HEALTH IMPROVEMENT PARTNERSHIP BOARD

OUTCOMES of the meeting held on 19th May 2022 commencing at 14:00

Present: Board members	Cllr Louise Upton, Oxford City Council (Chair) Ansaf Azhar, Director of Public Health, Oxfordshire County Council Dr David Chapman, Clinical Chair, Oxfordshire Clinical Commissioning Group Cllr Merilyn Davies, West Oxon District Council Cllr Maggie Filipova-River, South Oxfordshire District Council (Vice - Chair) Daniella Granito, District Partnership Liaison, Oxford City Council Diane Hedges, Chief Operating Officer, Oxfordshire Clinical Commissioning Group Cllr Mark Lygo, Oxfordshire County Council David Munday, Consultant in Public Health, Oxfordshire County Council (Lead Officer)
In attendance	Rosie Rowe, Head of Healthy Place Shaping, Public Health, Oxfordshire County Council Ruchi Baxi, Consultant Public Health Gemma Harris, Screening and Immunisation Manager Veronica Barry, Senior Community Involvement Officer, Healthwatch Oxfordshire Lizzie Moore, Public Health Registrar, Oxfordshire County Council Paul Brivio, Active Oxfordshire Lee Mason, Active Oxfordshire Cllr Bethia Thomas, Vale of White Horse District Council, on behalf of Cllr Helen Pighills Diane Hedges, Chief Operating Officer, Oxfordshire Clinical Commissioning Group Kate Austin Margaret Melling Amy Booth, Student shadowing David Chapman Cecilia Pyper, Observing as member of the public
Officer:	Beverley Manners, Minute taker, Oxfordshire County Council
Apologies:	Cllr Helen Pighills, Vale of White Horse District Council

Absent: Jonathan Capps, Detective Chief Inspector, Thames Valley Police

ITEM
1. Welcome Cllr Upton welcomed to the meeting:
2. Apologies for Absence and Temporary Appointments West Oxon District Councillor and Cherwell District Councillor appointed yesterday, South Oxon District Councillor to be appointed later today.
3. Declarations of Interest There were none
4. Petitions and Public Address There were none
5. Notice of Any Other Business David Munday – Making every contact count
6. Note of Decisions of Last Meeting The notes of the meeting held on 18th November 2021 were signed off as a true and accurate record.
7. Health Protection Update Ansaf Azhar, Director of Public Health, Covid numbers have drastically reduced and as we come into the summer months the expectation is these will continue to drop. We should be prepared to be living with Covid for the next decade with the figure fluctuating up and down as it does with other respiratory illnesses and our response will need to fluctuate accordingly. It is likely to mutate quite easily although the variants BA.4 and BA.5 did not take off within the UK. We have good systems in place to manage these when this happens. We will continue with the constant monitoring. The majority of the emergency Covid platforms have been stood down, the Covid Health Protection Board, multi agency operational cell and embedded that into business as usual. The surveillance unit is still

running fortnightly although this is probably due to be stood down and incorporated into the wider protection functions. I believe it's very vital to be able to stand things up again very quickly if required.

As we return to more normal living there is an increase in infections particularly in children's settings, such as Scarlet Fever, due to lower immunity but there are established systems in place to manage this. We learned a lot about how we reached into different communities, disadvantaged communities particularly around addressing health inequalities. There's a question about how do we pick up this learning and apply to the other issues that we deal with in public health. If we are not careful, over the next 5 years, we will see the indirect impact of Covid due to the lack of preventative services. The Health and Care partners and particularly Public Health are working really hard to stand up this function because if you don't and we carry on like we have in the last 2 years we will see the impact over the next 5 years. We need to proactively do things to address the backlog, need to learn from the vaccination programme how we reached out to the communities and apply that to things like screening.

We need to keep an eye on excess deaths during the Omicron rise. Noticed that they existed below what we would expect which is an indication of the success of the vaccination programme. We need to be careful that the excess deaths going up in the future are not necessarily because of Covid but due to other causes as a result of the lack of preventative service. A lot of learning that we can incorporate into general public health functions.

