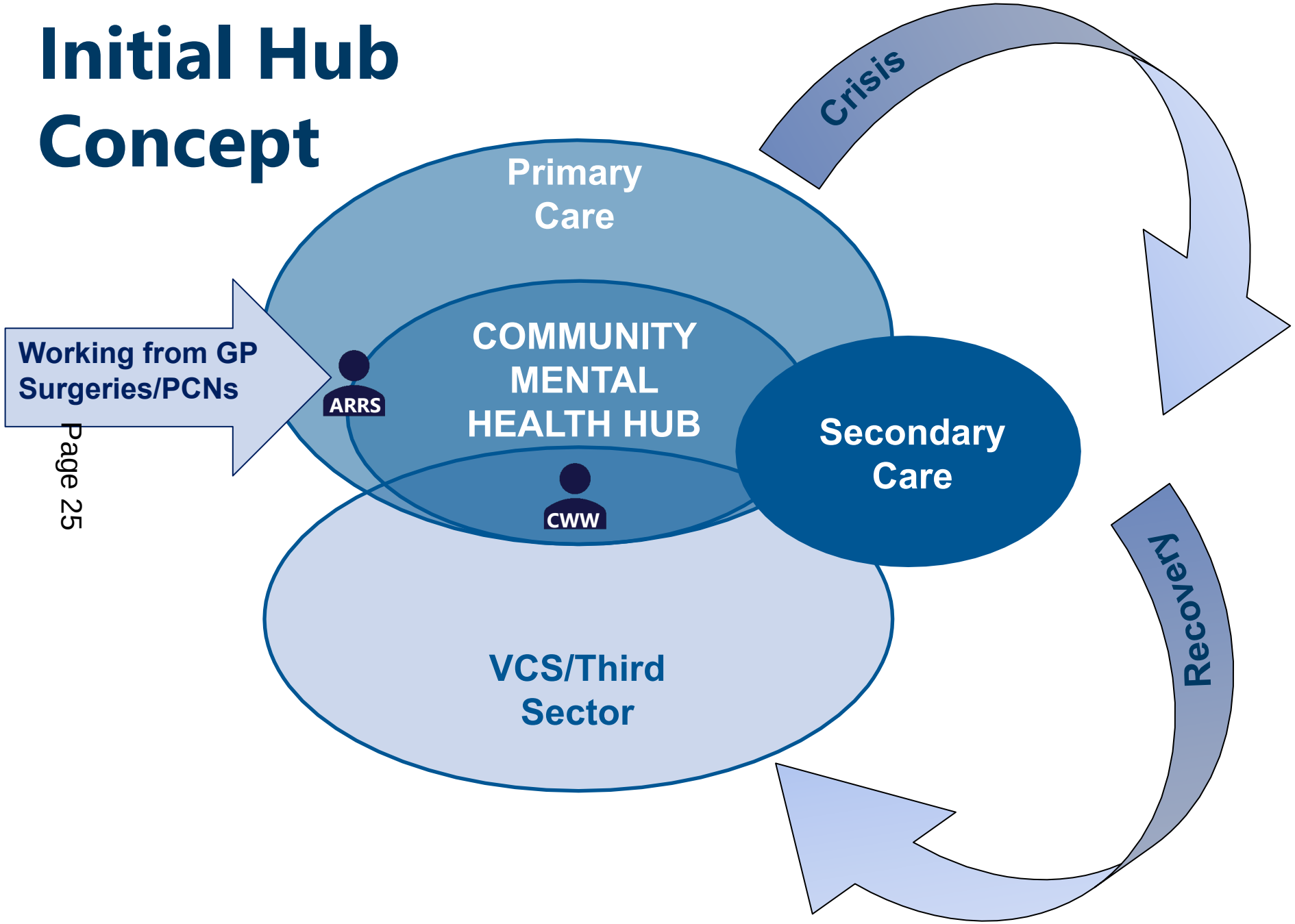
Keystone
Mental Health & Wellbeing Hub

Oxfordshire Community Mental Health Framework

BACKGROUND

- The Community Mental Health Framework is a NHSE transformation project with funding provided over 3 years. **2021/2022 – 2023/2024**
- CMHF is an opportunity to improve the health and wellbeing of people with significant mental health conditions
- The aim of the CMHF is for care to be closer to home, when and where patients need it.
- ***'This Framework locates community mental health services in the centre of the community, as the central pillar of mental health care, allowing all other services in the mental health care system to function more effectively'.***
- NHSE instructed mental health providers to make it easier for the public to access mental health advice and support, aligning with the 'Health on the High Street' agenda, which puts health service provision on the high street in vacant properties to increase accessibility of these services.
- Initially Oxfordshire's plan had been to base the PCMHTs in existing Primary Care premises rather than within existing mental health estate, but no GP practice had the space to accommodate the Keystone Teams. Our Partners were also approached, and likewise they did not have capacity for the teams.

Initial Hub Concept



CWW = Community Wellbeing Workers Including: MIND embedded navigators, Elmore, Age UK etc.
ARRS = Additional Roles Reimbursement Scheme Mental Health Practitioner

Background cont…

- For many years patients, carers, clinicians (across primary and secondary care) had reported a significant gap in services for people with a SMI, barriers to accessing services, long waits for specialist interventions, lack of capacity and training for secondary care professionals to provide evidenced based interventions, clinicians ‘firefighting’ due to a lack of appropriate Crisis Provision, and a void of individualised interventions for people when discharged from Secondary MH services.
- We repeatedly saw this through complaints, patient and carer feedback, front-line clinicians, GPs. Patients and Carers reported that they often got to crisis point before they were accepted back into mental health services, and the lack of early intervention in relapse impacted on flow across Mental Health Services.
- There were repeated complaints about patients being ‘bounced’ between services and long waits with no support during these waits if they reached the appropriate service. This led to a lack of trust in mental health services and risks for patients increasing during this time.

Why change?

We recognised the need for a different, more joined up approach, across all support providers, with staff from across the NHS, social care and the third sector working together to:

- improve access and remove barriers to care
- improve local services
- reduce health inequalities
- prevent unwarranted variation in care.

We wanted people with mental health problems to be active participants in accessing mental health care, so they could:

- access mental health care and support where and when they needed it
- manage their condition, or move towards individualised recovery, on their own terms
- contribute to and be participants in their community.

Feedback about Oxfordshire's services 2021

- Long waiting lists with gaps between primary and secondary care
- Barriers to getting the right treatment especially with co-existing conditions
- Too much city centric provision and not enough county-wide access to services
- Current pathways are confusing and complex
- Outcomes and services for people are variable with inequalities in access
- Thresholds and criteria for services differ confusingly
- Lack of tailored provision for older adults including the younger older adults
- Cliff edges after interventions

Development of the model

- The model in Oxfordshire was co-produced in partnership with representatives across the system. Workshops, focus groups, and engagement events were held with all stakeholders including partner organisations (across Primary/Secondary/Third/Voluntary/Acute/Local Government sectors and CCG), staff, patients, and carers to develop the hub model in Oxfordshire.

- The purpose of the CMHF Programme was to deliver radical change in the design of community mental health care for adults and older adults. This would be achieved by moving towards joined up care, designed using a whole population approach, whilst establishing a revitalised purpose and identity for community mental health services.

- People would be supported to live well, to maximise their individual skills, and to be aware and make use of the resources and assets available to them as they wish.

- This new approach of locally based mental health support, care and treatment for adults and older adults which is situated and provided in the community.

Partnership and Co-Production

In Oxfordshire we knew that to develop a successful framework for delivering good mental health support, care and treatment in the community we must work in co-production with our partners across all sectors, experts by experience, patients and carers.

Successful integration of primary and community mental health support also relied on active partnership working.

In Oxfordshire the Community Mental Health Framework programme was led in partnership by Oxford Health Foundation Trust, Commissioners (was OCCG), Primary Care Networks (PCNs), the Oxfordshire Mental Health Partnership & Age UK.

The Programme Aimed to:

- Promote mental and physical health and prevent ill health.
- Treat mental health problems effectively through evidence-based psychological and/or pharmacological approaches that maximise benefits and minimise the likelihood of inflicting harm, and use a collaborative approach that:
- builds on strengths and supports choice;
- is underpinned by a single care plan accessible to all involved in the person's care.
- Improve quality of life, including supporting individuals to contribute to and participate in their communities as fully as possible, connect with meaningful activities, and create or fulfil hopes and aspirations in line with their individual wishes.
- Maximise continuity of care and ensure no "cliff-edge" of lost care and support by moving away from a system based on referrals, arbitrary thresholds, unsupported transitions and discharge to little or no support. Instead, move towards a flexible system that proactively responds to ongoing care needs.
- Work collaboratively across statutory and non-statutory commissioners and providers within a local health and care system to address health inequalities and social determinants of mental ill health.
- Build a model of care based on inclusivity, particularly for people with coexisting needs, with the highest levels of complexity and who experience marginalisation.
- Establish new integrated diagnostic pathways to be delivered through integrated teams based in primary care and locally accessible Hubs in the community. This will allow patients to access and flow through services with no wrong door in or out.

Oxfordshire Hubs 'Health on the High Street

- Early intervention for people presenting for the first time and those with an existing diagnosis with signs of relapse, or advice/ reviews including support with physical health.
- Offering a welcoming and non-stigmatised outward facing façade with a social enterprise offer alongside mental health and wellbeing support services.
- Social Enterprise - to employ people with lived experience of SMI into a variety of roles and encourage volunteers to work alongside our PCMHT in offering advice and guidance to those coming into the building.
- A local point of access for all, non-emergency, mental health referrals
- Trusted assessment following triage, leading to self-help advice, signposting to Third/Voluntary sector, short term intervention from the KMHT, direct referral into Enhanced MH teams without the need for further triage or repeated assessment
- Truly integrated partnership working at a community level.
- One Stop Shop offering clinics on housing, benefits, Drug & Alcohol services, as well as health and wellbeing services
- Fully integrated MH provision at a local level, tailored to the SMI & socioeconomic needs of the local community.
- Potential for Mental Health support by day and local community groups by night

Community Mental Health Framework - Oxfordshire

Vision

To provide integrated, multi-agency care to adults with complex and serious mental illness in a way which is **proactive**, **personalised** & considers the needs of patients.

A service which works **collaboratively with primary care** and draws upon the **expertise** and **assets of the community** to enable effective, **accessible care** & **communication** across the whole system.

Co produced with patients, experts by experience

Principles for Delivery

No wrong front Door

Care Organised around communities, addressing inequalities and social determinants of serious mental illness

Co-Production

An evidence Based holistic partnership approach reducing unnecessary duplication or escalation

No artificial thresholds between Primary and Secondary care.

Specific focus on pathways for those with Eating Disorders, Personality Disorder and Complex psychosis

Reducing stigma

Fully integrated mental health provision at local level, tailored to people experiencing SMI & the health & wellbeing needs of the local community

Keystone Mental Health and wellbeing Hubs

https://youtu.be/g1WKA41aTYg

Current Situation

- 5 Keystone MH and Wellbeing Hubs open on the high street, Banbury, Kidlington, Oxford City, Abingdon and Wantage.
- 8 Keystone MH Teams (KMHTs) fully functioning – Abingdon, Banbury, Blackbird Leys/ City East, North City and NE Oxon and Wantage/ Didcot/ Farringdon ,Wallingford/Henley/Thame, Witney
- Witney KMHT based in Branch Trust in Chipping Norton every Friday
- Volunteers have started to support manning the front of house in some of the Keystone Hubs.
- OCA (Oxford Community Action)café as front of house for the Cowley Road Keystone Hub.
- Personality Disorder pathway embedded, Elmore Personality Disorder Intervention workers(PDI) in place
- Eating Disorder Pathway commencing SWEDA workers in place
- Continued partnership with Sport in Mind to increase provision across Oxon.
- Partnership with Bipolar UK to run self-management courses for those with bipolar across Oxon and ongoing Peer support groups.
- Self-referrals beginning to be accepted

Ongoing Challenges

- Recruitment
- Demand for Structured Psychological Support (SPS) for people with Personality disorder provided by Elmore PDI workers
- Increasing referrals and assessment leading to lack of capacity to provide timely responses as expected in some KMHTs
- Accommodation for the Wallingford/Henley/Thame and Witney Keystone Hubs.
- Manning front door, - ‘walk ins’ -aim for the front doors to always be open to public.
- Offer to social enterprises to use the ‘front of house’ space in the Hubs
- Use of the group room space in the Hub to local community groups, voluntary sector and statutory organisations to see people around issues which impact on MH
- ARRs(specialist Mental Health Workers) not all PCNs have adopted this offer to have staff embedded in the GPs surgeries, and some have chosen after a year to end contracts.

KMHT Staff

In the KMHT there are:

- Team manager (OH)
- Band 7 qualified clinician(nurse or OT) (OH)
- Band 6 qualified clinicians (nurse or OT) (OH)
- Psychologists(cross covering patches) (OH)
- Assistant psychologists (OH)
- Peer support workers (lived experience) (OH)
- Personality Disorder Intervention (PDI) workers - Elmore
- Wellbeing and Options Workers – Oxfordshire Mind
- Eating Disorder support workers – Southwest Eating Disorder Association (SWEDA)
- Individual Placement Support (IPS) workers (OH)
- Administrators
- Volunteer workers
- Consultant Psychiatrists in advisory roles

FEEDBACK

Re peer support worker *"never met such a comprehensive team" and "you give me hope."*

X said the Hub is helping him rebuild trust with mental health professionals

' I do appreciate everything you do, you understand me more than any professional help I've had over the years and I feel a little light pressing through a dark tunnel I've been in for many years, and not knowing what to do than end myself constantly.'

"Fastest support I have ever received"

Location – its great, you can pop into town, and it is a central location and works well.

It's was nice to be treated like a human and not someone on a piece of paper.

First time trauma has actually been **recognised** from a MH service. Other services are not trauma informed

"Many conversations and comments made and shared with the intervention will stick with me for the rest of my life. Whenever difficult times come up I often use the techniques and thoughts learned in this intervention to lessen the difficulty or at least think in a less negative way.

I thought it was fantastic, it was easier to access compared to other services. Once I got the courage to come through the door everyone was so friendly

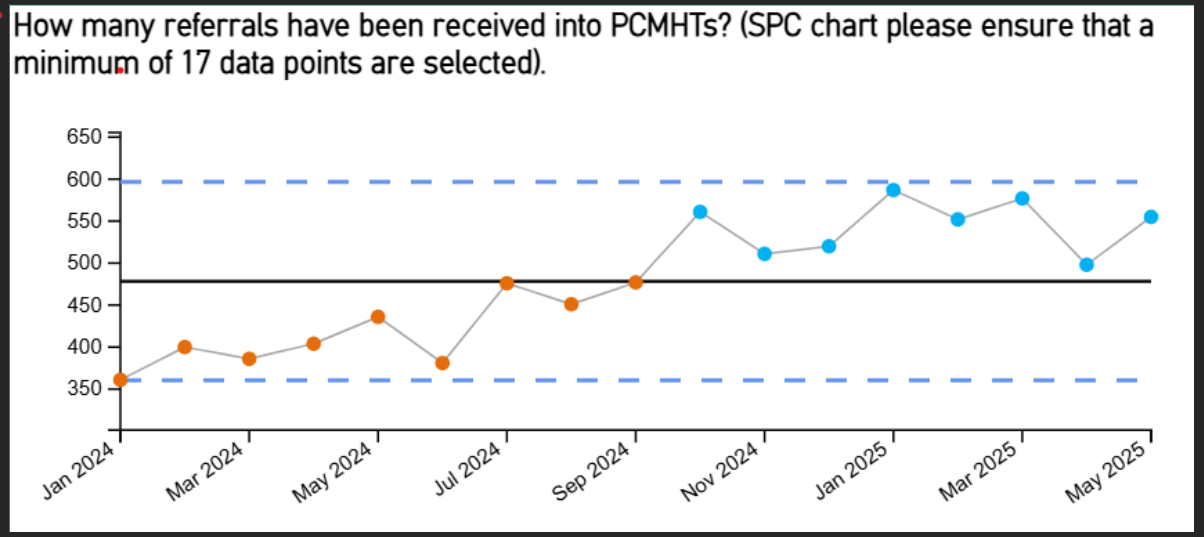
I wish I could have received this support years ago when my trauma happened.

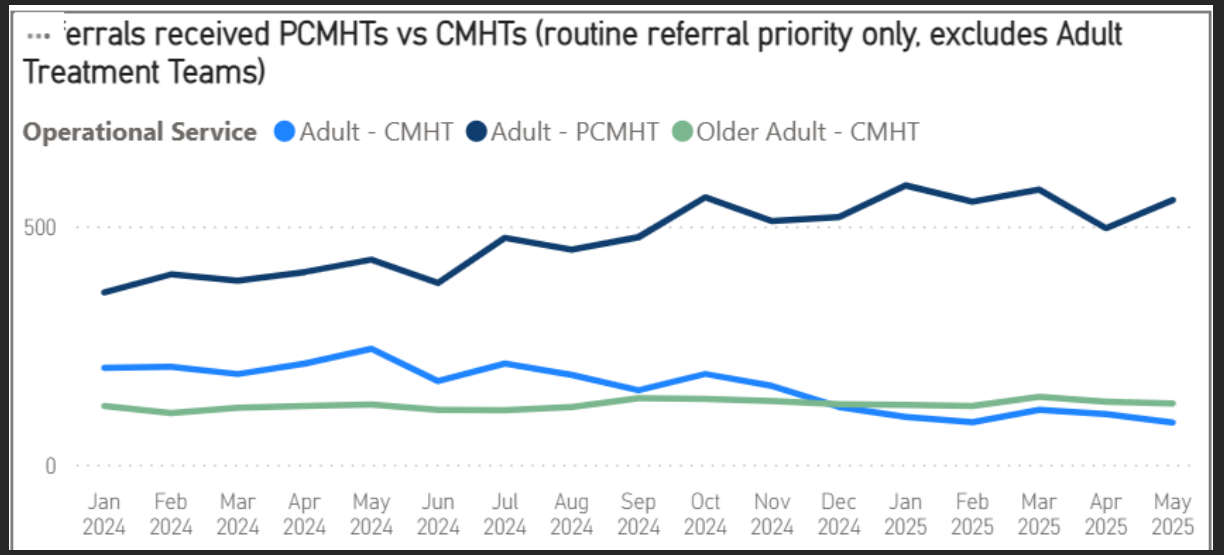
All the days were darker before I came to the Hub, now the days are brighter, and I feel content. I also do not feel as vulnerable.