8. Performance Report – Effect of COVID 19 (pages 7-10 in the agenda pack)

David Munday referred to the document *Performance Report*

Within our start well indicators we're within target for the metric which is reducing the levels of smoking withing pregnancy, the red arrow is pointing up as there has been a 0.2% fluctuation, this number fluctuates a little every quarter but we are below the 7% target and managing to stay below the 6% which is where we want to be moving towards 5% or lower. The immunisation targets for the mumps, measles and rubella programme is being covered later. There is no new data on childhood obesity as that comes out annually.

The live well indicator 2.16 is about physical inactivity and we have new data on that. Performance has improved but remains above 21%. It's above the target that we've set of 18.6. This is one of the areas referred to earlier by Ansaf, an indirect impact of Covid. Physical activity levels have been adversely impacted because of lockdowns. We have Active Oxfordshire speaking about their physical activity strategy later.

The smoking quitters data is above target, this is monitored quarterly. We will be taking a broader look at tobacco control as a theme at a future HIB meeting later this year. 2.19 and 2.2 no new data but worth noting that we are moving forward with the catch up and standing up of the health check programme both through primary care and other delivery models to ensure that we get the health check work back on track.

Comments/questions:

Veronica Barry – Interested to hear more about the new commissioning cycle for NHS checks and to draw attention to report done by health watch Oxfordshire a few years ago working with male footballers from diverse communities. They had lots to say on where and how NHS health checks could be delivered.
Ansaf Azhar – Really timely question as have just spoken about the indirect effect of Covid and one of the indirect effects is that the programme stopped during that period and we normally do approximately 28000 but only sent out a couple of thousand during the 2 years. We are in the process of commissioning extra provision to address the backlog. We will be looking at how do you reach out to the most disadvantage groups. Welcome input from Veronica Barry as that work is progressed.
David Chapman – Asks the question if there is any research done into vaccine fatigue. With winter coming up hope that we can deliver Covid vaccinations along side flu in order to achieve appropriate levels.
Ansaf Azhar – Some of the latest booster coverage rates, particularly around Covid, show that it hasn't been as great as we have seen in the past, planning a campaign across the country later in the year probably more around winter time, which is when we expect to see rising cases as well as other infections like flu. It is worrying the potential impact on other vaccination and immunisation programmes. For older adults if they have taken up the Covid they are more likely to take a flu vaccination however for children it moves in the other direction, the impact of not having a Covid vaccination is not as significant and not even comparable to not having your MMR vaccination, this is an area that needs to be very carefully navigated and to an extent separate.
Ruchi Baxi – The separation of adulthood and children's immunisations. There is anecdotal suggestion that Covid vaccination has impacted on routine immunisations for children. It is very difficult to unpick because there are so many factors that influence.

9. Screening and Immunisation Performance and Recovery (pages 11-26 in the agenda pack)

Ruchi Baxi and Gemma Harris

Ruchi Baxi.

Slide 3, Section 7A refers to the screening and immunisation programmes as the part of public health commissioned by NHS England and this include 18 immunisation programs across the life course, alongside breast screening, cervical screening as cancer screening programmes, abdominal aortic aneurysm and diabetic eye screening, the adult lung cancer screening programmes. Six until later and the new born screening programmes that happen across the antenatal and new born period.
Slide 5, MMR vaccination programme. The graph on the left shows a national picture and on the right the picture in Oxfordshire. Vaccination in Oxfordshire has recovered to pre pandemic levels but appears to have stabilized at that level. The national picture shows a decline in uptake prior to the pandemic this has been compounded by the pandemic. We see a higher uptake for the first dose of the MMR at 13 months compared to the second dose at 3 years 4 months. Also an issue for another preschool vaccination given at a similar age.