Outcome based measures

- Patient reported Outcome measures(PROMs) are being used within the Hubs. This consists of using questionnaires, talking with patients regarding their responses, and care planning around these, whilst monitoring the impact of interventions and care. People are sent a link via email or text to complete the PROMs online on a website called True Colours. Alternatively, these can be completed during the appointments.
- Questionnaires are:
- DIALOG scale
- Recovering Quality of Life Scale(ReQol-10)
- Goal Bases Outcomes (GBOs)

Oxon Keystone Hubs Data for Health Improvement Partnership Board



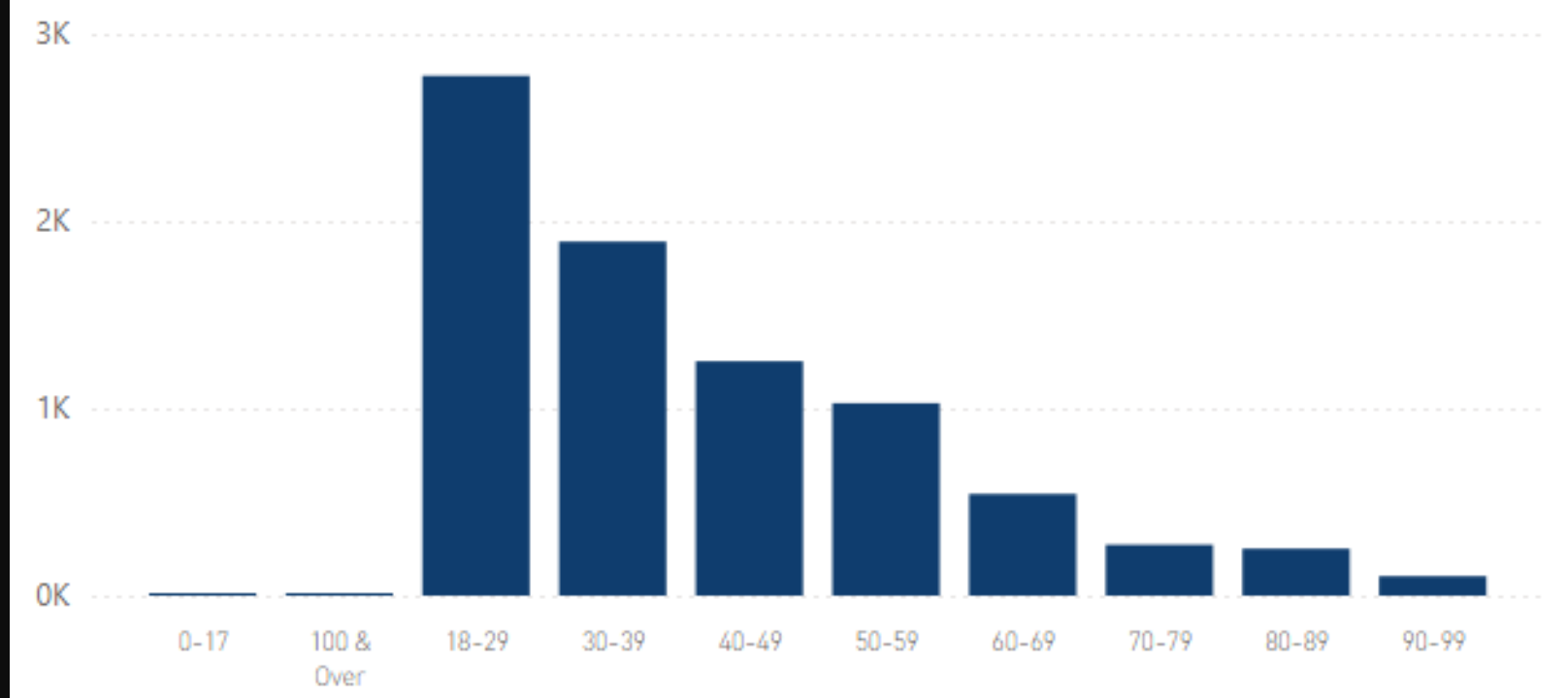


KMHT Activity

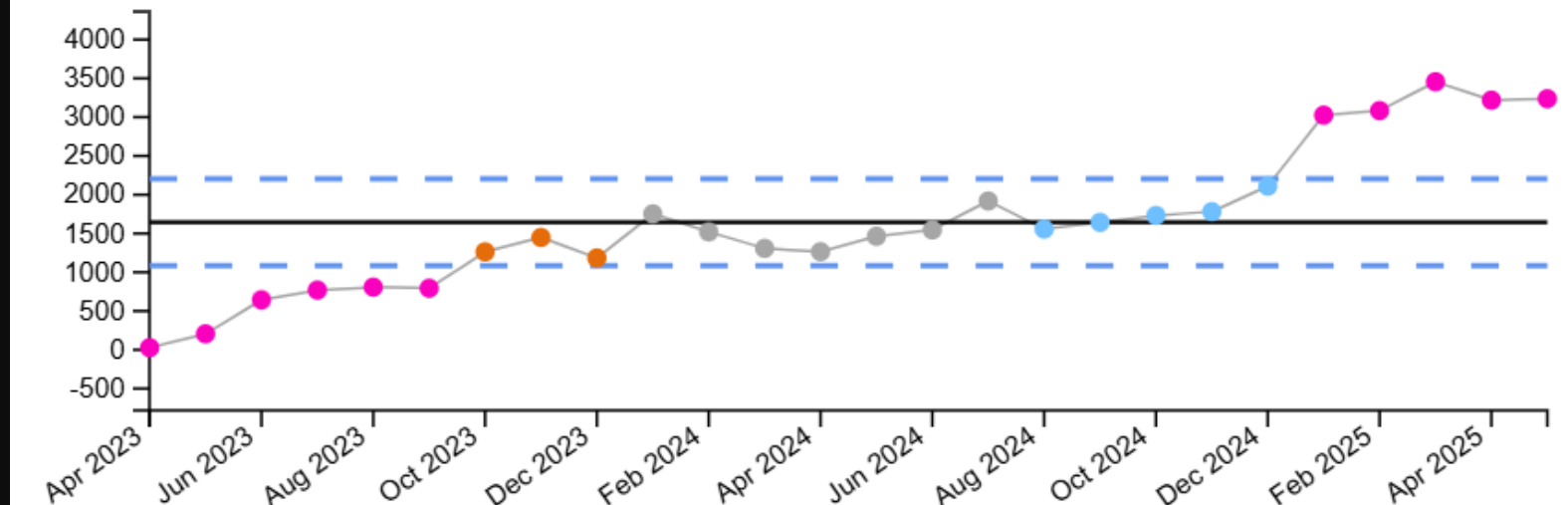
Referrals received and discharged referrals:

- 8,133 referrals received
- 8,077 discharged referrals
- 67 Days Average LOS of discharges

KMHT DATA Cont …



How many attended appointments were there? (SPC chart please ensu
of 17 data points are selected)



Thank You

Any Questions?

Oxfordshire Health Improvement Board
Report Sign Off Cover Page

Report Writer: Kate Austin, Public Health Principal, Fiona Ruck Health Improvement Practitioner

Line Manager: Kate Holburn, Interim Deputy Director of Public Health

Yes- Line Manager has signed off the report (tick box)

Director/SLT Member: Ansaf Azhar, Director of Public Health and Communities.

Director/SLT Member has signed off the report (tick box)

Style:

- The report should be written in third person e.g. 'The council will' rather than 'we will'
- Except for the Contact Officer please use job titles in the report and not officer names
- All acronyms should include the full name on first occurrence
- Any hyperlinks included must link to a publicly available source
- The report should be marked 'Draft' with appropriate watermark until ready to be submitted to Democratic Services for Council, Cabinet/Member or Committee. Please ensure that any mark-ups, tracked changes and watermarks are removed, so that Democratic Services receive a final, clean copy.
- Please ensure that the brackets and guidance contained within those brackets in the following pages has been removed before submission of your report and that you have selected one choice where required.

Report Writing Training:

- For refreshers on report writing, please refer to the Learning Zone, where a number of e-learning and virtual learning courses are available including **'Writing Effective Reports'**

Oxfordshire Health Improvement Board
3 July 2025

Community Health Development Officer Programme

Report by Ansaf Azhar, Director of Public Health and Communities

RECOMMENDATION

1. **The Health Improvement Board is RECOMMENDED to**

   1. Note the important role that Community Health Development Officers (CHDO's) play in supporting community level health and wellbeing, and their contribution to the Oxfordshire Health Improvement Board priorities.

   2. Champion the work of the CHDO's to support them to continue to work with local partners in their respective areas.

Executive Summary

2. Oxfordshire County Council have funded Community Health Development Officer (CHDO) posts in each of the areas where a community insight profile has been developed. The CHDO posts are hosted by the relevant district or city council for the area.

3. The CHDO programme is a key component of Oxfordshire County Council's public health work to reduce health inequalities across the county and is a key enabler in the Marmot programme allowing strong connections to be made with communities most likely to experience health inequalities.

4. CHDOs act as vital connectors within communities where they work. Their role includes:

   4.1 Supporting the implementation of the Community Insight Profile recommendations through local action planning.
   4.2 Organising and convening local partnership meetings and health promotion activities.
   4.3 Building capacity among local organisations and residents, connecting local organisations and encouraging joint working
   4.4 Facilitating access to grant funding for community-led health initiatives.
   4.5 Raising awareness of public health services and local health and wellbeing activities

5. The first ten areas covered within the CHDO programme (alongside the NHS ICB-funded Well Together (WT) programme) is being evaluated by the University of Oxford as part of the Oxfordshire Health Humanities Project. The first phase of the evaluation took place between January to December 2024 through an applied mixed-methods approach, including interviews, focus groups, and fieldwork. A second phase is now under way and due to be completed in March 2026.

Exempt Information

6. There is no exempt information in this report.

Background to the CHDO programme – the creation of community insight profiles

7. Since 2021, Oxfordshire County Council have been working with partners to carry out a programme of work to develop Community Insight Profiles (CIP). The work was initiated after the publication of the Director of Public Health Annual Report for 2019/20 which highlighted ten wards in Oxfordshire which have small areas (Lower Super Output Areas) that were listed in the 20% most deprived in England in the Index of Multiple Deprivation (IMD) update (published November 2019) and are most likely to experience inequalities in health. The publication of Community Insight Profiles for all ten of these areas was completed in December 2023.

8. Following on from this, a further four Community Insight Profiles have been developed for areas across the county identified as falling within the 30-40% most deprived nationally according to the IMD (2019) and where local partners identified that there would be added benefit to developing a profile.

9. The purpose of creating a Community Insight Profile is to ensure we understand as fully as possible the factors that influence health and wellbeing outcomes within areas in Oxfordshire where residents are most at risk of poor health, or experience health inequalities.

10. The profiles map the assets in each area, capture community insight around enablers and challenges to health and wellbeing and detail a data set of indicators for each area to help inform high level recommendations. The methodology of the community insight capture and asset mapping are explained in each of the individual community insight reports.

11. Each profile includes a series of locally led recommendations that outline objectives to enhance identified community assets and strengthen development opportunities. An action plan is developed for each area based on the specific recommendations of that profile. The table below explains the phasing of these 14 areas where profiles have been completed.

An Overview of the Community Insight Profile phases.

Phase	Areas	Notes
1.	Abingdon Caldecott (Vale of White Horse)	These were published in September 2022 and a report outlining the key findings from these profiles was taken to the Oxfordshire Health and Wellbeing Board on 6 October 2022.
	The Leys - Blackbird Leys and Northfield Brook combined (Oxford City)	
2.	Banbury Grimsbury and Hightown (Cherwell)	These were published in March 2023 and a report on the findings was presented to the Health and Wellbeing Board on 29 June 2023. *The Banbury Neithrop and Ruscote combined profile includes a refreshed profile for Ruscote from an original proof of concept.
	Banbury Cross and Neithrop and Banbury Ruscote – combined profile (Cherwell)*	
	Barton (Oxford City)	
	Rose Hill (Oxford City)	
3.	Littlemore (Oxford)	These were published in December 2023 and a report on the findings was presented to the Health and Wellbeing Board on 14 March 2024.
	A bespoke area of Central Oxford (referred to as the Oxford Central Community Insight area)	
4.	Berinsfield (South Oxfordshire)	The Berinsfield CIP was published in September 2024 and a report on findings was presented to the Health Improvement Board in September 2024. The Wood Farm and Witney Central CIPs were presented to the Health and Wellbeing Board in March 2025. The Bicester West CIP is due to be published at the end of June 2025.
	Wood Farm (Oxford City)	
	A bespoke area of Witney referred to as the Witney Central Community Insight area (West Oxfordshire)	
	Bicester West (Cherwell)	

The Community Health Development Officer (CHDO) programme

12. For longer term sustainability of this in-depth community work, Oxfordshire County Council have funded the city and district councils to host a Community Health Development Officer (CHDO) post to cover each of the profiled areas. The City and District Councils have been able to take an approach that works best for them in terms of how the posts are recruited to and how they proportion the hours. CHDO's started at different times and where a profile was already produced, they started by supporting the delivery of the recommendations identified. In the areas where the profile was still underway, they were able to support with community engagement in the creation of the profile as well as the delivery of the recommendations once completed.

13. Community Health Development Officers have an important role of working with community partners to deliver actions arising from the recommendations set out in the community insight profile reports, making the most of and building on community assets. They take a community-based approach to encourage collaborative work within communities, communicate health messages that support health and wellbeing, and facilitate health enabling activities to build social capacity and resilience in local communities.

14. The aim of a CHDO role is to:

    14.1 Support effective working between statutory services (such as local authorities and health services) and the voluntary and community sector to discover, develop and deliver a response to the locally identified need highlighted in the community profiles (and in some areas to help produce them).
    14.2 Enable the involvement of key partners, stakeholders and each local community in the delivery of the action plan in each area, usually through a Health and Wellbeing Partnership within the local area.
    14.3 Contribute to the network of Community Health Development Officer roles to test and learn from the programme, share good practice and provide mutual support. Reducing inequalities, strengthening community assets and giving communities a voice.

15. Some of the specific tasks they undertake include:

    15.1 Supporting the implementation of the Community Insight Profile recommendations through local action planning.
    15.2 Organising and convening local partnership meetings and health promotion activities.
    15.3 Building capacity among local organisations and residents, connecting local organisations and encouraging joint working.
    15.4 Facilitating access to grant funding for community-led health initiatives.
    15.5 Raising awareness of public health services and local health and wellbeing activities

Contributing to Oxfordshire as a Marmot Place

16. The CHDO's have become an invaluable resource in their communities, supporting with many activities and being able to cascade messages and share information with local communities. The CHDOs engage with a wide range of partners within the local communities where they work. This type of work is a fundamental enabler for the delivery of the Marmot Place programme as it supports with direct engagement with partners and communities in the areas that are most likely to experience health inequalities in Oxfordshire. The Marmot approach to tackling the social determinants of health has a strong link to this community-based working and the work of the CHDO's will complement the aims of the Oxfordshire Marmot programme.

17. In March 2025, Sir Michael Marmot visited Oxfordshire for the first Oxfordshire Marmot Place Advisory Board meeting. As the CHDO's play such an important role in addressing inequalities at a hyper-local level, a session was set up for Sir Michael to meet with the CHDO's. The CHDO's were able to discuss and reflect with Sir Michael on some of the challenges and opportunities that they encounter through their roles.

Impact in the Community and links to Health Improvement Board Priorities

18. In the table below, Community Health Development Officers have shared some examples of which CHDO activities have worked well, how they link to primary/community health services and how they support the Health Improvement Board (HIB) priorities in each area. All areas for phases one to three of the Community Insight Profile programme have been included, as well as an overview of Berinsfield as this one was of the earliest CHDO's to be in position for phase four. The work shared by the CHDO's below are examples of ways that they are working with local communities and partners rather than an exhaustive list. Further details of CHDO activities are captured in newsletters which are produced three times a year.

Barton
1. **Which CHDO initiatives have worked well?** • Community Outreach: Partnered with Aspire, Stop for Life OXON, Community Dental Services, and Alzheimer's Society for Larder roadshows. • Partnership Meetings: Quarterly Health & Wellbeing Partnership meetings grew 300% in attendance since March 2024, reflecting strong local engagement. • Community Collaboration: Supported local association with volunteer coordination, training needs assessments, and initiatives like the revived newsletter, 'Big Buffet', and recipe card trials. • Local Presence: Built trust through consistent visibility, enabling effective word-of-mouth promotion, especially among older and digitally excluded residents. **2. How CHDOs link with primary/community health services?**

- Joint Events: Co-hosted health promotion events with the OX3 PCN in Wood Farm and Barton. A variety of health partners were invited to showcase the service they provide to the local community – it includes some on-site provision e.g. blood pressure checks as well as signposting to other services.
- Information Sharing: Regular updates and occasional joint drop-ins with social prescribers.
- Partnership Engagement: Engagement with the Barton Health & Wellbeing Partnership strengthened social prescribing outcomes through increased service awareness.