The decline in MMR take up nationally led to the UK loosing WHO measles elimination status in the UK in 2018, we ideally want to see is not take greater than 95% sustainability. NHS England Commission improving immunisation uptake team, a team embedded in South Central and West commissioning support unit, they work closely with GP practices across Oxfordshire and deeper Thames Valley to focus on improving the uptake across the 5 immunisations. There is a particular focus on the 2nd MMR and the four in one, the pre school booster due to them having a lower uptake compared to the infant vaccinations. We are re vamping our plans in order to reduce inequalities and improve access, this is a work in progress to analyse and understand the communities that have a lower uptake and improve that.
Flu vaccination uptake in Oxfordshire is consistently above the national average. A very high uptake in the 65year plus bracket, now 86.4%. Always seeing a lower uptake amongst the under 65's who are in a clinical risk group.
Commend the huge amount of work done by the providers of the vaccination programme in the context of the pandemic.
Completing the evaluation of the flu campaign for 21/22 season and working towards a series of recommendations based to recognise what works and what additional actions can be put in place, this includes targeting the groups who have a lower uptake of the vaccine or are a high risk clinical.

Gemma Harris

Looking at page 19, shows 2 graphs covering the cervical screening in the 2 different age groups. The younger age group are screened every 3 years and the older group every 5 years. Both graphs show that we are sitting below the national target of 80%, we've had a 2% drop in the younger age group and a 1% drop in the older age group. Coverage is a measure of when people have their screen, we are seeing a year on year increase in the number of tests being taken, in the last recorded 12 months we saw an increase of 2000 samples being taken. During the early stages of the pandemic the invitations were slowed down, with the normal invitation process resumed in the summer.
By January 2021 all women were being seen within the national target time frame. 2 weeks for an urgent referral or 6 weeks for a routine referral.
There is a national direct enhanced service which requires the groupings of practices of the primary care networks to be responsible for improving coverage across the cancer screening programmes in the PCN's. Looking to target some work around the lowest performing practices to understand what challenges they may be facing.
Data for 20-21 for breast screening has been suppressed due to Covid. Page 21 show the pre Covid results. The top graph shows the women's attendance and the bottom graph shows if they were invited again within the target timeframe. Oxford performs much better that the South region and nationally and only taken a small dip from pre pandemic levels, this can be attributed to the invitations being sent out have a specific date and time on them. The round length (this is the measure of women being invited within 36 months) has dropped off in both Quarter 1 and Quarter 2. The target is to be offered screening every 3 years. Following a national shortage of mammographers it has been difficult for the programme to get to a point of recovery, as of January this year it has got there at 95%. Screening was taking place on time but this has unfortunately dropped again as staff levels have reduced.
Bowl screening cancer is a good news story, we are above pre pandemic levels for the uptake of screening. The new test is a lot simpler, now only need to take one sample not the previous three. Currently in the process of rolling out age extension of the bowel screening programme. Working backwards from age of 60, with 56 year olds now being

offered screening. Currently doing some work around how we identify certain groups, need to improve the coverage and uptake for some groups. It would really help if we can look at how data is shared with other organisations. Locally we had a national cervical screening campaign that is going to be continued later on in the summer, highlighting the link between HPV and cervical cancer.
One issue we've identified is finding locations for our mobile screening units. We do now have an Inequalities lead now in post who is starting to do that analysis of breaking down and getting more granular data. One issue is the quality of the data and the amount of missing data, for example on ethnicity, we are working to improve this. We have a registrar who can lead in an evaluation of the health on the move van and take forward how they might apply to other programmes.
Recognise the point on co production and the partnership with yourselves and others is fundamental, so that we can work more closely with communities and with people who know the communities better than we do. We do know this work is important and we were doing some of this before the pandemic.

Comments/questions:

Ansaf Azhar. In Oxfordshire we seem to have been impacted more than South and Nationally.
One of the identifiable reasons is that Oxfordshire appear to struggle to hold on to qualified staff, there is a very rigorous training schedule and due to the cost of living in Oxford they quickly move onto areas where the cost of living is lower.
I am a bit concerned when we focus at Oxfordshire level and if you repeat the indicators for some of the most deprived communities and deprived wards you will get a very different picture. It does seem a sensible way to go to talk to GP practices and PCN level. Asks if you can go down to ward levels, community groups space within the data and then the interventions will come from that, then start thinking about things like do I need to engage with the mosques, faith groups, set up an immunisation centre. Need to learn from the Covid vaccination programme and apply to the screening and immunisation. The mobile vaccination van going forward can be expanded to other health things. We have recently launched Oxfordshire Child Inequality Board which has a partnership for both health and let local government in there. It is focusing on 3 areas, cardiovascular disease, maternity vaccinations and immunisations, would be valuable to bring this discussion there.
Cllr Louise Upton. In Oxford City the planning policies that would normally have a big development build with 50% social housing has 100% employment linked social housing on sites at the Churchill and JR hospitals.
David Chapman. One of the most important parts of the flu vaccination programme is immunising children both in school and the 2-3 year olds and yet the adverts don't focus on these groups. Request for more efforts to be made around children's it's the most fundamental part of a flu vaccination programme and has a huge knock on effect to reduce the number of people going into hospitals and attending GP practices and Emergence departments.
Ruchi Baxi. The indirect and direct effects of vaccination, particularly in younger children is really critical and to make sure that we vaccinate as many as possible. The uptake this year is lower than last year but higher than previous years.
Veronica Barry. I was part of the Vaccine Equity Group and was used to reach a number of different groups but this has mixed experiences, in my observations based on lack of coordination and actual real planning, so I'd like to see that those lessons are learned for the future.

Rosie Rowe. This place based approach needs to be linked into a co production with community groups. We know from the work that's being done with Oxford Community Action Group around NHS Health checks that we work with these groups and they engage with their community members the uptake is really good. When people understand what is available, how it will help and what the benefits are they do want to engage.
David Munday. We may need to take away for further discussion, the degree to which it's the same population groups that we need to be engaging with, some populations with cervical screening are less likely to come forward, there's a hesitancy with MMR.

10. Report from Healthwatch Oxfordshire Ambassador (pages 27-30 in the agenda pack)

Veronica Barry went through the paper *Healthwatch Oxfordshire Report to Health Improvement Partnership Board* (page 27 in the agenda pack)

Highlighted peoples experiences of using interpreting services to access Health and Care and still found the need for greater awareness that interpreting was a right and that people were not generally being offered interpreters when accessing health appointments. David Chapman attended a roundtable event and some agreements came out of that, more collaborative working and a collaborative promotion of those opportunities, a focus within OUH, particularly looking at their maternity services within the hospital. The report with Communities First Oxfordshire focused on rural isolation. Funding from Health Education, England and Public Health England, South East enabled an initiative to develop training and support for community researchers. Two researchers came forward, one, Omotunde Coker, who wants to focus on black women's experiences of maternity services and has been instrumental in making a film, with others, to use as a way of speaking to maternity health professionals. The other report from Nagla Ahmed, focused on Sudanese experiences and insights into healthy lifestyle. They have highlighted the lack of culturally appropriate leisure services, in particular, lack of female only gyms and swimming sessions, and also female lifeguards are sometimes overlooked. Culturally and affordable food access was also mentioned.

Comments/questions:

Cllr Upton – the real strength you bring to this forum is that you hear from the people who are not normally heard from.
Rosie Rowe – Thank you for completing the rural isolation and loneliness survey, it's important that we tap into the insight from people in our more rural areas. This links in with the 20 minute neighbourhood tool, an interactive tool that people can use to see what amenities are available within a 20 minute radius. Been developed with the District Planning Department and will flag up with the local planning colleagues so that they are aware.

11. Performance Deep Dive (pages 31-44 in the agenda pack)

Rosie Rowe (page 31 onwards in the agenda pack)

Healthy Place Shaping is a strategic priority for the County and has been since 2019. This paper is still a work in progress however we wanted a view from the HIB in terms of the progress made and the future direction of this work. This will be a phased approach, we will start to incorporate as we generate the data rather than waiting until there is a full set of

indicators. Need to engage and work with the districts and see what data they currently gather.
Margaret Melling – The second annex lists the indicators: built environment, community activation, new models of care, process indicators and wellbeing outcome measures. We are looking to include data to the smallest possible geographical level. We will need to compromise and have some data available at Oxfordshire and district level and some from national surveys. Looking at the possibility of working with national surveys and increase the sample number taken and to see if we can make use of the surveys and consultation work that is currently being carried out. Annex C gives you a indication of how we might represent some of the data we get back. The 20 minute neighbourhood tool will continue to be developed.