3. How the CHDO work supports the HIB priorities?

- Tobacco & Alcohol: Promoted Very Brief Advice training and DrinkCoach toolkit.
- Mental Wellbeing: Funded 'Hear4You' listening service—70+ hours of support for 13 residents.
- Healthy Weight & Activity: Recipe cards, community picnics, Barton Growers allotment project, and gentle dance sessions.

The Leys (Blackbird Leys and Northfield Brook)

1. Which CHDO initiatives have worked well?

- Collaboration between Blackbird Leys Adventure Playground (BLAP -who provide afterschool and holiday programmes for children aged 8-13) and WEmpowered (Women Empowered) who focus on empowering women and their children through exercise and social brunches). Funding from CHDO operational budget was also offered to support continuation of the family sessions including a family Saturday session where they will rent the space from BLAP for a 'Mom's Brunch'. This will benefit both groups in term of finance and a positive working relationship.
- Body Mind Soul Community Interest Company (CIC) supported to launch walking netball and mentoring sessions. Body Mind Soul CIC delivers wellbeing and mindfulness sessions to the local community. Their aim is to support those who have experienced trauma, loneliness, health problems and anxiety at the grassroots level.

2. How CHDOs link with primary/community health services?

- Acting as the link to community-based health and wellbeing activities and supporting Primary Care Network priorities e.g. focus groups with parents around uptake of the HPV vaccine and cervical screening.
- Working with the Integrated Neighbourhood Team (INT) for the Leys to try and secure some space for the mental health youth workers, that could also be used as a co-location space for the INT, Oxford City Council and other partners to increase partnership working in The Leys.
- A meeting between the Social Prescribers for the SEOxHA Primary Care Network (PCN) and the Leys CHDO happens every six weeks. In this meeting we discuss opportunities for patients, future projects and any support that the Social Prescribers may need. This is a really worthwhile meeting as it keeps everyone in the loop with the latest activities happening in the Leys.
- Coordinating annual local health promotion events in collaboration with the local PCN and wider health partners such as public health commissioned services. Local residents can access information and support from a variety of service providers at the event.

3. How the CHDO work supports the HIB priorities?

- Mental Wellbeing: Supporting local organisations that run activities aimed at improving mental wellbeing e.g. Body Mind Soul Community Interest Company (CIC) with their walking netball and youth mentoring sessions.
- Healthy Weight & Physical Activity: Funding exercise sessions, swimming and walking netball. A particular highlight is supporting WEmpowered to run a parent and child exercise class to combat the childcare barrier that disproportionately affects women's ability to exercise.

Abingdon Caldecott

1. Which CHDO initiatives have worked well?

- Nature trail promotion and community walking groups.
- Caldecott Collaboration Day (in partnership with the Well Together programme) and a relaunch of the South Abingdon Partnership.
- Easter holiday activities and Makespace community arts session.
- Asset-based community development training and plans for collaboration with Abingdon Carousel.
- Cooking classes promoting healthy eating.

2. How CHDOs link with primary/community health services?

- Networking with social prescribers, NHS Talking Therapies, and mental health charities like Abingdon Bridge and Oxfordshire Mind.

3. How the CHDO work supports the HIB priorities?

- Tobacco and Alcohol: Has attended Very Brief Advice training and toolkit dissemination.
- Mental Wellbeing: Funding and support for mental health groups and services.
- Healthy Weight & Physical Activity: Promoting activities such as walking groups and the Maximus healthy weight service. Planning to explore opportunities for future cooking sessions.

Rose Hill and Littlemore

1. Which CHDO initiatives have worked well?

- Rose Hill Low Carbon group partnered with local organisations for nature walks and education funded partly through the CHDO operational budget.
- Littlemore-The Stacey & Tracey Community Slow Cooking Course expanded and partnered with a local allotment.
- Intergenerational lunches – linking with Age UK Oxfordshire

2. How CHDOs link with primary/community health services?

- Strong relationships with Leys Health Centre and social prescribers.
- Health Promotion events in collaboration with social prescribers and local health partners. These often prove very popular with both providers and local residents. Those attending can receive information and can be signposted to services that support their health and wellbeing.
- Participation in local community partnership meetings to align priorities.

3. How the CHDO work supports the HIB priorities?

- Tobacco and Alcohol: promotion of support services is integrated into community meetings and events.
- Mental Wellbeing: Activities to reduce isolation and promote inclusion.

- Healthy Weight & Physical Activity: Cooking courses and nature-based activities.

Central Oxford

1. Which CHDO initiatives have worked well?

- Establishment of the Hinksey Park Community Food Larder in January 2025, serving 45 members weekly.

2. How CHDOs link with primary/community health services?

- Coordinating annual health promotion events in collaboration with wider health partners such as public health commissioned services.
- Still working on engagement with the local Primary Care Network and health inequalities lead for the area.

3. How the CHDO work supports the HIB priorities?

- Mental Wellbeing: Addressing food insecurity and community cohesion.
- Healthy Weight & Physical Activity: Access to healthy, affordable food through establishment of the larder.

Banbury Ruscote, Neithrop and Grimsbury

1. Which CHDO initiatives have worked well?

- The Hill and Community Album singing projects.
- St Joseph's School Allotment and sensory garden.
- Little Seeds Music project and upcoming songwriting initiative.
- These and other projects have been sustained through feedback, evaluations, and additional funding.

2. How CHDOs link with primary/community health services?

- Partnerships with Oxfordshire Mind for wellbeing workshops.
- Engagement with local Integrated Neighbourhood Teams (INTs) and Communities of Practice.

3. How the CHDO work supports the HIB priorities?

- Tobacco and Alcohol: Life Education Wessex workshops and Stop for Life participation at events.
- Mental Wellbeing: Funded projects targeting mental health through education and support.
- Healthy Weight & Physical Activity: Collaborations with Cherwell District Council activators, cooking sessions, and nutrition education.

Berinsfield

1. Which CHDO initiatives have worked well?

- Supporting the setup of bi-weekly drop-in sessions by Turning Point (from June 2025).
- Riverside Counselling resumed drop-in sessions.
- Men's Sheds pilot workshops, SEND movie sessions, and a pre-school sensory room funded by the Health and Wellbeing grant.
- Berry Youth Centre expanded youth engagement during school holidays.
- Energy Champion Scheme to address fuel poverty and mental health issues.
- Additional SEND play equipment and Alternative Provision via Abingdon Gymnastics Club.

2. How CHDOs link with primary/community health services?

- Collaboration with Berinsfield Health Centre for Stop for Life clinics and cervical screening uptake

- Engagement with Abingdon & District Primary Care Network (PCN) Health Inequalities Lead to co-produce over 60's health service provision
- Social prescribers regularly participate in the Berinsfield Health and Wellbeing Working Group led by CHDO
- Working with The Abingdon Bridge to assess youth mental health needs and provide services accordingly
- Attend Patient Participation Group (PPG) meetings and Communities of Practice

3. How the CHDO work supports the HIB priorities?

- Tobacco and Alcohol: Supporting the setup of clinics and drop-ins for cessation support.
- Mental Wellbeing: Several initiatives have been funded, including funding for resumption of counselling drop-in sessions, youth engagement, and community-based mental health activities.
- Healthy Weight & Physical Activity: Sports programmes, outdoor activities, and inclusive play facilities
- Participation in local community partnership meetings to align priorities.

Evaluation of the Community Health Development Officer Programme

19. Linking to the Community Insight Profiles and the CHDO programme, the NHS Integrated Care Board (ICB) has dovetailed with this work by directly funding a programme called 'Well Together'. This is a grants programme which recognises the essential role community and voluntary organisations play in addressing health inequalities at a local level. The programme has invested in community-led health and wellbeing activities and projects by providing funding and support for new and existing groups and organisations in the 10 areas in Oxfordshire most likely to experience inequalities. These are the areas in phases one to three of the community insight profile programme.

20. The CHDO and ICB funded Well Together programmes in these 10 areas are being jointly evaluated by the University of Oxford as part of the Oxfordshire Health Humanities Project. The first phase of the evaluation took place between January to December 2024 through an applied mixed-methods approach, including interviews, focus groups, and fieldwork. This phase focussed on an evaluation of the roles within each programme and the processes involved with setting up the grant schemes. A second phase is now under way and due to be completed in March 2026 which will go into greater depth around the value of longer-term investment in this type of approach and the impact of the programmes that have been grant funded and facilitated by the roles.

21. The key findings from the evaluation highlighted that:

    21.1 The CHDO and Well Together programmes *'demonstrably fulfilled their objectives in terms of distribution of grant funding as well as widespread and sustained engagement with community groups'.*

21.2 Local and social relationships are important in improving access to existing health assets by tackling indifference or distrust.