Comments/questions

Veronica Barry – Ask if there was an indicator around healthy affordable and accessible food? The 20 minute neighbourhood tool does show access to retail outlets for food but doesn't specify if it's healthy or not.
Cllr Upton – Ask how the indicator, people supported by social prescribing, will be measured? Both the numbers of the link workers in practices and also the number of contacts is currently collected. Work is currently going on nationally to agree a core data set around social prescribing.
Ansaf Azhar – If we can make a case to Health Partners, saying if you invest this much money upstream here, we would actually reduce the demand by this much. I think this is the next stage to take Healthy Place Shaping into.
Looking at the built environment indicator, I can see you've got the fuel poverty, wondering around things like insulation and affordability of housing, how would this feature? These are housing standards, need to identifying if the standards are included in the design codes that the local planning authorities have. From a health and well being aspect we need to look at our current housing stock and how we can improve and retrofit improved insulation. There is currently a pilot programme running called better housing, better health that is doing home visits to try and address housing needs and particularly from an energy crisis and fuel poverty perspective that will help to signpost and enable clients to access grants to improve the insulation in their homes and also link them into health and social care services.

12. Access to Nature Programme (pages 45-62 in the agenda pack)

Lizzie Moore (page 45 in the agenda pack)

There are some real issues for Oxfordshire in terms of the opportunities that people have had for health and well being, access to nature and access to green spaces.

We submitted a paper to the board, introducing the theme of access to greenspace and nature as a new area for public health. It summarises the relevant evidence based in the local context and identified some areas of action where we are likely to have the greatest impact on health inequalities. Sets out some strategic objectives for longer term programme of work and introduces relevant current projects. Finally the paper introduces relevant current projects. The recommendation to the board is to review the programme and hopefully to support this and come back in 9 months to report back. Access to green spaces has been found to be associated with a number of physical and mental health outcomes related to physical and mental health and well being. Most of the research has been focused on mental health but it's also been linked to overall mortality, overall

morbidity, cardiovascular health, increase in and physical activity, core conditioning, children, loneliness and isolation. A review paper by PHE now OHID in 2020 called improving access to greenspace that summarised the mechanism through which access to green space improves health and wellbeing. There is a reasonable amount of evidence that suggests that physical activity that's done in a green space is more beneficial than that done in a gym, through social contact and the community connectedness. The type of activities that people engage in, in a green space helps people develop new skills and capabilities. Nature connection has been shown to have an independent effect on mental health and health and wellbeing, this is now measurable. There's an additional effect of improving access to green space which is an indirect effect of mediating environmental harm, such as air pollution, noise and flooding.

Socioeconomic related health inequalities are lower in communities who haven't the most access to green space, and those from a more deprived backgrounds experience the greatest health gains when engaging in nature based activities and interventions. Access to green spaces – nature based interventions or nature based activities, these tend to be relatively inexpensive compared to healthcare and low resource, they reduce demand for healthcare which is incredibly carbon intensive, they can increase biodiversity and have been shown to increase pro environmental behaviours. The UK's 25 year environment plan recognises that access to nature was important and the importance of green social prescribing. We're 1 year into a cross government programme to test out our better understanding of how green social prescribing can improve health and wellbeing, the UK's Covid 19 mental health and wellbeing recovery action plan mentions that access to green spaces being really important. Oxfordshire has it's 9 priorities and improving access to green space is one of them. Last year there was a mental health and wellbeing needs assessment for Oxfordshire that highlighted access to green spaces as one of four key areas for action. The aim of the public health team is to apply public health principles and healthy place shaping approaches to increase opportunities for those with the greatest health need to spend time in green space and connect with nature in order to improve physical and mental wellbeing and address health inequalities.