21.3 The CHDO and Well Together programmes *'are crucial in linking residents to existing medical and health provision in the wards, as well as ensuring that key health infrastructure is accessible and trusted.'*

21.4 CHDO and Well Together staff play a crucial role in community engagement and partnerships with existing networks and groups. The researchers found that the individual CHDO's and Well Together staff *'are particular strengths of each programme, able to effectively engage with local communities through regular presence in community activities; excellent communication and networking skills; and active partnerships with existing organisations and networks*.'

21.5 Rather than novelty or parachute projects, there should be a focus on long-term 'rooted' projects. Researchers highlighted that it is important to have an awareness that *'Policy-makers have short-term recall but communities have long-term memory'*.

Corporate Policies and Priorities

22. The CHDO programme builds on the Oxfordshire Health and Wellbeing Strategy which identified action on health inequalities as one of the three cross cutting principles that spans across all priority areas for action. The Strategy's 10 priorities span across four thematic area, the first three being stages of the life course, with the fourth the Building Blocks of Health. This final theme describes the social determinants of health that are the structural drivers of much of the inequality we see locally.

Financial Implications

23. There are no direct funding implications from this report. The work areas described have been funded by the Public Health grant and the NHS BOB ICB.

Comments checked by:

Emma Percival, Assistant Finance Business Partner,
emma.percival@oxfordshire.gov.uk

Legal Implications

24. The powers and duties of the Council to engage in the activities set out in this report are covered by the Health and Social Care Act 2012 ("the Act"). The Council has a statutory duty to take such steps as it considers appropriate for

improving the health of the people in its area (s12 of the Act). In addition, s31 of the Act requires the Council to have regard to the Government's public health outcomes framework setting out the Government's goals for improving and protecting the nation's health and for narrowing health inequalities through improving the health of the poorest, fastest.

Comments checked by:
Jonathan Pool Solicitor (Contracts) jonathan.pool@oxfordshire.gov.uk

Staff Implications

25. Oxfordshire County Council officers are working on the delivery and implementation of the Community Health Development Officer programme alongside colleagues from partner organisations.

Equality & Inclusion Implications

26. The Community Health Development Officer programme of work seeks to help to address inequalities. A formal Equality Impact Assessment is not required.

Sustainability Implications

27. There are no sustainability implications to note with this report.

Risk Management

28. A detailed risk assessment is not required for this work.

Consultations

29. Public Consultation is not required for this report, however extensive engagement has been undertaken with communities in areas where a community insight profile has been produced.

Ansaf Azhar, Director of Public Health and Communities, **Oxfordshire County Council.**

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Fiona.ruck@oxfordshire.gov.uk

Acknowledgements:

Thank you to our colleagues below for their valuable contributions to the report:

- Community Health Development Officers (CHDO's) at Oxford City Council, Vale of White Horse District Council, South Oxfordshire District Council and Cherwell District Council.
- Professor Erica Charters – Faculty of History, University of Oxford.

June 2025

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Oxfordshire Health Improvement Board
3 July 2025

Local Area Coordination in Oxfordshire

Report by Karen Fuller, Director of Adult Social Services

RECOMMENDATION

1. **The Health Improvement Board is RECOMMENDED to**

    1. Note the important role that Local Area Coordinators (LACs) play in supporting prevention initiatives and building connected communities, and their contribution to the Oxfordshire Health Improvement Board priorities.

    2. Champion the work of the LACs to support them to continue to work in their respective areas.

Executive Summary

2. Oxfordshire County Council has funded Local Area Coordinator (LAC) posts in four areas each with a c10k population, initially where Census and other data suggested poorer health, wellbeing and life outcomes for residents, but not in the ten most deprived wards.

3. The LAC approach is a valuable component of Oxfordshire County Council's Oxfordshire Way vision to support people in, and build stronger, communities; and supports the Marmot Place programme to enable strong connections to be made with communities most likely to experience health inequalities, supporting families to give children the best start in life, and better understand rural inequalities beyond the ten most deprived wards.

4. LACs are present and accessible in their communities and impose no referral procedures, needs thresholds or time limits. Anyone can introduce themselves or another person to the LAC to receive the right support at the right time for them and at their own pace. LACs guide people to use their own strengths and connect with their community to resolve their issues, gaining confidence and resilience in the process.

5. The outcomes for health and social care are the avoidance, delay and reduction of need for formal services and reduction in 'revolving door' and crisis contacts.

6. The LAC approach in Oxfordshire is being evaluated by Public Health and the University of Oxford. The first phase of the evaluation has just begun with a framework having been developed and the first phase – process review – is

beginning with a desk review of local and national programme documents and interviews of key stakeholders. This is due to be completed in March 2026.

The Local Area Coordination approach

Background to the Local Area Coordination approach

7. Local Area Coordination is a neighbourhood-based, asset- and strengths-focused approach that is accessible, relational, and capacity-building, while remaining connected to the statutory system, offering insight and enabling the prevention, reduction, or delay of unnecessary statutory service demand.

8. Oxfordshire County Council joined the Local Area Coordination Network in 2023. This is a national development organisation helping councils in England and Wales to adopt, embed and sustainably deliver Local Area Coordination, which originated in Western Australia as a new approach to working with people, families and communities.

9. A leadership group was established, comprising members from the county council's commissioning, social care and public health teams, city and district council wellbeing teams, voluntary organisations and primary healthcare.

10. The leadership group used data from Census 2021, the Joint Strategic Needs Assessment for Oxfordshire and Community Insight Profiles (where available) to identify areas in Oxfordshire meeting the following criteria:

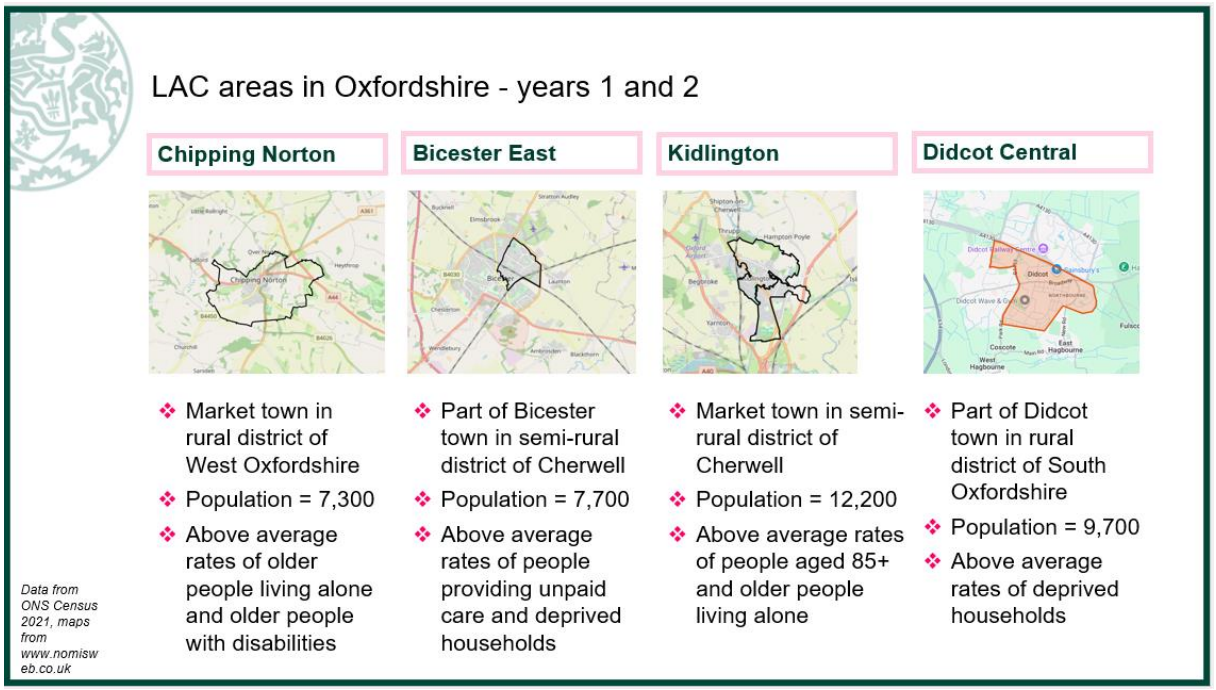
    11.1 A town / area of a town / village / built up population surrounded by rural area with a population of 10-12k
    11.2 Not one of the ten most deprived areas
    11.3 Data indicated poorer health, wellbeing and life outcomes for residents

11. Two areas were identified by the leadership group to start embedding the approach – Chipping Norton and Bicester East. District council colleagues helped identify residents, local councillors and organisations working in the areas, who were invited to local meetings to learn more about the approach and to be involved in its implementation. This allowed local groups and organisations within the communities to gain a detailed understanding of the LAC approach, suggest how it could embed into their area and become part of the implementation.

12. During the recruitment process for the Local Area Coordinators, long-listed candidates were invited to a community recruitment event in the respective areas they had applied to work. The candidates were each interviewed by residents employing a method akin to speed dating, and were scored on soft skills such as approachability, ability to listen and whether people would feel comfortable discussing a sensitive issue with them. The combined scores and comments from the community recruitment were used as part of the overall decision. Involvement in the community recruitment gave residents ownership of the Local Area Coordinator approach for their area, and provided the LAC

with a network of people and organisations to assist them embed into and learn about the community in depth once they started working there.

13. The first two LACs began working in summer 2024 and the leadership team then followed the same processes to identify two further areas – Kidlington and Didcot Central – and recruit two further LACs. The Kidlington LAC started in April 2025 and Didcot Central's LAC starts at the beginning of July 2025.



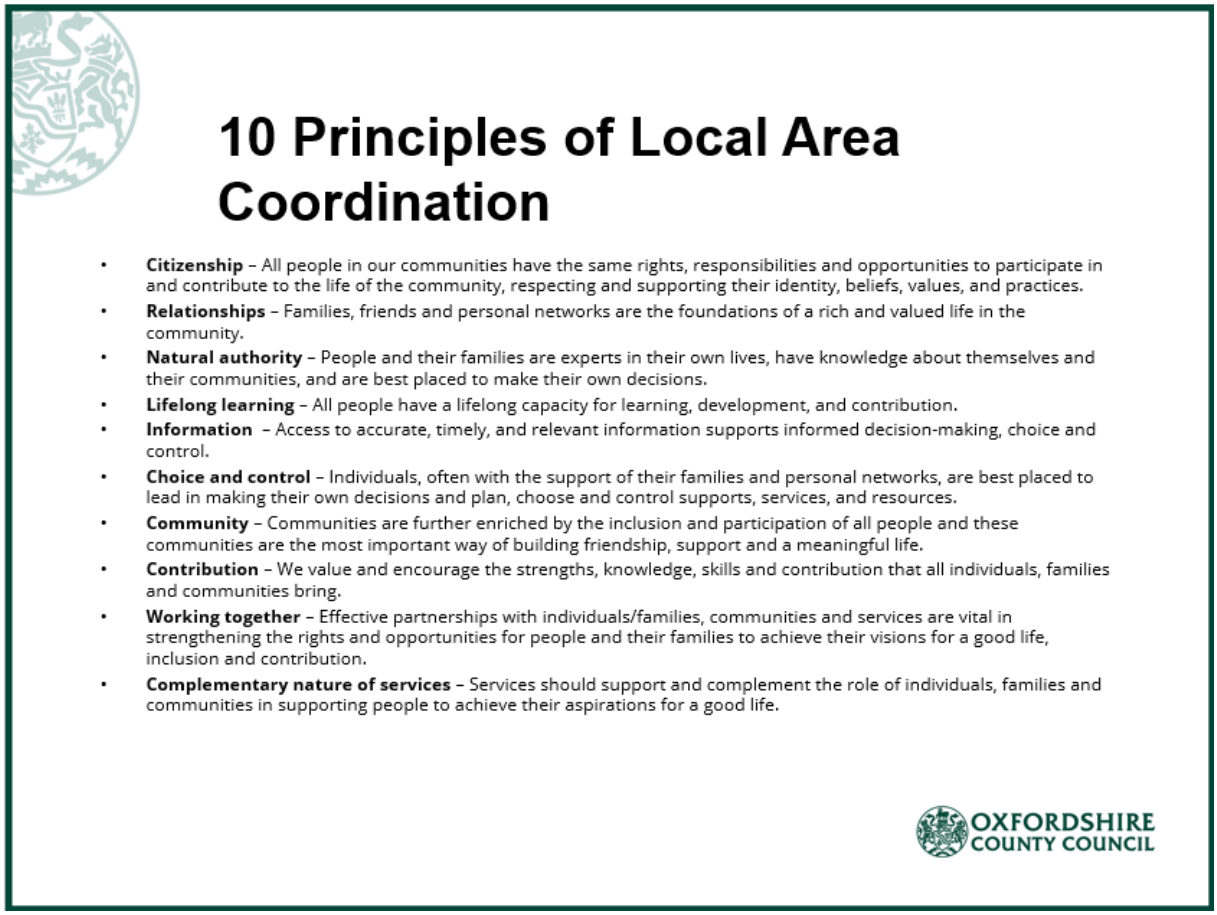
The Local Area Coordination (LAC) approach

14. The Local Area Coordination approach in Oxfordshire aims to foster community resilience and independence by connecting people with local resources and support networks. The approach works closely with local communities to understand their unique needs and strengths. By collaborating with various stakeholders, including council teams, voluntary organisations, and healthcare providers, it seeks to create a supportive environment where residents can thrive.

15. One of the key aspects of this approach is the involvement of the community in the recruitment and integration of Local Area Coordinators (LACs). By engaging residents in the selection process and incorporating their feedback, the program ensures that the LACs are well-suited to address the specific needs of each area. This community-driven method not only empowers residents but also helps build trust and rapport between the LACs and the communities they serve.

16. As the program expands, the leadership team continues to use data-driven insights to identify new areas for implementation. The success of the initial phase in Chipping Norton and Bicester East has paved the way for further growth, with Kidlington and Didcot Central being the next areas to benefit from Local Area Coordination. By maintaining a strong focus on collaboration and community engagement, Oxfordshire County Council aims to create sustainable, long-term improvements in health and wellbeing across the county.

17. The Local Area Coordinators follow an evidence-based design approach and methodology grounded in a set of principles rather than service pathways and targeted outcomes.



18. The majority of the time in the role is spent alongside people and families who are often experiencing some form of exclusion and complex challenges in their lives. The Local Area Coordination role includes:

19.1 Helping people access personalised information and short-term support in their local area.

19.2 Developing longer-term relationships with people/families facing more complex life situations (Local Area Coordinators dedicate time to helping people recognise their strengths, explore options, make choices, plan for the future, and develop sustainable solutions)

19.3 Cultivating strong partnerships with community members, groups, agencies, and services to support local community 'capacity building' and closer collaboration.

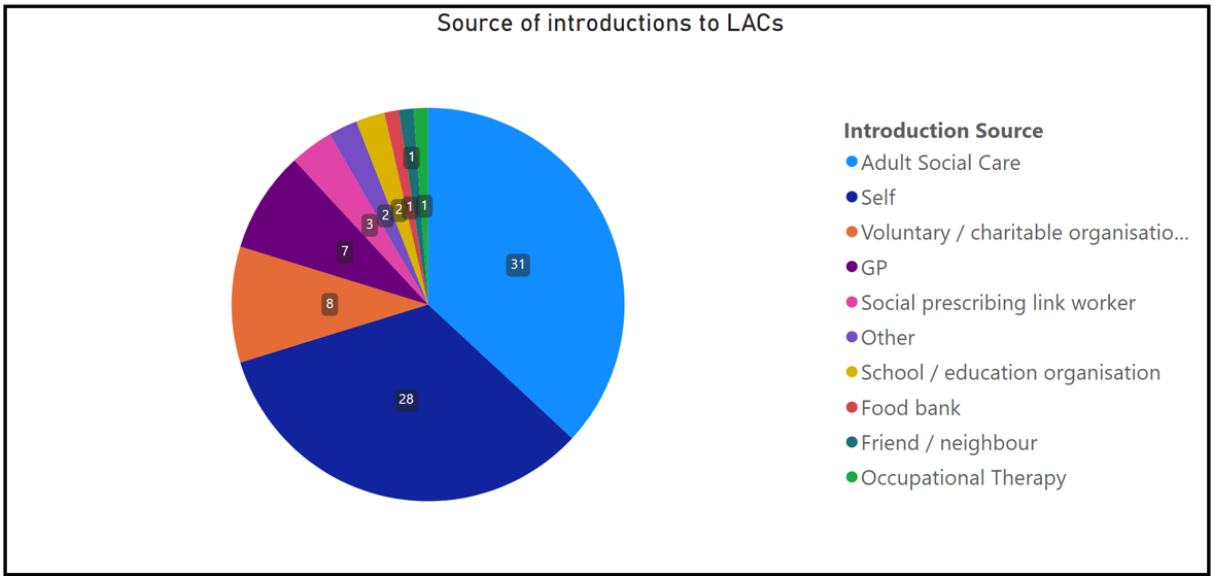
19.4 Collecting stories and information to drive transformative changes in the wider health and social care system, showcasing how the Local Area Coordination approach and principles can reduce the need for statutory / funded supports, and commissioned services.