General population - We're thinking about ways to increase everyday or incidental contact with nature. People experiencing/at risk of health inequality – Look at targeted ways of reaching these and supporting them through nature based health promotion initiatives. People with defined complex needs – Targeted therapeutic nature based programmes are really helpful for people with established mental health conditions. The groups we really want to target are: young people, particularly girls, people living in areas of deprivation, people from black and minoritized ethnic backgrounds, people experiencing loneliness, isolation, anxiety or depression and people with long term physical or mental health conditions. Programme of work for the next few years is to raise the profile of nature for health and advocate for equitable access, making sure that local planning policy reflects national guidance and best practice in relation to green infrastructure standards, development around asset national level to be led by Natural England, work with stakeholders to raise public awareness or opportunities to participate in nature based activities and to identify and address local and national gaps and data evidence. Hoping to run a pilot green social prescribing project in Cherwell to be evaluated on a formal basis.

Comments/Questions:

Maggie Filipova-Rivers – Request for further examples from other places in the future. This will be part of the Community strategy for South.

Cllr Upton – In Oxford City there is the go outdoors programme and recently changed Lord Mayor and had move with Mayor Mark campaign.
All the districts are engaged and supportive with this. Need to ensure the planning policy is also informed as that is looked at in terms of green space and high quality green space but not necessarily at how to enable and activate people to use the green space.
Need to look at how we connect the green spaces to other key locations in the communities, green spaces will be used if they're easy to get to.
Amy Booth – My research is on environmental sustainability and health systems with focus oh pharmaceutical prescribing so this is an important initiative using nature based solutions and green social prescribing, would be happy to chat about this.

13. Active Oxfordshire – PA Strategy (pages 63-92 in the agenda pack)

Paul Brivio (page 63 in the agenda pack)

The top line of the graph shows we are the most active, that's people doing 5 x 30 mins, we are also the least inactive, that's the people doing less that 0 to 30mins. The red colour on the graph indicates over 105,000 people that are inactive. Before the pandemic the average was about 18% but we are now up to 21%. All of the districts are trying to open their facilities however people haven't come back because they've lost the habit and confidence. The effects of Covid is disproportionately high if you're poor, on a low income, got a disability, got a long term health condition, if you're a woman, if you're disabled, if your old. Need to reach the 95,000 we weren't reaching pre Covid. Young people pre Covid were not meeting Chris Whittey's guidelines of 60 minutes of activity per day. There has been a massive impact on mental health but also obesity levels. This evidence points to the fact that the people that are being most disproportionately impacted are the poorest or the most disadvantaged in our society.
Almost 50% of young people not active enough, 20% of them having mental health issues, a lot of people already below the poverty line. We have big differences in the activity levels between the areas of affluence and deprivation and also around the older population. We have big disparities within 10 minutes of Oxford with children learning to swim and being able to ride a bike.
With the support of Covid funding we're doing some good work to out to the most frail, most isolated and most lonely. FAST has been a massive success in Cherwell, it has been re branded it to You Move and is being spread out across the county. We are going round each of the districts, all of our partners to work out what binds us together and then to work out how we can work together to make a difference to change the system. We need to create a different way of working, if we don't we will continue to get the same results. We need to do more and better and reach the people who are constantly missed out, or not engaged or marginalised or not reached.

Comments/Questions:

Cllr Upton – Physical activity is the most important thing that everybody can do.
Need to promote movement, in your allotment, fitness or support.
Ansaf Azhar – we have great projects like yours and are making good inroads but need to stay active priority in various different settings, there's a definite value in raising the profile of this. Often people are too busy coming out of Covid to focus on physical activity, need to realise the benefits in their own corporate codes within their directorates. Second – Equality, we have the same struggles as we have in terms of inequality with immunisation and

vaccination that we talked about earlier, we need to merge those message together. We have an opportunity to evaluate You Move in a much bigger scale than FAST.
Paul – We need to talk not only to our traditional colleagues in local authority, but also those in planning, different parts of the health service. We need to get out there and talk to people, listen to people and then do more of what works but also think differently and work differently.

14. AOB

Making every contact count

David Munday – this is not a new initiative. A workshop with the member of the Health and Wellbeing Board, which was a combination of training in the techniques and also thinking about how it can be utilised, it's scale and how it could eb implemented in Oxfordshire. Money has been found to help drive forwarded some of that expansion work. It aligns with the prevention agenda and the inequalities agenda. Will bring back to the meeting in September and November what the planned thinking is and the next steps forward.

Future HIB meeting dates 15 September 2022, 17 November 2022