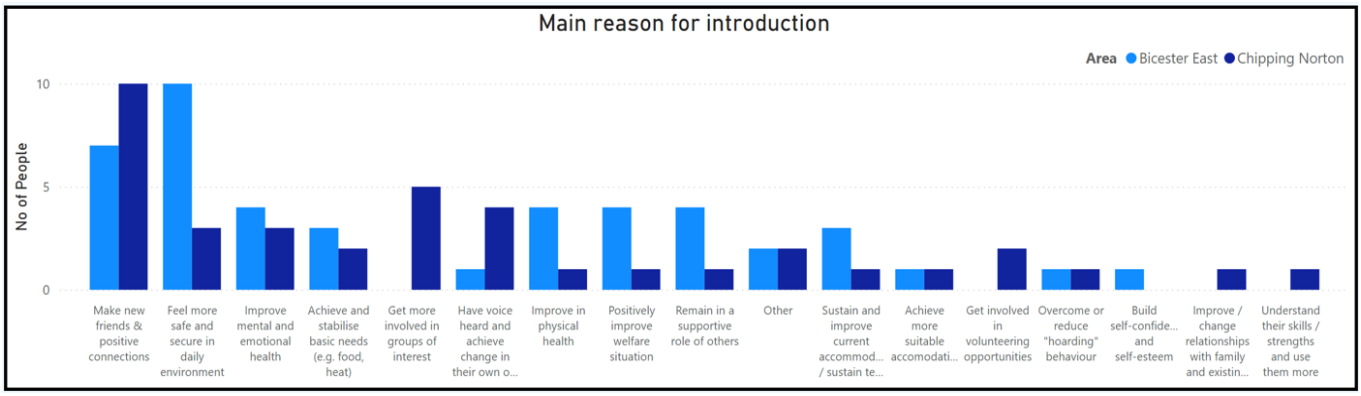
Supporting Oxfordshire as a Marmot Place

19. The role of Local Area Coordinators supports the delivery of the Marmot Place programme as it works directly with residents, partners and communities in areas that are most likely to experience health inequalities in Oxfordshire.

Impact in the Community and links to Health Improvement Board Priorities

20. Data emerging from Chipping Norton and Bicester East where Local Area Coordinators have been working for about a year show that introductions to the LACs are coming from sources across a broad spectrum of partners as well as people themselves and the community. There is also a broad range of reasons for making the introduction.





21. A story which illustrates the Local Area Coordination approach and how working at the person's own pace, building a relationship and guiding them to resolve their own issues improves outcomes for people; also, that by having in-depth knowledge of local services and community assets, LACs help connect people into their community:

    A woman (LS) was introduced to the Chipping Norton LAC by a voluntary organisation that was helping her with finances. Through spending time with LS, the LAC learned that having been abused by her father she had later been abused by subsequent partners and had ended up estranged from family and friends, in poor physical and mental health and, when her partner died, discovered he had taken out debts in her name. She was further feeling judged and dictated to by those who were helping her. Through taking time and encouraging LS to come up with her own solutions, the LAC facilitated LS stopping smoking, attending a domestic abuse course and gaining confidence to attend community groups. Through those groups she gained friends and skills, including IT skills. Just as life had improved for LS, she was hospitalised following a stroke. The new friends she had made visited her in hospital, cared for her dog and then provided a support network to assist her at home after discharge. She is now concentrating on getting better and planning to volunteer as a befriender once she is stronger.

Evaluation of Local Area Coordination in Oxfordshire

22. Local Area Coordination is a nationally evaluated approach (NIHR-funded research project carried out by the Universities of Sheffield, Hull, Exeter, York and Leeds 6037030615-Hull-University-4pp-A4-Report-Print-Version-St5.pdf).

23. The LAC approach in Oxfordshire is being evaluated by Public Health and the University of Oxford. The first phase of the evaluation has just begun with a framework having been developed and the first phase – process review – is beginning with a desk review of local and national programme documents and interviews of key stakeholders. This is due to be completed in March 2026.

Phase 1 – deliverables and activities

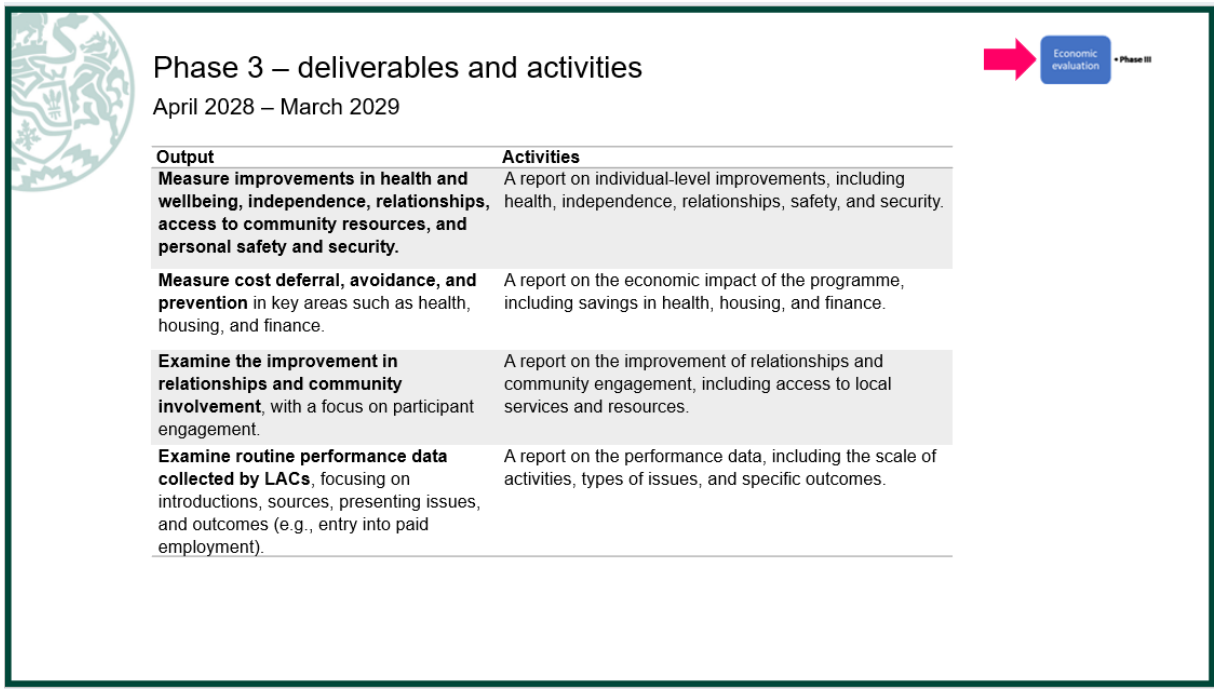
June 2025 to March 2026

Output	Activities
A detailed contextual analysis highlighting key enablers and barriers.	Desk review of programme documents Interviews with key stakeholders Environmental and situational analysis
A refined set of programme goals, ensuring they are specific, measurable, and achievable.	Review of original programme objectives Stakeholder consultations to validate goals Alignment check with community needs
Recommendations for programme enhancements in structure, resources, and engagement strategies.	Process evaluation to compare planned vs. actual implementation Surveys and feedback sessions with participants Gap analysis of resources and service delivery
A lessons-learned report outlining adaptive strategies and best practices.	Case study documentation of challenges faced Key informant interviews on adaptive responses Recommendations for risk mitigation
A stakeholder engagement framework with improved communication and coordination strategies.	Stakeholder mapping and relationship analysis Workshops on best practices for collaboration Creation of a stakeholder communication plan

Phase 2 – deliverables and activities

April 2026 – March 2028

Output	Activities
A comprehensive stakeholder feedback report identifying strengths, weaknesses, and areas for improvement.	Surveys and interviews with key stakeholders (families, staff, local authorities). Focus groups to assess satisfaction and challenges.
A comparative analysis report highlighting similarities, differences, and lessons learned.	Comparative data collection (programme design, implementation process, stakeholder engagement). Benchmarking with other LAC programs.
A summary report on peer learning, key insights, and best practices.	Engage Tom Richards for knowledge sharing. Document lessons from other LAC programs.
An early outcomes report assessing the impact of the LAC programs.	Collect and analyse data on early outcomes (e.g., participant satisfaction, improved outcomes for individuals and families). Identify common patterns in outcomes across the programmes.



Phase 3 – deliverables and activities

April 2028 – March 2029

Output	Activities
Measure improvements in health and wellbeing, independence, relationships, access to community resources, and personal safety and security.	A report on individual-level improvements, including health, independence, relationships, safety, and security.
Measure cost deferral, avoidance, and prevention in key areas such as health, housing, and finance.	A report on the economic impact of the programme, including savings in health, housing, and finance.
Examine the improvement in relationships and community involvement, with a focus on participant engagement.	A report on the improvement of relationships and community engagement, including access to local services and resources.
Examine routine performance data collected by LACs, focusing on introductions, sources, presenting issues, and outcomes (e.g., entry into paid employment).	A report on the performance data, including the scale of activities, types of issues, and specific outcomes.

24. A recent informal survey of residents and organisations asking for feedback about Local Area Coordination in the town returned overwhelmingly positive comments including 'there are lots of good projects going on but the LAC ties all the threads together'.

Equality & Inclusion Implications

25. The Local Area Coordination approach seeks to help to address inequalities by working with people of all ages or families to help them surmount issues that are important to them.

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June 2025